STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245254	A. Building B. Wing	07/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regina Senior Living	1175 Nininger Road Hastings, MN 55033

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow resident to participate in the development and implementation of his or her person-centered plan of care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to offer a care conference during 1 of 3 residents (R1) reviewed for ostomy care. This resulted in R1's inability to participate in his care planning.Findings include:R1's care plan, dated 6/6/25, indicated he required assist of one staff for personal cares. The care plan lacked individualized care for R1's colostomy, as it did not specify the supplies requires or the process to complete the colostomy care.R1's medication administration record (MAR), dated June and July 2025, directed to change ostomy bag two times weekly and as needed for leakage, on Monday and Wednesday evenings.R1's admission Minimum Data Set, dated [DATE], indicated R1 had diagnoses of Crohn's disease (chronic inflammatory bowel disease) and had a colostomy (a surgical procedure that creates an opening in the abdominal wall, bringing a portion of the large intestine to the surface). R1's MDS indicated he was cognitively intact.R1's chart lacked documentation of a care conference.On 7/15/25, at 10:21 a.m., R1 stated he would prefer his colostomy bag be scheduled in the morning. He stated there was only one time that it was changed in the morning. He stated he had never attended a care conference in the 5 1/2 weeks had been at the facility. R1 stated he had several episodes of his colostomy leaking in the first 20 days at the facility. R1 stated he repeatedly asked the facility to use the products he was familiar with, including rings (intended to create a secure and comfortable seal between an ostomy pouch and the skin around the stoma, to prevent leakage) and wings (small flexible pieces of hydrocolloid adhesive that attach to the edges of an ostomy skin barrier to provide extra security and prevent leaks). R1 stated the facility started providing the requested supplies on 6/25/25. R1 stated his colostomy has had fewer incidents of leaking since the facility has provided the supplies he needed.On 7/15/25, at 1:32 p.m., licensed practical nurse (LPN)-A stated there was not a care conference documented in R1's chart.On 7/15/25, at 3:01 p.m., the director of nursing (DON) stated she was not aware if R1 had a care conference.A facility document, Comprehensive Assessments and Care Planning, dated 2017, directed the residents and resident representatives will be involved in the comprehensive person-centered care planning. If participation of resident and representative in development of plan not practicable explanation must be in resident's medical record.A facility document, Resident Rights and Notification of Resident Rights, 2017 directed Resident Rights include: Planning and Implementing Care.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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	245254	A. Building B. Wing	07/15/2025

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Regina Senior Living	1175 Nininger Road Hastings, MN 55033

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to develop and implement a comprehensive, individualized care plan for 1 of 3 residents (R1) reviewed for ostomy care. The facility failed to have a process in place to instruct staff on physician ordered ostomy care. This resulted in R1's colostomy bag leaking on multiple occasions and emotional distress for R1.Findings include: R1's care plan, dated 6/6/25, indicated he required assist of one staff for personal cares. The care plan lacked individualized care for R1's colostomy, as it did not specify the supplies requires or the process to complete the colostomy care.R1's medication administration record (MAR), dated June and July 2025, directed to change ostomy bag two times weekly and as needed for leakage, on Monday and Wednesday evenings.R1's bowel assessment, dated 6/8/25, failed to appropriately assess his ostomy site with measurements and description.R1's admission Minimum Data Set, dated [DATE], indicated R1 had diagnoses of Crohn's disease (chronic inflammatory bowel disease) and had a colostomy (a surgical procedure that creates an opening in the abdominal wall, bringing a portion of the large intestine to the surface). R1's MDS indicated he was cognitively intact.A progress note, on 6/11/25, indicated colostomy bag was changed. [NAME] brand used and cut to measure to size of stoma. Skin surrounding stoma is clean, intact and free of breakdown/maceration. No redness, foul odor or signs/symptoms of infection. A progress note, on 6/25/25, indicated colostomy bag and appliance changed. Area is red and macerated around appliance. Skin barrier applied. Patient denies pain but voices that this is not typical appliance he uses at home. Facility will order device familiar to patient.A progress note, on 6/25/25, indicated R1 was up the majority of the night dealing with his colostomy bag. R1 was in clear emotional distress. He reported to writer that he is traumatized and devastated and began to become tearful stating he got no sleep. The progress note indicated he was very upset and stated, I should just put a shotgun to my head and making comments he did not want to be alive anymore. On 7/15/25, at 10:21 a.m., R1 stated he had several episodes of his colostomy leaking in the first 20 days at the facility. R1 stated he repeatedly asked the facility to use the products he was familiar with, including rings (intended to create a secure and comfortable seal between an ostomy pouch and the skin around the stoma, to prevent leakage) and wings (small flexible pieces of hydrocolloid adhesive that attach to the edges of an ostomy skin barrier to provide extra security and prevent leaks). R1 stated the facility started providing the requested supplies, after he became suicidal due to lack of sleep, from the colostomy leaking four times on 6/25/25. R1 stated his colostomy has had fewer incidents of leaking since the facility has provided the supplies he needed. On 7/15/25, at 1:14 p.m., licensed practical nurse (LPN)-B stated R1's colostomy bag changes required the use of skin prep (creates a protective barrier) and the supplies located in his room. She stated the orders in his chart indicated frequency of scheduled colostomy changes. On 7/15/25, at 1:32 p.m., LPN-A stated the facility did not have the exact supplies R1 wanted for his colostomy, as the facility had formulary colostomy supplies. She stated he was experiencing more incidents of leaking during his first few weeks at the facility. She stated she obtained the required products after he was sent to the hospital on 6/25/25. She stated R1 taught the staff how to perform the colostomy bag changes. She stated two other products were tried for him prior to using the supplies he was prescribed. She stated the supplies for each resident were placed in their rooms. She stated the care plan did not list the process or specific supplies required. She stated she expected the nurses would know how to change the colostomy bags. LPN-A stated the HUC should have listed all the steps ordered by the physician for the colostomy care in the orders for R1. On 7/15/25, at 2:28 p.m., registered nurse (RN)-B stated the facility obtained R1's correct colostomy supplies after he went to the hospital on 6/25/25. RN-B stated the colostomy supplies were located in the residents' rooms. She stated, There is not anything in the care plan for the step-by-step process or the specific products required. RN-B stated she had changed R1's colostomy on one occasion. She stated she could not confirm if the physician order was followed at that time. She stated she had not seen the order. On 7/15/25, at 3:01 p.m., the director of nursing (DON) stated, the order is part of the care plan. The DON also stated, the order feeds the MAR. She stated the facility was using formulary colostomy supplies. She stated there was not an order from the physician to use the facility's formulary colostomy supplies or change the physician ordered process. A facility document, Comprehensive Assessments and Care Planning, dated 2017, directed the facility must make a comprehensive assessment of the resident's needs. Baseline care plans address at a minimum, the following: physician orders. The assessment must include at least the following: Continence and Special

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to assess and evaluate the appropriateness of the colostomy care supplies and ensure proper fitting of the wafer to prevent leakages and failed to provide physician-ordered care for colostomy care for one resident (R1). This failure caused psychosocial harm to R1 when his colostomy care was delayed, and he suffered emotional distress and suicidal ideation. Findings include:On 7/15/25, at 10:21 a.m., R1 stated he had several episodes of his colostomy leaking in the first few weeks at the facility. R1 stated he repeatedly asked the facility to use the products he was familiar with, including rings (intended to create a secure and comfortable seal between an ostomy pouch and the skin around the stoma, to prevent leakage) and wings (small flexible pieces of hydrocolloid adhesive that attach to the edges of an ostomy skin barrier to provide extra security and prevent leaks). R1 stated the facility started providing the requested supplies, after he became suicidal due to lack of sleep, from the colostomy leaking four times on 6/25/25. R1 stated the colostomy leaked stool on the bed, on the floor and on himself. He stated this made him feel filthy, dramatic, depressed, and dirty. He stated it made it harder to socialize because he was afraid it would leak. R1 stated his colostomy has had fewer incidents of leaking since the facility has provided the supplies he needed.R1's hospital record dated 6/1/25 to 6/5/25 indicated R1 was brought by ambulance because of a fall related to weakness, lack of sleep due to burning around his leaking colostomy bag. R1 had problems with ostomy leakage and the hospital would facilitate the necessary ostomy supplies. R1 was discharged on 6/5/25 in stable condition. R1's hospital discharge orders and instructions dated 6/5/25 instructed the facility to care for R1's ostomy.Procedure for pouch change:1) Prepare new pouch, using a Coloplast 16716 or your normal pouches. Opening should be 1/16- 1/8 larger than the stoma. Set pouch aside.2) Remove old pouch, and discard.3) Cleanse peristomal area with warm water only and Versalon 4 x 4's (#118746). *Do not use soap, wipes, adhesive remover, or skin prep to cleanse peristomal skin.4) Allow skin to dry. At this point - CRUST the peristomal skin 1x. See below for crusting steps.5) Apply Adapt barrier ring (#116786) and then apply new pouch.6) Press down firmly all-around stoma and have patient place hand over pouch for 2-3 minutes to enhance seal.7) Change pouch two times week or immediately if there is a leak. Procedure for crusting:1. Clean skin gently with warm water and gauze, paper towel or soft wash cloth2. Sprinkle a layer of ostomy powder over area to be treated-red, irritated, weeping skin surrounding stoma. Gently brush off excess powder using a 4x4 gauze, tissue, or your finger. You want a thin layer of powder completely covering the moist area.3. Blot/pat or spray Cavilon No Sting Barrier Film over powder. Allow barrier film to dry. If an area is missed, allow the entire area to dry first, then go back and spray or blot the area that was missed.4. Reapply with pouch change until redness clears up. Do not do this procedure if your skin is clear and intact. If your skin worsens or does not heal, please contact your ostomy nurse as you may need a stronger treatment. R1's nurse note, dated 6/5/25, indicated he was admitted to the facility from the hospital after a fall and weakness. It also indicated the skin around his colostomy was irritated and painful. R1 had reported he fell off the toilet from weakness due to lack of sleep from his colostomy bag leaking for 4 days. R1's care plan, dated 6/6/25, indicated he required assist of one staff for personal cares. The care plan lacked individualized care for R1's colostomy, as it did not specify the supplies requires or the process to complete the colostomy care. R1's nurse note, dated 6/11/25, indicated his colostomy bag was changed. [NAME] brand used and cut to measure to size of stoma. R1's nurses notes indicated his colostomy bag was changed on 6/6/25, 6/11/25, 6/15/25, 6/20/25, 6/23/25, and 6/25/25. No identifying information was noted related to colostomy supplies used, R1's ostomy redness, or leakage. R1's nurse note, dated 6/25/25, indicated R1 was up the majority of the night dealing with his colostomy bag, as it needed to be changed and reinforced multiple times throughout the night. The note indicated at 6:15 a.m. the nurse found R1 picking at it stating it needed to be changed again and was in clear emotional distress. He reported he was traumatized, devastated, and became tearful, stating he did not get sleep. The note indicated at 8:45 a.m. R1 reported his colostomy was leaking again. R1 was very upset with the situation and made the comment, I should put a shotgun to my head and making comments he did not want to be alive any longer. R1's nurse note, dated 6/25/25, indicated colostomy bag and appliance were changed that morning. The skin area was red and macerated around the appliance. R1 voiced this was not the typical appliance he used at home and facility would order device familiar to R1. R1's social work progress note, dated 6/26/25, indicated when discussing discharge with R1, R1 told the social worker if he had to discharge

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F 0691 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate colostomy, urostomy, or ileostomy care/services for a resident who requires such services. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0691 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to ensure 1 of 3 residents (R1) reviewed for ostomy care, received colostomy care as ordered by the physician. This resulted in inappropriate care, as evidenced by frequent leakage incidents for R1.Findings include: R1's care plan, dated 6/6/25, indicated he required assist of one staff for personal cares. The care plan lacked individualized care for R1's colostomy, as it did not specify the supplies requires or the process to complete the colostomy care. R1's after discharge orders from the hospital, dated 6/5/25 directed:Procedure for pouch change:1) Prepare new pouch, using a Coloplast 16716 or your normal pouches. Opening should be 1/16- 1/8 larger than the stoma. Set pouch aside.2) Remove old pouch, and discard.3) Cleanse peristomal area with warm water only and Versalon 4 x 4's (#118746). *Do not use soap, wipes, adhesive remover, or skin prep to cleanse peristomal skin.4) Allow skin to dry. At this point - CRUST the peristomal skin 1x. See below for crusting steps.5) Apply Adapt barrier ring (#116786) and then apply new pouch.6) Press down firmly all-around stoma and have patient place hand over pouch for 2-3 minutes to enhance seal.7) Change pouch 2x/week or immediately if there is a leak. Procedure for crusting:1. Clean skin gently with warm water and gauze, paper towel or soft wash cloth2. Sprinkle a layer of ostomy powder over area to be treated-red, irritated, weeping skin surrounding stoma. Gently brush off excess powder using a 4x4 gauze, tissue, or your finger. You want a thin layer of powder completely covering the moist area.3. Blot/pat or spray Cavilon No Sting Barrier Film over powder. Allow barrier film to dry. If an area is missed, allow the entire area to dry first, then go back and spray or blot the area that was missed.4. Reapply with pouch change until redness clears up. Do not do this procedure if your skin is clear and intact. If your skin worsens or does not heal, please contact your ostomy nurse as you may need a stronger treatment. R1's admission Minimum Data Set, dated [DATE], indicated R1 had diagnoses of Crohn's disease (chronic inflammatory bowel disease) and had a colostomy (a surgical procedure that creates an opening in the abdominal wall, bringing a portion of the large intestine to the surface). R1's MDS indicated he was cognitively intact. R1's nurse note, dated 6/11/25, indicated his colostomy bag was changed. [NAME] brand used and cut to measure to size of stoma. R1's nurses notes indicated his colostomy bag was changed on 6/6/25, 6/11/25, 6/15/25, 6/20/25, 6/23/25, and 6/25/25. No identifying information was noted related to colostomy supplies used, R1's ostomy redness, or leakage. R1's medication administration record (MAR), dated June and July 2025, directed to change ostomy bag two times weekly and as needed for leakage, on Monday and Wednesday evenings. A physician order, dated 7/9/25, directed facility to facility and consult with an ostomy nurse to review R1's current set up and offer suggestions about decreasing frequency of nighttime leaks, which are very distressing for him. R1's medical record review 7/15/25 did not indicate the facility followed R1's physician order dated 7/9/25 to schedule an ostomy consult. On 7/15/25, at 10:21 a.m., R1 stated he had several episodes of his colostomy leaking in the first 20 days at the facility. R1 stated he repeatedly asked the facility to use the products he was familiar with, including rings (intended to create a secure and comfortable seal between an ostomy pouch and the skin around the stoma, to prevent leakage) and wings (small flexible pieces of hydrocolloid adhesive that attach to the edges of an ostomy skin barrier to provide extra security and prevent leaks). R1 stated the facility started providing the requested supplies on 6/25/25. R1 stated his colostomy has had fewer incidents of leaking since the facility has provided the supplies he needed. R1 stated he had not seen an ostomy nurse. On 7/15/25, at 1:14 p.m., licensed practical nurse (LPN)-B stated R1's colostomy bag changes required the use of skin prep (creates a protective barrier), and the supplies located in his room. She stated orders indicated frequency of scheduled colostomy changes. On 7/15/25, at 1:32 p.m., LPN-A stated the facility did not have the exact supplies R1 wanted for his colostomy. She stated he was experiencing more incidents of leaking during his first 20 days at the facility. LPN-A stated the health unit coordinator entered R1's orders and should have listed all steps, as the physician wrote them. LPN-B stated she was responsible to order colostomy supplies. She stated she obtained the required products after he was sent to the hospital on 6/25/25. She stated the supplies for each resident were placed in their rooms. She stated the care plan did not list the process or specific supplies required. She stated she expected the nurses would know how to change the colostomy bags. LPN-A stated the appointment with the ostomy clinic, chosen by R1, had not yet been arranged, although it was ordered 6 days prior. She stated the facility was working on discharge planning. On 7/15/25, at 2:28 p.m., registered nurse (RN)-B stated the facility obtained R1's correct colostomy supplies after he went to the hospital on