STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245491	A. Building B. Wing	07/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Moose Lake Village	710 South Kenwood Avenue Moose Lake, MN 55767

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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 minimum dishwasher temperatures were attained during the rinse cycle for 1 of 1 dishwasher. This had the potential to affect all current residents, as well as staff or visitors, who ate food served from dishes and tableware that were cleaned in the dishwasher.Findings include:During an observation on 7/6/26 at 1:58 p.m., the dishwasher wash cycle reached 153 degrees Fahrenheit (F) and the final rinse cycle reached 150 degrees F per the temperature gauges on the machine. A manufacturer sign posted next to the dishwasher instructed the final rinse cycle range should be 180-195 degrees F.During an interview on 7/6/26 at 1:58 p.m., culinary director (CD) indicated the dishwasher was a high temperature machine and stated the final rinse cycle must reach 180 degrees F. CD confirmed the low temperature and stated they needed to call the dishwasher company for service.During an interview on 7/9/26 at 9:25 a.m., the infection preventionist (IP) expected the dishwasher temperature to be hot enough to prevent the spread of any infectious materials. They stated if the dishwasher was not temping correctly, staff should report it to their supervisor or CD.During an interview on 7/9/26 at 9:46 a.m., the administrator expected the dishwasher temperature to be hot enough to sanitize dishes. They stated if the dishwasher was not reaching the correct temperature, staff should stop using the dishwasher and report it to their supervisor or CD so they could call the company that services it.Dishmachine Temperature Log dated 7/2026, the rinse temperature was logged at less than 180 degrees F for lunch use on 7/3/26 and for dinner use on 7/2/26, 7/3/26, and 7/7/26 with no indications of temperature correction.Sanitation policy revised 1/10/25, instructed the dishwasher rinse temperature specification was 180 degrees F, and if temperatures specifications were not reached, culinary staff was to stop using the machine immediately, contact their supervisor, and begin manually washing dishes.

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview and document review the facility failed to ensure medication refrigerators were kept within the recommended temperature range for 1 of 2 medication refrigerators. This deficient practice had the potential to affect any resident who received medications stored in the refrigerator.Findings include:During an observation on 7/7/26 at 2:07 p.m., the medication refrigerator in the main medication storage room had a reading of 42 degree's Fahrenheit (F). The medication log for July documented the last reading recorded as 39 degrees F. There were no temperatures recorded for July 1, 2, 3, 4, 6. The temperature log identified the safe range as 32 degrees to 41 degrees F (staff were using the food refrigerator temperature logs). Instructions identified staff were to report to the supervisor any time the temperature was out of range. Licensed practical nurse (LPN)-A verified the temperature for July was recorded only one time during July.A review of the medication temperatures for the past four months identified the following:-June there were only four temperatures recorded. There were 26 days were temperatures were not recorded. -The facility was unable to produce any temperature readings for the month of May.-The temperature readings for April had three readings recorded, with 28 days with no temperature readings recorded.A record of the medications in the refrigerator was as follows:R3, Lantus (long-acting insulin) and Trulicity (GLP-1 receptor lowers blood sugar)R62, Lantus and NovoLog (fast-acting man-made insulin)R32, Lantus, NovoLog, TrulicityR52, calcitonin spray (treats osteoporosis), Evenity (treats osteoporosis)R60, Humalog (fast-acting man-made insulin) and LantusR45, Lantus and NovoLogR17, LantusR31, Lantus, Basaglar (long-acting insulin) and NovoLogR37, Humalog vialsStock medications; Aplisol (diagnostic skin test to detect tuberculosis), Engerix B (vaccination to prevent hepatitis B virus), and Comirnaty (vaccine to prevent coronavirus).During an interview on 7/7/26 at 2:10 p.m., the director of nursing (DON) stated the concern was if the temperatures were too hot or too cold, it had the potential to ruin the medications. The DON stated she would expect staff to check refrigerator temperatures daily.During an interview on 7/8/26 at 10:31 a.m., LPN-B stated she knew there was an issue with the medication refrigerator temperatures, so she checked the medication refrigerator temperature in the main medication refrigerator at around 7:15 a.m., and noted the temperature was about was 50 degrees F. The medications were moved to a different refrigerator.During an interview on 7/8/26 at 12:43 p.m., the consultant pharmacist (CP)-G stated once the medication refrigerator exceeds the safe temperature all insulins should be dated as opened. CP-G stated the medication refrigerator should be between 36-46 degrees F. CP-G looked up all of the medications on the list and gave the following information:-Trulicity okay for 14 days-calcitonin spray would be okay for 35 days-Evenity would be okay for 30 days-Aplisol should be disposed of once out of the safe range-Enerix-B would be okay for seven days-Comirnaty would be okay for 12 hoursCP-G stated he would start counting the hours and days as when the last known temperature was recorded.The Medication Storage policy dated 6/30/23, identified nursing staff would be responsible for maintaining medication storage in a clean, safe, and sanitary environment. The policy further identified the refrigerator temperatures would be maintained between 36-46 degrees F.

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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 document review, the facility failed to ensure that all staff (including outside contracted staff) wear appropriate personnel protective equipment (PPE) and perform appropriate hand hygiene while completing wound care on a resident. This affected 1 of 1 (R60) residents reviewed for infection control. The facility also failed to change oxygen tubing timely to decrease the risk of infection for 1 of 1 (R37) reviewed for respiratory care. Findings Include: Wound Care: R60's quarterly Minimum Data Set (MDS) dated [DATE], indicated R60 had intact cognition. Diagnoses included peripheral vascular disease. Section M indicated R60 was at risk for pressure ulcers/injuries and had one stage two pressure ulcer that was not present on admission. R 60 also had one open lesion that was not a pressure ulcer, rash or cut. R60's infectious disease progress note dated 7/6/26, indicated R60 had an ulceration to the abdominal wall. On 11/6/26 at 3:48 p.m., a contact precautions sign was observed on R60's door frame, outside the room. The sign stated providers and staff must clean their hands, put on gloves, a gown, and use either dedicated equipment or disposable equipment. Clean and disinfect reusable equipment before us on another person. R8's quarterly MDS dated [DATE], indicated R8 had intact cognition. Diagnoses included anemia, heart failure and osteomyelitis in the sacral area. Section M indicated R8 was at risk for pressure ulcers and had a stage 4 pressure ulcer. On 11/6/26 at 4:18 p.m. an Enhanced Barrier Precautions (EBP) sign was observed on R8's doorframe before entering room. The sign stated providers, and staff must perform hand hygiene, wear gloves and gown when performing high contact resident care activities such as performing wound care: any skin opening requiring a dressing. During an observation on 7/8/26 at 9:03 a.m., three members of the contracted wound care clinic staff member (WCCSM)-D, wound care clinic registered nurse (WCCRN)-B, and wound care clinic medical doctor (WCCMD) approached R60s room, along with facility licensed practical nurse (LPN)-C. LPN-C washed her hands and then placed a gown and gloves on. WCCSM-D and WCCRN-B entered R60's room without placing appropriate PPE on and raised R60's bed and touched R60's bedding and other items in the room. WCCM-D and WCCRN-B then left R60's room. LPN-B then requested WCCRN-B to place PPE on and handed a gown to her. LPN-B also requested WCCSM-D and WCCMD place appropriate PPE on since the resident was on contact precautions. WCCRN-B placed gown and gloves on at that time and then handed WCCMD and WCCSM-D a gown. WCCMD asked what the gown was for and WCCSM-D stated, this is what they do here for wounds. WCCSM-D and WCCMD then proceeded into R60's room without placing PPE on. WCCMD stood at the foot of the bed, his clothing contacting the bedding and footboard, and next to the wound care cart. WCCRN stood to the right of the resident, and WCCSM-D sat next to the left side of R60, the same side of the abdominal wound. WCCRN-B held R60's abdominal fold out of the way while WCCSM-D removed R60's old dressing, performed measurements of the wound and applied a new dressing. All was done without changing gloves or performing hand hygiene after going from dirty to clean. While the abdominal wound was exposed WCCRN-B released the abdominal fold with the right hand, ungloved the right hand, reached into the wound cart with the ungloved, unwashed hand and grabbed a sterile package, opened the package and then handed it to WCCMD. WCCMD then proceeded to lean over R60's bedding, coming in contact and obtained a sample from the wound. All staff then left the room, removing what PPE they had on and performed hand hygiene. WCCSM-D, WCCRN-B and WCCMD then proceeded to walk into R8's room, without placing a gown on to perform wound care. WCCMD stopped surveyor from entering room while wound care was performed. During an interview on 7/8/26 at 9:13 a.m., LPN-B stated the other three members doing wound care were the contracted wound care providers for the facility. LPN-B stated the request was made for all three to place gown and gloves on prior to entering the rooms but WCCSM-D and WCCMD ignored the request and entered the room with only gloves on, instead of the gown and gloves as required. R60 had Methicillin-Resistant Staphylococcus aureus (a contagious staph infection that has (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	become resistant to many common antibiotics) and LPN-B stated the infection preventionist and director of nursing should have been notified when WCCMD and WCCSM-D refused to place a gown on prior to going into the isolation rooms. When WCCSM-D, WCCRN-B, and WCCMD left R8's room they were requested to answer questions. WCCRN-B and WCCMD kept walking towards the front door and refused to answer questions. WCCSM-D did stop, provided her first name and stated, we don't work for the facility. All three WCC staff members left without answering questions. Oxygen Tubing: R37's admission Minimum Data Set (MDS) dated [DATE], indicated R37 was cognitively intact. Diagnoses included chronic obstructive pulmonary disorder (COPD) and sleep apnea ([NAME]). The MDS indicated R37 had oxygen therapy and non-invasive ventilation (use of continuous positive airway pressure (CPAP) machine). R37's care plan dated 5/29/26 indicated an altered respiratory status due to COPD and OSA. Interventions included oxygen therapy as ordered and CPAP. R37's Physician Order Report dated 6/9/26 to 7/9/26, indicated orders for CPAP, use home settings and use 2.5 liters(L) of oxygen with humidity. R37 also received oxygen at 1 to 2.5 L as needed. The orders lacked any orders to change oxygen tubing with a time limit. On 7/6/26 at 2:34 p.m., long dark green oxygen tubing was observed connect to the liquid oxygen compressor and ran to R37's CPAP machine. There was no label indicating the last time the oxygen tubing had been changed. During an interview on 7/6/26 at 2:36 p.m., R37 stated the facility had not changed the oxygen tubing going to his CPAP since he had been admitted about a month prior. R37 stated the current tubbing had been provided to the facility by the resident due to having an extra and the staff used it instead of getting one out of supply. During an interview on 7/8/26 at 10:34 a.m., licensed practical nurse (LPN)-A stated all oxygen tubing was changed on a weekly basis, the date was based on when the resident was admitted . An order would be placed by the health unit coordinator so the nursing staff was aware the tubing needed to be changed weekly, and the nursing staff would acknowledge the order every time the tubing was changed. The facility did not date the tubing so the only way to know when the tubing was last changed would be based on the actual tubing change order. LPN-A reviewed R37's orders and confirmed there were no orders to change the oxygen tubing weekly, so LPN-A was unsure when R37's oxygen tubing was changed last. During an interview on 7/9/26 at 9:37 a.m., the director of nursing (DON) stated an expectation that all staff, including contracted staff, would wear the appropriate PPE and perform hand hygiene correctly when doing wound care. There also was an expectation that oxygen tubing would be changed weekly and documented as such. During an interview on 7/9/26 at 10:20 the infection preventionist (IP) stated wearing the appropriate PPE and performing hand hygiene when going from dirty to clean wound care steps were important to prevent the increased risk of spreading infection to other residents in the facility. Changing oxygen tubing weekly was important to decrease the risk of infection for the resident's using oxygen. Oxygen and humidified air cause increased moisture which can harbor infection bearing bacteria. Facility policy Personal Protective Equipment last reviewed 7/2/25, indicated PPE appropriate to specific task requirements were always available. All staff (Center for Disease Control (CDC), and Center for Medicare and Medicaid (CMS) define to include contracted staff providing care in the facility) were required to wear the correct PPE (gowns, gloves, masks) when providing certain care and when certain levels of isolation were reached.Facility policy Oxygen, portable liquid tanks last reviewed 2/18/26, indicated oxygen tubing would be replaced weekly or more frequently if needed. The weekly changes would be documented in the EHR.

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. Based on observation, interview, and document review the facility failed to complete a Self-Administration of Medication (SAM) assessment and acquire a physician order for self-administration for 1 of 1 resident (R72) who was observed to have medications left at bedside.Findings include: R72's Brief Interview for Mental Health performed on admission indicated moderate cognitive impairment. R72's electronic medical record (EMR) indicated diagnoses of urinary tract infection and chronic obstructive pulmonary disease. The EMR Lacked a SAM assessment or orders to keep medications at bedside. R72's care plan undated lacked a care plan related to ability to self-administer medications On 7/6/26 at 3:05 p.m., medications including nystatin cream and refresh eye drops were observed in a pink wash basin on the counter in R72's room. On 7/7/26 at 1:21 p.m., nystatin cream, refresh eye drops, and diclofenac cream were observed in the pink basin in R72's room. On 7/8/26 at 10:32 a.m. nystatin cream, refresh eye drops, and diclofenac cream were again observed in the pink basin on the counter in R72's room.During an interview on 7/8/26 at 10:34 a.m., licensed practical nurse (LPN)-A stated prior to leaving medications at bedside a SAM assessment needed to be completed and orders received. The registered nurse did the SAM assessments usually a week after admission so the staff could get a good understanding of cognition and if it would be safe to leave medications at bedside and for the residents to self-administer medications. Before the week was up all medications were to be kept in the nurse's medication cart. R72 was admitted on Thursday 7/2/26, so the SAM would not be completed until around Thursday 7/9/26. LPN-A looked in R72's room and confirmed the nystatin cream, refresh eye drops, and diclofenac cream were in the room. LPN-A reviewed R72's EMR and confirmed there was no SAM assessment completed for R72.During an interview on 7/8/26 at 2:46 p.m., registered nurse (RN)-A stated the RN's would do the SAM assessments. Most SAM assessments were done about a week after admission, unless the resident requested, then they were completed quicker. A week gave the staff time to get a good understanding of cognition level.During an interview on 7/9/26 at 9:37 a.m., the director of nursing (DON) stated the expectation was the SAM assessment would be completed prior to medications being left at bedside.Facility policy Self Administration of Medication last reviewed 9/30/25, indicated a SAM assessment would be performed at admission and orders obtained, if approved, prior to medications left in the room. The care plan would also be updated, adding the SAM assessment to the care plan.

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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 interview and document review the facility failed to ensure orders for blood sugar readings were followed for 1 of 5 residents (R19) reviewed for unnecessary medications. Findings include:R19's Face Sheet dated 7/9/26, identified he had diagnoses which included chronic heart failure (a chronic progressive condition where the heart muscle does not pump blood effectively), recurrent dislocation of right shoulder, type 2 diabetes mellitus with diabetic neuropathy, and hypertension. R19's admission Minimum Data Set, dated [DATE], identified he was cognitively intact, had no rejections of care, and required substantial assistance with activities of daily living.R19's care plan identified he was at risk for a decline in medical condition related to diabetes mellitus. Interventions included to administer medications and treatments per the medical doctor's order.R19's Physician Order Report dated 6/1/26, identified the following: Test blood sugars QID (four times a day), before meals, and prior to bedtime. Special Instructions: Contact Hospice if blood sugar 450 or higher. Under 70 treat with juice and recheck 1 hour after.A review of R19's vital sign report identified the following:6/2/26 at 7:55 a.m., blood sugar reading was 626/2/26 at 9:55 a.m., over one hour later the reading was 2306/6/26 at 7:56 a.m., blood sugar reading was 686/6/26 at 12:24 p.m., over one hour later the reading was 1756/7/26 at 6:43 a.m., blood sugar reading was 616/7/26 at 9:18 a.m., over one hour later the reading was 1596/14/26 at 5:44 p.m., blood sugar reading was 500A review of R19's June 2026 progress notes did not identify a note indicating hospice had been called on 6/14/26, about the blood sugar reading.6/15/26 at 5:53 p.m., blood sugar reading was 453A review of R19's June 2026 progress notes did not identify a note indicating hospice had been called on 6/15/26, about the blood sugar reading.6/28/26 at 5:50 p.m., blood sugar reading was 516A progress note dated 6/29/26 at 2:37 p.m., identified they notified hospice staff in person of recent blood sugar.7/9/26 at 6:35 a.m., blood sugar reading was 657/9/26 at 8:29 a.m., over one hour later the blood sugar reading was 158During an interview on 7/6/26 at 2:09 p.m., R19 expressed concerns about having low blood sugars in the morning.During an interview on 7/8/26 at 10:53 a.m., registered nurse (RN)-C with hospice stated he had been very involved with his care and would speak up about what his needs were. RN-C stated she would expect the staff to follow the orders for blood sugars and recheck R19's blood sugar in one hour to ensure his blood sugar was coming up and to ensure it was trending downward. RN-C stated she would also expect them to follow the order to notify hospice when the blood sugar was greater than 450.During an interview on 7/8/26 at 11:47 a.m., licensed practical nurse (LPN)-C reviewed R19's orders and verified the order specified if the blood sugar was less than 70, they needed to give juice and recheck the blood sugar in one hour. LPN-C stated it was important to follow the order to ensure the blood sugar wasn't staying low. LPN-C stated the order also specified the order included to notify hospice if the blood sugar was 450 or higher.During an interview on 7/9/26 at 8:22 a.m., LPN-D stated when R19's blood sugar was low, they were supposed to recheck his blood sugar in one hour. LPN-D stated they needed to make sure the blood sugar was coming up and not going lower.During an interview on 7/9/26 at 9:24 a.m., the director of nursing (DON) stated when a blood sugar was low staff needed to get the blood sugar up. The DON stated it was important for staff to follow orders as written. The DON stated if the blood sugar was too low the resident could have cognition changes, potential for falls, confusion, and/or sedation. If the resident refused the recheck, she would expect staff to document the refusal.The Hypoglycemia management policy dated 11/21/19, identified the objective was to identify hypoglycemia and restore normal blood sugar as quickly as possible. Steps identified to take included to treat hypoglycemia promptly and follow the protocol, report and document the episode.