STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245348	A. Building B. Wing	01/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Estates at Rush City LLC	650 Bremer Avenue South Rush City, MN 55069

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and document review the facility failed to ensure dishes were properly dried and stored to prevent the growth of bacteria. In addition, the facility failed to ensure safe storage of resident personal food item occurred at the facility. These deficient practices had the potential to impact all residents who dined at the facility and or stored food in the designated resident fridge. Findings include:During an observation on 1/28/26 at 9:40 a.m., the dietary aide (DA-A) was washing dishes in the kitchen. DA-A removed plates from the washing rack, stacked the plates, and then put them in the plate cart. The plates had visible droplets of water on them. DA-A removed wet plate holders and lids from wash racks, stacked them, and then placed them on storage carts. Upon interview, DA-A confirmed the plates, lids and plate holders had been put away wet. DA-A explained the dishwasher had a drying agent that dried dishes fast, so they waited until things were mostly dry before they put them away. They had not been told it was not okay to stack and put things away if they were not all the way dry.During an interview on 1/28/26 at 10:09 a.m., the culinary director (CD) inspected the plate holders, lids, and plates and confirmed they were not dry. The CD stated all dishes should be completely dry before being stacked. The primary concern with putting dishes away wet was infection prevention. Trapped stale moisture or water sitting could lead to mold, mildew, or bacteria growth.During a resident fridge review on 1/28/26 at 11:43 a.m., the CD stated the mini fridge/freezer in the dining room was designated for resident storage of personal food items. The CD opened the fridge and then the freezer compartment. The CD found a large, folded icepack under frozen meals in the freezer. The CD removed the ice pack from the freezer, put it in the garbage, and stated only food should be stored in the fridge. There should never be therapeutic ice packs or non-food items stored in the fridge as it was unsanitary and created risk for cross contamination of food items. The icepack was approximately 8.5 by 14 inches long with the wording equate therapy combo hot or cold packs with illustrations of the ice pack applied to different body parts. During an interview on 1/29/26 at 1:50 p.m., the director of nursing (DON) stated their expectation was that only food would be stored in the resident fridge. For food safety, there should never be personal use packs or other non-food items stored in the fridge.On 1/29/26, a request for dishwashing and storage policies was made. The facility response indicated the facility did not have policies specific to dish washing and storage.The resident policy for personal food items did not address the storage of non-food items within the fridge.

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to ensure accuracy of the minimum data set (MDS) for 3 of 4 residents (R1, R26, R34) reviewed for accuracy of assessments.Findings include:R1's quarterly minimum data set (MDS) dated [DATE], identified severe cognitive impairment and diagnoses of metabolic encephalopathy and palliative care. The functional assessment, section GG, was not completed.R1's care plan dated 1/27/26, identified R1 was non-ambulatory and needed assistance with all activities of daily living (ADL)s. R26's admission minimum data set (MDS) dated [DATE], identified intact cognition with diagnoses of disc displacement of the lumbar region, chronic pain, and congestive heart failure (CHF). The functional assessment, section GG, was not completed.R26's care plan dated 1/6/26, identified the need for assistance with bathing, dressing, personal hygiene, ambulation, and transfers.R34's quarterly minimum data set (MDS) dated [DATE], identified intact cognition and diagnoses of congestive heart failure and hypertension (HTN). M=no pressure ulcer/injury, risk for PU, no stage 1-4, no unstageable, no venous or arterial. Negative responses for other ulcers, wounds and skin problems, pressure relieving device for bed. R34's provider order dated 11/19/25 identified to provide wound care to the right posterior thigh lesion by cleansing with wound cleanser, pat dry, apply skin barrier to peri wound, dust collagen particles over the wound bed and cover with hydrocolloid dressing and change every three and as needed for saturated or missing dressing.R34's January treatment administration record (TAR) identified R34 had dressing changes performed on 1/3, and 1/6.During an interview on 1/29/26 at 11:44 a.m., registered nurse (RN)-A who identified as an MDS coordinator confirmed R34's MDS dated [DATE], section M didn't indicate dressing changes were performed and R34's TAR had wound care for a lesion on 1/3, and 1/6/26. For R 1 and R26, RN-A confirmed section GG was not done and stated they had a nurse manager who wasn't working out during that period.During an interview on 1/29/26 at 2:33 p.m., the director of nursing (DON) stated MDS accuracy was important because it needs to be accurate and correct and was part of their payment.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure proper personal protective equipment (PPE), hand cleaning and gloving practices were in place during the care of a resident on enhanced barrier precautions (EBP) for 1 of 1 resident (R1) reviewed for catheter care. In addition, the facility failed to provide hand hygiene or sanitation prior to meals. This had the ability to affect all residents who ate in the dining room.Findings include: R1: During a medication administration observation on 1/29/26 at 11:25 a.m., licensed practical nurse (LPN-B) was getting R20's medications ready for administration. LPN-B stepped to the wall hand sanitizer, sanitized their hands, and without gloves broke one of R20's pills in half. LPN-B administered an inhaler to R20 first and then proceeded to administer R20's pills with apple sauce. R20 stated they could not swallow one of the pills and asked LPN-B to break the pill in half. LPN-B picked up the pill, broke it in half and administered it to R20. LPN-B did not perform hand hygiene or apply gloves prior to handling the pill. During an interview on 1/29/26 at 11:31 a.m., LPN-B stated they had sanitized their hands before they broke the tablet in half at the medication cart, but gloves would have been better. LPN-B confirmed they had not sanitized their hands and/or applied gloves before they broke R20's pill in the room. For infection control, they should have sanitized their hands and put gloves on before they handled R20's pill. During an interview on 1/29/26 at 1:50 p.m., the DON stated for infection prevention reasons nurses should not directly handle resident pills. They expected nurses to properly sanitize their hands and apply gloves before they directly handled resident medications. The facility policy Preparation and General Guidelines Medication Administration dated 5/2022, section 6. Medication Splitting: instructed prior to handling tablets for splitting hands are to be sanitized and examination gloves are to be worn to prevent touching tablets during splitting. R1's quarterly minimum data set (MDS) dated [DATE], identified severe cognitive impairment and diagnoses of metabolic encephalopathy, palliative care, unstageable pressure ulcer (PU) left buttock, stage four PU to the right elbow, vascular dementia, restlessness, agitation, and delusional disorder. The MDS also identified R1 had an indwelling urinary catheter and wound care but didn't assess R1's functional status under section GG. R1's care plan dated 1/21/26, identified the need for assistance of two to assist with toileting hygiene, dressing, grooming, and bathing, to provide catheter care per policy, an assist of two with mechanical lift for transfers, and to provide assistance with bed mobility and repositioning. R1's provider orders dated 1/19/26, identified enhanced barrier precautions (EBP) be in place related to R1 having wounds and a catheter. During an observation and interview on 1/28/26 at 10:05 a.m., nursing assistant (NA)-D donned gloves and checked R1's incontinent brief and used a disposable wipe to clean the top layer of barrier cream off R1's groin and inner thigh area. NA-D turned from the bed and opened the bathroom door with the (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	knob using her still-gloved hand. NA-D brought a trash can from the bathroom to the bedside, with the same gloves, and proceeded to wipe his front perineal area. NA-D then removed her dirty gloves, grabbed the bed controller and adjusted the bed height and attempted to roll R1 onto his right side. After NA-D was not successful with this, she stated she needed to go get help. At 10:14 a.m., NA-D stated she did know what the EBP sign on R1's door meant and realized she had forgotten to put it on the first time she went in and attempted to turn R1. At 10:30 a.m., licensed practical nurse (LPN)-A and NA-D donned gown and gloves on entering R1's room. NA-D used disposable wipes to clean up his rectal area, stated she had forgotten to grab a clean brief and proceeded to use her still-gloved hands to open two different drawers to find an incontinent brief. After completing care for R1, NA-D removed her dirty gloves, didn't perform hand hygiene, collected the trash, walked down the hall and opened the door to the dirty utility room to throw the trash, then cleaned her hands. During an interview on 1/28/26 at 1:54 p.m., NA-D stated she understood she should have worn PPE and taken her gloves off before she touched things, so she didn't spread infection. A policy, Enhanced Barrier Precautions dated 4/4/24, identified it was the practice of the facility to implement enhanced barrier precautions for the prevention of transmission of multidrug-resistant organisms. Enhanced barrier precautions refer to the use of gown and gloves for use during high-contact resident care activities for residents known to be colonized or infected with a MDRO as well as those at increased risk for MDRO acquisition (e.g., residents with wounds or indwelling medical devices). All staff receive training on enhanced barrier precautions on hire and at least annually and are expected to comply with all designated precautions. All staff receive training in high-risk activities and common organisms that require enhanced barrier precautions. Clear signage will be posted on the door or wall outside the resident room indicating the type of precautions. The policy defined high-risk contact as activities including dressing, bathing, transferring, providing hygiene, changing linens, changing or assisting with toileting, wound care and device care. A Handwashing Policy dated 2/2024, identified proper hand-washing techniques should be used to protect the spread of infection. The section, Hand Washing and Gloves, identified when conducting a procedure requiring the use of gloves, proper hand washing shall be completed before donning gloves and after removing gloves. Dining: During an observation of dining on 1/26/26 starting at 5:34 p.m., residents were seated in the dining room. Dietary staff and the culinary director (CD) delivered meals to the residents. A nursing assistant remained in the dining room. There was a wall mounted hand sanitizer by the kitchen door. No other portable hand sanitizing products were visible in the dining area. No observations of residents' hand sanitization occurred. During an observation of the breakfast meal on 1/27/26 starting at 8:33 a.m., staff present and/or delivering food to residents in the dining room did not offer residents hand sanitization before meal delivery. No portable hand sanitizing products were visible in the dining area. During a breakfast observation on 1/28/26 starting at 8:20 a.m., staff present and/or delivering food to residents in the dining room did not offer residents hand sanitization before meal delivery. No portable hand sanitizing products were visible in the dining area. During an observation of breakfast meal on 1/29/26 starting at 8:30 a.m., staff present and/or (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	delivering food to residents in the dining room did not offer residents hand sanitization before meal delivery. No portable hand sanitizing products were visible in the dining area. During an observation on 1/29/26 at 12:22 p.m., NA-A entered R23's room with a meal tray and exited without offering R23 an opportunity to sanitize their hands before eating. NA-B entered R40's room with meal tray and did not offer R40 an opportunity to sanitize their hands before they began to eat. During an observation of the lunch meal on 1/29/26 starting at 12:24 p.m., NA-A remained in the dining room other staff intermittently present and/or delivering food to residents in the dining room did not offer residents hand sanitization before delivery and consumption of their meal. No portable hand sanitizing products were visible in the dining area. During an interview on 1/29/26 at 12:46 p.m., both R40 and R23 were present. R40 stated they had not been offered to sanitize their hands prior to meals today. Staff used to offer all the time, but they had stopped offering hand sanitization at mealtimes. R23 voiced agreement with R40. During an interview of a family member FM-A in the dining room on 1/29/26, FM-A stated they were often present at meals, and it had been quite a while since they had seen staff offer hand sanitization to residents before meals. During an interview on 1/29/26 at 12:49 p.m., NA-A stated they kept hand sanitizer in the dining area. NA-A looked for hand sanitizer on the dining tables and in cabinets in the dining room and did not find any. NA-A confirmed they had not offered any residents hand sanitization prior to meals on that day. During an interview on 1/29/26 at 1:57 p.m., the DON stated for infection control reasons, they would expect hand sanitization to be offered and happen for all residents before every meal. During an interview on 1/29/26 at 2:15 p.m., the CD stated it was culinary staff's responsibility to deliver food to the residents in the dining room. Nursing staff were always present to monitor residents for choking. Offering hand sanitization to residents was not something that culinary staff did, that was routinely done by the NA staff. The CD confirmed room delivery meal trays did not have individual hand sanitizing packets on them. The facility had containers of hand sanitizing wipes for resident use. During an interview on 1/29/26 at 2:51 p.m., NA-C stated staff offered residents wipes to clean their hands before meals. NA-C went to the dining room counter by the coffee dispenser and stated the wipes were usually on the counter. NA-C thought maybe the wipes had been relocated but did not find any after they searched dining room cabinets. NA-C went to storage room, returned with a container of hand sanitizing wipes and placed them on the dining room counter. The facility policy Handwashing dated 2/2024, directed hand washing techniques should be used to protect the spread of infection. Before eating food was included in list of when handwashing should be completed.

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to ensure informed consent, as well as the risk, benefits, and alternatives to psychotropic medications were provided to 1 of 5 residents (R26) reviewed for unnecessary medications.Findings include:R26's admission minimum data set (MDS) dated [DATE], identified intact cognition with diagnoses of chronic pain, panic disorder, major depression and post-traumatic stress disorder (PTSD). Section N identified R26 took antidepressant medication. R26's care plan dated 1/6/26, identified a focus statement for potential for psychotropic drug adverse drug reactions (ADR)s related to daily use of a psychotropic medication with interventions to administer medication per order, monitor target behaviors and report signs of ADRs.R26's medication administration record (MAR) had an order dated 1/17/26, to give duloxetine (an antidepressant, considered a psychotropic medication) 30 milligrams (mg) in the morning related to panic disorder. The order was signed off as given from 1/17/26 through current.R26's electronic medical record (EMR) didn't contain evidence of informed consent for the psychotropic duloxetine which she started receiving on 1/17/26.During an interview on 1/29/26 at 2:33 p.m., the director of nursing (DON) stated they get consent for psychotropic medications, she would look for it. A policy, Psychotropic Medication Use Policy dated 05/2025 identified the following for consent: Provide the resident or resident representative with information on the medication indication dose, side effects, adverse consequences and goal of treatment. Obtain consent and document education, information regarding the medication indication and directions for use, side effects and potential adverse consequences, risks and benefits of the medication and resident choice.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to provide the resident or their representative a written bed hold notice for 1 of 3 residents (R36) reviewed for hospitalization. Findings include:R36's admission Minimum Data Set (MDS) dated [DATE], identified R36 had diagnoses with included metabolic encephalopathy (a change in how the brain works due to an underlying condition that can cause confusion), diabetes mellitus, long term use of anticoagulant, prosthetic heart valve, and depression. In addition, R36's MDS identified he was able to understand and be understood and was moderately cognitively intact.A progress note dated 12/3/25 at 10:54 a.m., identified R36 had had a fall with a closed head injury and was sent to the emergency department for evaluation.A progress note dated 12/3/25 at 9:25 p.m., identified facility staff had called the emergency department for and update and were told R36 had been admitted . The note further identified an attempt was made to call R36's family with no success.A further review of the notes gave no indication if R36 had signed a bed hold or if further attempts were made to contact R36's family.During an interview on 1/29/26 at 2:26 p.m., the administrator verified they would expect staff to have a resident sign the bed hold or get a verbal confirmation. The administrator verified attempts should be made to notify the family as well, stating the goal is to get the bed hold signed. He stated he would expect staff to follow the process.A request was made for a copy of the bed hold; the facility was unable to provide this information.A review of the Bed-Holds and Returns dated 5/2023, identified the following: When a resident is temporarily transferred on an emergency basis to an acute care facility, this type of transfer is considered to be a facility-initiated transfer, and a notice of transfer must be provided to the resident and resident representative as soon as practicable before the transfer.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to ensure timely turning, repositioning and oral care for the comfort for a resident on end-of-life services for 1 of 2 (R1) residents and in addition, the facility failed to provide ordered interventions for a resident with constipation for 1 of 2 residents (R26) reviewed for quality of care.R1's quarterly minimum data set (MDS) dated [DATE], identified severe cognitive impairment and diagnoses of metabolic encephalopathy, palliative care, unstageable pressure ulcer (PU) left buttock, stage four PU to the right elbow, vascular dementia, restlessness, agitation, and delusional disorder. The MDS also reflected that R1 received hospice and end-of-life care. The functional assessment at section GG was not completed. R1's care plan dated 1/21/26, identified hospice care and coordination with Ecumen Hospice Services, to monitor pain, assess pain per protocol, treat with non-pharmacologic interventions and as-needed (PRN) pain medication and document effectiveness. R1 needed physical assistance of two for toileting hygiene, dressing, grooming, and bathing. To turn and reposition JR1 every two to three hours. The care plan lacked direction for R1's oral care during the active dying process.R1's provider orders dated 7/27/23, identified an order for pain monitoring every shift every day, on 12/15/25 for non-pharmacologic pain interventions, to administer PRN pain medication before wound care, and to give hydromorphone two milligrams (mg) every four hours for pain or dyspnea (difficult breathing) AND give two mg every one hour PRN pain or dyspnea.During a continuous observation on 1/28/26 from 7:17 a.m. until 10:30 a.m., R1 was not observed to be provided with oral care. R1 was observed to be breathing with his mouth open during this time. R1 was observed in his bed with eyes closed, lying mostly on his back with his upper torso rotated to his right. At 9:51 a.m., NA-B peeked into R1's room then went back to the nurse's station. At 9:55 a.m., NA-D entered the doorway to R1's room pulled the privacy curtain further shut so R1 wasn't visible from the hall, then NA-D left and went down the hall. At 10:05 a.m., NA-D entered R1's room and attempted to reposition him. NA-D explained he was actively dying. R1 appeared to have irregular shallow breaths and a smooth face. NA-D used a chuck pad to roll R1 onto his right side, R1 grimaced and opened his eyes. NA-D explained she needed to go get some help because he keeps slipping. At 10:22 a.m., LPN-A came over and talked with NA-D and stated she wanted to check if she should do the dressing change or if hospice would be doing it. An unidentified hospice nurse entered the building and talked with LPN-A and ultimately decided she would come back at 3 p.m. when the wound care provider was there. NA-D asked LPN-A if she should continue cleaning and turning R1. At 10:30 a.m., LPN-A and NA-D entered R1's room and worked together to turn R1 onto his right side to clean his rectal area. R1 had a facial grimace and LPN-A said to him, I know, I'm sorry. LPN-A stated it had been 45 minutes since he had pain medication, and suggested they not move him anymore until he had some more. LPN-A and NA-D worked together to cover him back up and R1 remained in the same position as when they started. Neither provided oral care.During an interview on 1/28/26 at 1:29 p.m., LPN-A stated R1 had a dry mouth so she performed oral care every time she went in there and would also expect it to be part of his morning cares. LPN-A stated she thought R1's care plan indicated two to three people because even before his decline he was a big guy and would kind of push against them when they repositioned him.During an interview on 1/28/26 at 1:54 p.m., NA-D stated she worked for the float pool, has worked here before, and knew how to care for the residents based on the group sheets. NA-D demonstrated the group sheet for R1 which identified he needed two people for bed mobility, NA-D stated she was wrong earlier when she thought she could do it alone.During an interview on 1/29/26 at 2:58 p.m., the director of nursing (DON) stated she would expect staff to attempt to offload after three hours, confirmed the care guide indicated an assist of two for repositioning, and stated the care guide was the primary source of information for the nursing assistants. The DON stated the risk of repositioning a resident without enough help would be the potential for injury to the resident and themselves. Furthermore, the DON (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stated her expectation would be for oral care to be done every time a someone went in his room because R1 was actively dying, and this would be her expectation for any dying resident. A policy related to end-of-life or comfort care was requested but not received.R26's admission minimum data set (MDS) dated [DATE], identified intact cognition and diagnoses of chronic pain and gastroparesis (a condition with delayed gastric emptying, where the stomach muscles don't function properly, leading to slow movement of food through the digestive tract). Section N identified R26 had opioid medication. The functional assessment at section GG was not completed. Always continent of bowels and constipation was present.R26's care plan dated 1/6/26, identified the potential for alteration in elimination related to need for staff assist with transfers and included interventions for an assist of one with toileting and to monitor BMs as the occur. R26's care plan lacked direction for constipation management.R26's medication administration record (MAR) identified an order dated 12/31/25, for sennosides (a laxative medication) tablet 8.6 milligrams (mg) every 12 hours PRN for constipation. There were no other activated orders related to bowel management.R26's electronic medical record (EMR), for the period of 12/31/25 to 1/21/26 identified the following:No bowel movement (BM) recorded 12/31/25 through 1/5/26. Sennosides were administered on 1/3 and1/4/26. A small BM was recorded on 1/6/26.BM recorded 1/10/26, Sennosides were administered on 1/13/26. BM recorded 1/15.No BM recorded 1/17 through 1/20/26. Sennosides were administered on 1/19/26. A small BM was recorded on 1/21/26.R26's EMR contained a nurse note entry on 1/19/26 at 4:21 p.m., resident shared she hadn't had a BM in three days, sennosides 8.6 mg 1 tab administered. At 7:30 p.m., a follow up note indicated the intervention was not effective. On 1/20/26 at 2:57 p.m., a note indicating sennosides 8.6 mg 1 tab administered per resident request for constipation. At 4:05 p.m., a follow-up note indicated the intervention was not effective. No other interventions or assessments for constipation were identified.During an interview on 1/26/26 at 3:44 p.m., R26 stated she had trouble with constipation and would sometimes go weeks without a BM. R26 wasn't sure what the facility was doing to help her.During an interview on 01/29/2026 2:33 p.m., the DON stated the facility followed the bowel protocol in the standing orders and would start interventions at three days or more of no BM. The DON stated ideally overnight shift ran a BM report and then handed off to day shift or do an intervention prior to the end of their shift. The DON stated she would expect the nurses to be going off the standing house protocol with the next intervention if the previous one wasn't effective after 24 hours.A policy regarding bowel management was requested but not received.A document, Standing Orders for Skilled Nursing Facilities revised 2025, identified the following for constipation (perform steps sequentially):Consider rectal check to determine if an impaction was present.Encourage 2000 milliliters (mL) daily unless contraindicated.Consult nutrition services for dietary recommendations.Give sennoside 8.6 mg two tablets by mouth daily PRN for up to three days, if no BM by day three, offer/give Bisacodyl suppository 10 mg rectally once daily PRN for up to two days.Reattempt sennosides or Bisacodyl if no results after 24 hours and notify provider.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245348	A. Building B. Wing	01/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Estates at Rush City LLC	650 Bremer Avenue South Rush City, MN 55069

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure 1 of 2 residents (R9) had accessibility to their call light to call for help. Findings include.R9's comprehensive Minimum Data Set (MDS) dated [DATE], indicated R9 was significantly cognitively impaired with the diagnoses of dementia, dysphagia, cognitive communication deficit, and hypertension. MDS section GG. indicated R9 required moderate assistance with transfer from bed to chair and with toileting. R9's undated facility provided care plan included focus areas with interventions for: fall risk, mobility related to impulsivity, communication, and behavior. R9's care plan directed assist of 1 with toileting and pivot transfers.R9's care plan did not include call light placement or use in fall risk, impulsivity or behavior interventions. During observations on 1/27/26:-at 3:03 p.m. R9 was seated in their wheelchair beside the head of their bed facing the door. R9's call light was located hanging on the wall above the foot of R9's bed. R9's tv was located on a stand just beyond the foot of R9's bed. -at 3:48 p.m., call light is still hanging on the wall behind R9. During an interview on a1/27/26 at 3:57 p.m., nursing assistant (NA-G) stated the call light should always be placed within a resident's reach before they left a resident room. NA-G stated they had not been in R9's room yet, but R9's call light should always be within reach. During an interview on 1/27/26 at 4:03 p.m., NA-A stated R9 was one of their residents. As part of their routine, they rounded on R9, but if R9 needed something between rounds, R9 would call on the call light. During an interview on 1/27/26 at 4:06 p.m., registered nurse (RN-B) stated R9 used a soft touch call light. R9 also required frequent checking because R9 required transfer assistance but often took self to the bathroom. RN-B confirmed R9's call light was hanging on the wall out of R9's reach. RN-B stated they always made sure R9 had their call light when they left R9's room, but they were not sure R9 could use it. During an interview on 1/27/26 at 4:11 p.m., NA-G stated before they left resident rooms they always made sure a resident's call light was within reach. When they took care of R9 they always positioned R9's call light across the bed so R9 could reach it from their wheelchair. R9 didn't always use their call light, but sometimes R9 did. During an observation on 1/28/26 at 7:19 a.m., R9 was in bed, turned away from the wall with eyes closed and lights off. R9's soft touch call light hanging on the wall above the foot of R9's bed. During an interview on 1/28/26 at 7:52 a.m., NA-B confirmed R9's call light was hanging on the wall. NA-B did not enter R9's room to address the call light. During an observation on 1/28/26 at 7:54 a.m., R9 self-transferred self to wheelchair and self-propelled self into the hallway. NA-F asked R9 if they wanted to go back to their room to get ready, but R9 declined. NA-B and NA-F confirmed R9's call light was hanging on the wall. NA-F stated normally they put R9's call light on R9's bed. NA-F questioned if R9 put the call light on the wall themselves or if maybe the night staff had forgotten to put the call light back on the bed. During an observation on 1/28/26 at 8:37 a.m., R9's call light was laying across R9's bed. On 1/28/26 at 12:00 p.m., NA-F stated R9's call light was found hanging on the wall. R9 must have put it there. During an observation on 1/28/26 at 3:53 p.m., R9 was seated in their wheelchair. R9's call light was out of reach hanging on the wall behind the bed. During an observation on 1/29/26 at 8:04 a.m., R9 was in bed. R9's call light was out of reach hanging on wall at the foot of the bed. During an interview on 1/29/26 at 1:47 p.m., the director of nursing (DON) stated it was their expectation that a call light be placed within reach for all residents every time staff left a resident room. The facility Call Light Policy dated 5/16/23, instructed a nurse call must be provided for each resident and must be placed within reach of the resident.