STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245512	A. Building B. Wing	05/28/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
First Care Living Center	900 Hilligoss Boulevard Southeast Fosston, MN 56542

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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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to investigate, document, and track resolution of a resident grievance regarding another resident (R8) entering their room and going through their belongings for 1 of 1 resident (R22) reviewed for grievances.Findings include:R22's quarterly Minimum Data Set (MDS) dated [DATE], identified R22 was cognitively intact and required set up and clean up assistance with eating and oral hygiene. R22 was dependent on staff in all other care areas. Diagnoses included hemiplegia (one-sided paralysis) and hemiparesis (one-sided weakness). R8's comprehensive MDS dated [DATE], identified R8 had severe cognitive impairment and had diagnoses that included dementia, depression and psychotic disorder. R22's nursing progress note dated 5/21/26 at 4:57 a.m., identified R22 wanted to talk to someone in charge in the morning about R8 digging in his drawers. R22's care plan revised 4/1/26, failed to identify R22 wishes to prevent other residents from entering his room uninvited. R22's medical record failed to identify any further documentation related to R22's concerns related to R8. A review of the facility's formal grievances and informal grievances dated 8/1/25 through 5/26/26, failed to identify R22's grievance including investigation and action taken by the facility.During an interview on 5/26/26 at 1:12 p.m., R22 stated R8 came into his room and accused him of stealing her things, especially R8's dentures. R22 stated he turned on his call light but by the time staff arrived R8 had already left. R22 stated he had told staff he didn't like R8 coming into his room and they told him to turn on his call light if R8 did. During an interview on 5/28/26 at 10:44 a.m., the social worker designee (SWD) stated when a resident filed a complaint or grievance, staff went over the grievance form with the resident if the resident wanted to make a formal grievance. If the resident just wanted to vent whatever the issue was, they would talk with the resident and make a way to fix it. The SWD kept a spreadsheet so all concerns would be tracked whatever the issue was. However, the SWD stated there was no documentation regarding R22's grievance because R22 had never wanted to file a formal grievance and R22's daughter had stated understanding with the situation. R22 did have a right to privacy in his room, and it was R22's right to file a grievance. The SWD had not documented an informal grievance for R22 and stated there should have been documentation. During an interview on 5/28/26 at 11:18 a.m., the director of nursing (DON) stated she expected staff to follow the grievance process whether it was formal or informal because staff needed to track all grievances to determine if there was a resolution or if the interventions implemented were working or not. The facility policy Resident grievances dated 4/21/26, identified a resident has the right to voice grievances (orally or in writing) without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff or other residents, and other concerns regarding their stay in the SNF. The resident has the right to, and the facility must make, Prompt efforts to resolve grievances the resident may have. The Resident may file grievances orally or in writing and may also file a grievance anonymously. All grievances will be responded to within seven (7) days of receipt. A grievance in which the Resident or Resident Representative requests be handled as a written formal grievance will (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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	be investigated and responded to in writing. Written responses to grievances will include a. The date the grievance was received, b. A summary statement of grievance; c. The steps taken to investigate the grievance; d. A summary of the pertinent findings or conclusions e. A statement as to whether the grievance was confirmed or not confirmed, f. Any corrective action taken or to be taken by the facility because of the grievance; and g. The date the written decision was issued, if required. Regardless of whether a written decision is required to be issued to a Resident or Resident Representative, the facility will document in writing (for its own records) all decisions.

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review, the facility failed to assess and evaluate wandering behaviors, including entering other residents' rooms and going through personal belongings, for 1 of 3 residents (R8) reviewed for behavioral symptoms.Findings include:R8's significant change Minimum Data Set (MDS) dated [DATE], identified R8 had severe cognitive impairment and identified a worsening of behaviors. R8's diagnoses included: non-Alzheimer's dementia, depression, hallucinations and a psychotic disorder other than schizophrenia. R8's behavioral symptoms Care Area Assessment (CAA) dated 4/9/26, identified R8 had worsening behaviors along with hallucinations. R8's behaviors included: isolation, pain, anxiety, hollering out, and disruptive sounds; however, did not comprehensively assess wandering or a plan to minimize it. R8's progress note dated 5/20/26, identified R8 had been wandering into three other resident's rooms tonight and had been caught by staff digging in drawers. During observations on 5/26/26 at 12:53 p.m., R8 had wandered down the south hallway and entered another resident's room. As the surveyor walked by R8 came out of the room and asked where her room was. During an interview on 5/26/26 at 1:12 p.m., R22 stated R8 came into his room and accused him of stealing her things, especially R8's dentures. I tell her I don't need her teeth, that I have my own. R8 would call R22 every name in the book. R8 was rummaging in R22's closet and said all R22's things belonged to R8. R22 stated R8 just kept stating it's mine! R22 told R8 to get out of his room and R22 was upset by what R8 said and did. R22 stated he turned on his call light but by the time staff arrived R8 had already left. R22 stated he had told staff he didn't like R8 coming into his room and they told him to turn on his call light if R8 did. [R22's quarterly MDS dated [DATE] identified R22 was cognitively intact.]During an interview on 5/28/26 at 8:53 a.m., registered nurse (RN)-D stated R8 did wander into other residents' rooms from time to time. For a long time, R8 believed R22 was the doctor and would go into R22's room to talk to him. After meals, staff tried to direct her to her room. RN-D stated she did not work in the evening or night but believed R8 wandered into other rooms more frequently during that time because R8's sundowning (a state of increased confusion, anxiety, and agitation that affects people with dementia.) RN-D did not know of any interventions to prevent R8 from entering other residents' rooms. It's just redirection. RN-D did not identify the assessment process for wandering.During an interview on 5/28/26 at 9:08 a.m., trained medication assistant/nursing assistant (NA)-A stated R8 wandered a lot and went in and out of other residents' rooms. R8 was always easily redirected, and she would go to her room. There was nothing care planned about wandering, but staff always kept a close eye on R8 when she was out of her room. During an interview on 5/28/26 at 9:11 a.m., NA-B stated she had never seen R8 go into R22's room but had heard about it. When R8 was wandering staff just tried to keep an eye on R8 and redirect her back to her room. I think that's all you can do. During an interview on 5/28/26 at 10:44 a.m., the social worker designee (SWD) stated at one point, R8 had entered R22's room and accused them of taking her dentures. Staff tried a lot of redirection with R8 because she was fixated on her dentures. There was no regular documentation of R8's behavior. SWD did not identify the assessment process for wandering.During an interview on 5/8/26 at 10:54 a.m., registered nurse supervisor (RN)-A stated R8 would get mixed up on where she was and would wander down the hall and enter other residents' rooms. Most of the time she was easily redirected, but other times R8 would start going through other residents' personal belongings. R8 required a lot of redirection to find her way back to her room. RN-A stated they were currently trying to always keep an eye on R8 when she was out of her room. R8's wandering should have been assessed and identified in the care plan due to being consistent behavior for her. During an interview on 5/28/26 at 11:14 a.m., the director of nursing (DON) stated resident care plans should have identified any regular resident behaviors and any interventions implemented. R8 did wander and enter into other residents' rooms and in recent (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	months and had an escalation in wandering. R8 usually wanders right after meals, and they try to keep an eye on her and will redirect R8 back to her room. R8's should have been assessed and the care plan should have been updated to identify the wandering behavior and interventions in place. A wandering policy was requested, but it was not received.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to assess pneumococcal immunization status, provide education, and document discussion and offering of pneumococcal vaccination in accordance with current CDC recommendations for 2 of 5 residents (R20, R27) reviewed for immunizations. Findings include:R20:R20's admission Minimum Data Set (MDS) dated [DATE], identified R20 was admitted on [DATE], was cognitively intact and able to make her needs known. R20's diagnoses included diabetes and hypertension.R20's Preventive Health Care Report dated 5/25/10 through 5/28/26, identified R20 received Prevnar13 on 6/17/15. R20's electronic health record failed to include evidence R20 or R20's representative received education regarding pneumococcal vaccine booster and there was no indication R20 was offered the pneumococcal vaccine per CDC guidance in conjunction with their provider.R27:R27's annual MDS dated [DATE] identified R27 was admitted to the facility on [DATE] and was [AGE] years old. R27's diagnoses included coronary heart disease, heart failure, and thyroid disease.The facility immunization report dated 5/28/26, identified R27 received PCV13 on 8/30/17, and PPSV23 on 11/16/18. R27's electronic health record failed to include evidence R27or R27's representative received education regarding pneumococcal vaccine booster and there was no indication R27 was offered the pneumococcal vaccine per CDC guidance in conjunction with their provider.On 5/27/26 at 1:28 p.m., registered nurse (RN)-D stated immunizations were offered upon admission and seasonally. RN-A stated she reviewed the resident's immunization status upon admission. Immunizations were either administered, or a declination was signed after they were discussed with the resident and/or resident representative.On 5/28/26 at 8:53 a.m., the director of nursing (DON) stated she was uncertain what process the infection preventionist (IP) used to determine when a resident was due for the pneumococcal vaccine, although had recommended using the PnuemoRecs VaxAdvisor App or website (a standalone application that provides patient-specific guidance related to pneumococcal immunization schedule). The DON stated she was uncertain if R27 had received the most recent pneumococcal immunization. The DON stated there were no notes in the medical record identifying that the pneumococcal immunization was discussed or offered to R20 or R20's representative. Further, DON stated she expected all immunizations would be discussed with the resident and/or resident representative upon admission and per CDC guidance, as well as documenting a progress note in the resident's medical record.The Essentia Health Standard Work Process dated 3/5/26, identified staff reviewed vaccination history for all residents at the time of admission and assess if the resident needed vaccinations including pneumococcal. Staff provided and discussed the most current Vaccination Information Statement (VIS) with each resident and/or resident representative prior to administration, and document administration or declination in the resident's medical record.The CDC Pneumococcal Vaccine Recommendations dated 2/25/26 identified The United States uses 2 types of pneumococcal vaccines. Each individual vaccine helps protect against different serotypes of pneumococcal bacteria. Pneumococcal conjugate vaccines (PCVs) PCV15, PCV20 and PCV21; and Pneumococcal polysaccharide vaccine (PPSV23). Adults 50 years or older Administer PCV15, PCV20, or PCV21 for all adults 50 years or older, who have never received any pneumococcal conjugate vaccine, whose previous vaccination history is unknown. PCV15: Additional vaccination recommended If PCV15 is used, administer a dose of PPSV23A one year later. Only one dose of PPSV23 is indicated. If PPSV23 was previously administered, another dose isn't needed. The patient's pneumococcal vaccinations are complete. The minimum interval is 8 weeks and can be considered in adults with: An immunocompromising condition. A cochlear implant, A cerebrospinal fluid leak. PCV20 or PCV21: Additional vaccination not recommended If PCV20 or PCV21 is used, a dose of PPSV23 isn't indicated. Regardless of which vaccine is used (PCV20 or PCV21), the patient's pneumococcal vaccinations are complete. Recommendation for shared clinical decision-making: Based on shared clinical decision-making, adults 65 years or older have the option to (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	get PCV20 or PCV21, or to not get additional pneumococcal vaccines. They can get PCV20 or PCV21 if they have received both PCV13 (but not PCV15, PCV20, or PCV21) at any age and PPSV23 at or after the age of [AGE] years old.

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to assess COVID-19 vaccination status and ensure current CDC-recommended COVID-19 vaccination was offered and documented for 2 of 5 residents (R20, R27) reviewed for immunizations. Findings include:R20:R20's admission Minimum Data Set (MDS) dated [DATE], identified R20 was admitted on [DATE], was cognitively intact and able to make her needs known. R20's diagnoses included diabetes and hypertension.R20's Preventative Health Care Report identified the last documented COVID-19 vaccination was administered on 11/23/21. The medical record lacked evidence the resident's COVID-19 vaccination status was assessed upon admission, that current CDC recommendations were discussed, or that the resident was offered recommended COVID-19 vaccination since admission on [DATE]. R27:R27's annual MDS dated [DATE] identified R27 was admitted to the facility on [DATE] and was [AGE] years old. R27's diagnoses included coronary heart disease, heart failure, and thyroid disease.R27's medical record lacked evidence staff assessed the resident's COVID-19 vaccination status upon admission, provided education regarding current CDC recommendations, offered vaccination, or obtained a documented declination. On 5/27/26 at 1:28 p.m., registered nurse (RN)-D, who is also the infection preventionist, stated immunizations were offered upon admission and seasonally. RN-A stated she reviewed the resident's immunization status upon admission. Immunizations were either administered, or a declination was signed after they were discussed with the resident and/or resident representative.On 5/28/26 at 8:53 a.m., the director of nursing (DON) stated she expected all immunizations would be discussed with the resident and/or resident representative upon admission and per CDC guidance, as well as documenting a progress note in the resident's medical record.The Essentia Health Standard Work Process dated 3/5/26, identified staff reviewed vaccination history for all residents at the time of admission and assess if the resident needed vaccinations including COVIS-19. Staff provided and discussed the most current Vaccination Information Statement (VIS) with each resident and/or resident representative prior to administration, and document administration or declination in the resident's medical record. The Centers for Disease Control 2025-2026 COVID-19 Vaccination Guidance dated 11/4/25, identified COVID-19 vaccination is recommended for all adults ages 65 years and older based on individual-based decision-making (also known as shared clinical decision-making). For people ages 6 months-64 years, vaccination is recommended based on individual-based decision-making (also known as shared clinical decision-making)-with an emphasis that the risk-benefit of vaccination is most favorable for individuals who are at an increased risk for severe COVID-19 disease and lowest for individuals who are not at an increased risk, according to the CDC list of COVID-19 risk factors. In addition to the CDC list, the Moderna (Spikevax) package insert states that prematurity (birth at <37 weeks gestational age) has been associated with COVID-19-related hospitalizations in children ages 6-23 months. Ages 65 years and older Unvaccinated: Administer 2 doses of 2025-2026 vaccine; Unvaccinated 2025-2026 Dose 1 (Moderna, Novavax, or Pfizer-BioNTech): Day 0 2025-2026 Dose 2 (Moderna [Spikevax], Novavax, or Pfizer-BioNTech): 6 months (minimum interval 2 months) after 2025-2026 Dose 1; (Moderna [mNexspike]): 6 months (minimum interval 3 months)? after 2025-2026 Dose 1. Previously vaccinated before 2025-2026 vaccine: Administer 2 doses of 2025-2026 vaccine 1 or more doses any COVID-19 vaccine (Moderna, Novavax, or Pfizer-BioNTech) 2025-2026 Dose 1 (Moderna [Spikevax], Novavax, or Pfizer-BioNTech): At least 8 weeks after last dose; (Moderna [mNexspike]): At least 3 months after last dose?2025-2026 Dose 2 (Moderna [Spikevax], Novavax, or Pfizer-BioNTech): 6 months (minimum interval 2 months) after 2025-2026 Dose 1; (Moderna [mNexspike]): 6 months (minimum interval 3 months)? after 2025-2026 Dose 1.