STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245312	A. Building B. Wing	07/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Flagstone	12500 Castlemoor Drive Eden Prairie, MN 55344

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. (continued on next page)

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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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to ensure professional standards of practice were followed during medication administration for 5 of 5 residents (R1, R2, R4, R5, R6) observed for medication administration.Findings include:R1R1's annual Minimum Data Set (MDS) assessment dated [DATE], indicated she was cognitively intact and required moderate assistance in activities of daily living.R1's physician order from the medication administration record, dated 1/6/25, indicated Ativan Oral Tablet 0.5 milligrams (Lorazepam). Give 0.5 milligrams by mouth every 6 hours as needed for panic attack. Camera footage dated 6/21/25 at 12:53 a.m., showed registered nurse (RN)-A entered R1's room with a medication cup and spoon. RN-A stated to R1, I think you are describing a lot of tension. This will help, the lorazepam. R1 said Is it like Ativan? I can't have that. RN-A stated the medication was the same as R1's gabapentin order, administered the medication to R1 and immediately left the room.On 7/17/25 at 9:00 a.m., trained medication aid (TMA)-A went to the medication cart and grabbed an already prepared cup of medications for R1. TMA-A gave R1 her medications one at a time, mixed in applesauce and with a spoon. TMA-A did not explain the purpose of all medications to R1. On 7/17/25 at 12:15 p.m., R1 was interviewed and stated not all staff stayed in the room to make sure she finished her medications.R2R2's quarterly MDS assessment dated [DATE], indicated she was cognitively intact and required moderate assistance in activities of daily living.On 7/17/25 at 10:18 a.m., R2 was interviewed and stated that not all staff wait for her to finish her medications before they left her room.R4R4's quarterly MDS assessment dated [DATE], indicated she was cognitively intact and required moderate assistance in activities of daily living.On 7/17/25 at 8:46 a.m., TMA-A was observed administering medications to R4. TMA-A administered the pills mixed in applesauce by spoon and handed her a cup of water after every spoonful. TMA-A did not explain what medications she was administering to R4. R5R5's quarterly MDS assessment dated [DATE], indicated she was cognitively intact and required moderate assistance in activities of daily living.On 7/17/25 at 9:05 a.m., TMA-A started to prepare medications for R5, she did not verify the expiration dates for the medications. At 9:11 a.m., TMA-A stated she checked medication expiration dates when new medications arrived from the pharmacy and the nurses came around to check expiration dates.R6R6's quarterly MDS assessment dated [DATE], indicated she was moderately cognitively impaired and required substantial assistance in activities of daily living.R6's physician orders dated 7/17/25, included an order for Polyethylene Glycol 3350 powder (Miralax). Give 17 grams by mouth one time a day for constipation. It also included an order for Potassium Chloride extended-release oral tablet. Give 20 milliequivalent by mouth one time a day for malnutrition. The order lacked instructions to administer with any amount of water. R6's orders lacked a self-administration order allowing R6 to administer her medications independently.On 7/17/25 at 9:28 a.m., TMA-B was observed preparing medications for R6. TMA-B was not verifying medication expiration dates while going through each medication. TMA-B poured 17 grams of Miralax powder into a cup and mixed it with water, he also placed one Potassium Chloride tablet into the medication cup. At 9:40 a.m., TMA-B entered R6's room and R6 was laying at about a 30-degree angle in her bed, TMA-B did not raise the head of the bed prior to giving R6 her medications. R6 swallowed all of her pills at once and drank half of the cup of Miralax. TMA-B walked out of the room before verifying R6 finished the Miralax and the Miralax was left on the bedside table. TMA-B stated there was a staff person who came around and checked expiration dates about once per month.On 7/17/25 at 1:04 p.m., RN-A was interviewed and she stated that staff should inform residents what their medications were and what they were for during medication passes. Medication expiration dates should be checked before medications were administered. Staff should stand with the resident until all of the medications had been taken.On 7/17/25 at 1:38 p.m., RN-B was interviewed and stated staff should inform residents what medications they were receiving and what they were for. Medication expiration dates should be checked everyday. Staff should make sure residents drank everything and took all medications before staff left the room and document. On 7/17/25 at 2:04 p.m., TMA-B was interviewed and stated that it depended on the resident if the medications should be explained to them or not. Some residents did not care. Potassium chloride should be given with a full glass of water and if there was a medication mixed in with a glass of water, staff should ask residents to drink the full glass of water. On 7/17/25 at 2:20 p.m., a pharmacist was interviewed. She stated staff should follow doctors orders to mix the Miralax so if the directions state to mix 17 grams in 8 ounces of water, it would be expected that the patient would drink the

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observation, interview, and document review, the facility failed to ensure hand hygiene was completed during medication administration for 5 of 5 residents (R1, R2, R4, R5, R6) observed for medication administration.Findings include:On 7/17/25 at 8:46 a.m., trained medication assistant (TMA)-A was observed administering medications to R4. TMA-A entered the room and touched R4, assisted her to stand up from her bed and then touched the resident's personal fridge to retrieve some apple sauce. TMA-A did not sanitize her hands before administering the medications to R4. TMA-A administered the medications mixed in applesauce by spoon and handed her a cup of water after every spoonful. After administering the medications, TMA-A used hand sanitizer but then touched her face. TMA-A returned to the medication cart and grabbed an already prepared cup of medications for R1. TMA-A did not sanitize her hands prior to entering R1's room at 8:54 a.m. TMA-A gave R1 her medications one at a time, mixed in applesauce and by spoon. TMA-A did not use hand sanitizer after administering the medications.On 7/17/25 at 9:28 a.m., TMA-B was observed preparing medications for R6. At 9:40 a.m., TMA-B entered R6's room without sanitizing his hands. After TMA-B administered R6's medications, hand sanitization was not completed.On 7/17/25 at 10:34 a.m., registered nurse (RN)-B was observed preparing medications for R2. RN-B was not observed completing hand hygiene prior to handling medications at the medication cart. RN-B brought the medications into R2's room for R2 to verify the medications per her preference. RN-B placed the medications into a med cup and handed the medications with a cup of water to R2, R2 finished her medications. RN-B left the room and did not complete hand sanitization.On 7/17/25 at 12:15 p.m., R1 was interviewed and stated she did not usually see staff completing hand hygiene before or after giving her medications.On 7/17/25 at 1:38 p.m., RN-B was interviewed and stated hand sanitizer should be used before and after medication passes.On 7/17/25 at 2:04 p.m., TMA-B was interviewed and stated that staff should sanitize their hands before and after medication administration.On 7/17/25 at 3:25 p.m., the interim director of nursing (DON) was interviewed. She stated hands should be sanitized between medication passes.The facility policy, Infection Control Standard Precautions, no revision date, directed staff that hand hygiene should be performed before and after contact with the resident, after contact with objects in the resident's room and before meals.