STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245624	A. Building B. Wing	08/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Allina Health Restorative Suites	2775 Campus Drive North Plymouth, MN 55441

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. (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 0657 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 revise the comprehensive care plan to include individualized person-centered interventions identifying the needed level of supervision to negate the risk of falls for 2 of 3 residents (R2, R3) reviewed for falls.Findings include:R2R2's minimum data set (MDS) assessment dated [DATE], indicated she admitted to the facility on [DATE] with diagnoses including displaced simple supracondylar fracture without intercondylar fracture of the right humerus (broken bone in the lower part of the upper arm), other fracture, history of falling, and other disorder of bone density and structure. R2 had mild cognitive impairment. R2 had fallen in the last month prior to admission, had a fracture related to a fall in the six months prior to admission, and had one fall with a non-major injury since admission to the facility. R2's Nursing admission assessment dated [DATE], included a John's Hopkins Fall Risk Assessment. R2 was identified as at high risk for falls with score of 14.R2's care plan focus dated 8/8/25, identified she was at risk for falls with history of falls. Intervention dated 8/8/25, included physical therapy and occupational therapy to evaluate and treat as needed. Interventions dated 8/9/25 included: Ensure I am wearing appropriate footwear; If a fall should occur, take vital signs and assess for injury. Document circumstances and possible causes of fall. Notify family and physician of all falls; Monitor for side effects of medications and update provider as indicated; Observe for restlessness. If restless, attempt to determine cause of restlessness (such as pain or toileting need) and meet that need as able.R2's progress note dated 8/14/25, indicated R2 fell. A nurse saw R2 on the floor next to her recliner with knees on the floor and clinical coordinator assisting her. She had a left elbow skin tear. Her call light was not on, it was clipped to the blanket covering her, but she did not use it before getting up. R2 was assisted to the bathroom and had a large bowel movement. Interventions were to offer toileting every two hours and as needed, remind to use call light and not transfer without assistance, keep call light in reach at all times, staff to anticipate needs, and frequent checks, door stays open. The progress note did not identify what frequent checks meant or the corresponding needed level of supervision to mitigate the risk of falls.R2's progress note dated 8/15/25, identified it was inter-disciplinary team (IDT) fall follow up. R2 had fallen attempting to get herself to the bathroom and due to cognitive deficit did not use her call light which had been clipped to her blanket. Staff were to anticipate her need for use of toilet, a toileting plan was initiated, and frequent checks and door open when appropriate. Care plan and care strip [a paper summary of care plans used by nursing assistants] were updated with interventions. The progress note did not identify what frequent checks meant or the corresponding needed level of supervision to mitigate the risk of falls.R2's fall care plan intervention dated 8/15/25, directed see skin care plan for toileting plan. Staff to anticipate needs for toileting. Revision dated 8/18/25, changed this intervention to pharmacist medication review. Interventions dated 8/17/25, included see bowel and bladder care plan for my toileting schedule and frequent checks, keep door open when appropriate. R2's fall care plan did not identify what constituted frequent checks and failed to identify what R2's specific individualized needed level of supervision was to mitigate the risk of falls.R2's progress note dated 8/18/25, indicated it was an IDT review of the fall on 8/14/25. Root cause identified was poor cognition, possible urgency feeling need to have a bowel movement and had received a dose of a laxative on 8/14/25. Initial interventions were initiation of a toileting plan as well as frequent checks and door open when appropriate. The IDT interventions were pharmacist medication review and offer toileting every two to three hours and as needed.R2's care strip dated 8/27/25, identified she was a fall risk. The General Notes section included, Fall risk - frequent checks & door open, anticipate needs for toileting. The care strip did not identify what constituted frequent checks and failed to identify what R2's specific individualized needed level of supervision was to mitigate the risk of falls.During an interview on 8/27/25 at 8:36 a.m., nursing assistant (NA)-A stated R2 was a little confused and sometimes used her call light when she needed to toilet, but it depended on the day. NA-A stated staff checked on R2 every one to two hours and she was toileted every two hours. NA-A stated frequent checks meant someone was a fall risk, staff needed to check on them to prevent falls, and checks were done every one to two hours.During an interview on 8/27/25 at 10:02 a.m., NA-B stated care strips were a version of the care plan and directed staff what cares a resident needed. Care strips told staff how often someone needed checks and if they were a fall risk. Frequent checks meant checking on someone more than usual, like rounding every 15 minutes if they fell frequently or were known to not use a call light. NA-B stated R2 was a fall risk, didn't always use the call light, and was to be checked

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. (continued on next page)

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F 0880 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 observation, interview, and record review, the facility failed to ensure staff followed infection control protocols for proper handwashing for 1 of 1 resident (R3) reviewed on contact precautions. Findings include:R3's minimum data set (MDS) assessment dated [DATE], indicated she admitted to the facility on [DATE] with diagnoses including enterocolitis (inflammation of the large and small intestines) due to Clostridium difficile (C. diff, a bacterium that causes severe diarrhea and colon inflammation) and was always incontinent of bowel.R3's physician order dated 8/14/25, identified she was on contact enteric isolation precautions (measures taken to prevent the transmission of infectious agents including C. diff which include the use of personal protective equipment and hand hygiene). The order directed staff to gown and glove upon room entry, hand hygiene with soap and water, bleach sanitizing wipes, all meals and services in room every shift. R3's care plan focus dated 8/13/25, identified R3 had an infection with C. diff. Interventions included follow contact enteric precautions when caring for R3.During a continuous observation on 8/27/25 at 9:00 a.m., R3's room had a container with personal protective equipment (PPE) outside the door and a sign on the door. The sign directed, Contact enteric precautions (in addition to standard precautions) . Everyone must: Clean hands with sanitizer when entering room and wash with soap and water upon leaving the room. Doctors and staff must: Gown and glove at door. Use dedicated or disposable equipment. Clean and disinfect shared equipment. At 9:25 a.m., registered nurse (RN)-A approached R3's room, utilized hand sanitizer, donned (put on) a gown and gloves, and entered the room. At 9:26 a.m., RN-A exited R3's room with gown and gloves removed and was observed rubbing his hands together with a foamy substance present. RN-A then walked down the hall to a medication cart.During an interview on 8/27/25 at 9:27 a.m., RN-A stated he saw a sign on R3's door for enteric contact precautions. RN-A identified this meant when entering, he had to clean his hands and put on a gown and gloves. When exiting, there was foam sanitizer right by the door inside the room and he would use that. RN-A stated he utilized the hand sanitizer in the room after removal of gown and gloves. RN-A identified the precautions sign on R3's door directed staff to wash hands with soap and water when leaving the room and there was a sink down the hall where staff could wash their hands. RN-A confirmed he utilized hand sanitizer when he exited R3's room, did not wash his hands with soap and water, and had subsequently gone to and touched the medication cart. RN-A stated for enteric precautions, like someone with C. diff, hand hygiene with soap and water was needed to prevent spreading infection and transmitting C. diff to another resident or even himself.During an interview on 8/27/25 at 9:46 a.m., the director of nursing (DON) stated when staff exit a room with contact enteric precautions, they need to remove their PPE and then wash their hands. She expected staff to go out of the room and straight to an area to wash their hands. Anything touched along the way before washing hands would need to be sanitized. The DON noted it was not okay to touch the medication cart before washing hands. With C. diff, soap and water was the standard for hand hygiene. The risk of not using soap and water for hand hygiene was the potential to spread C. diff bacteria.During an interview on 8/28/25 at 10:22 a.m., the facility's infection preventionist (IP) stated she expected staff exiting a room of a resident with C. diff to wash their hands with soap and water. The IP noted this is what she trained staff to do, what the contact enteric precaution door signs directed, and what facility policy indicated. Hand sanitizer was not effective against C. diff. The risk of not washing hands with soap and water was still having some of the contagious organism present on hands or skin, touching other surfaces or people, and spreading it to other people or oneself. Facility policy titled Infection Control dated 5/13/25, identified transmission based precautions were used in addition to standard precautions for diseases with multiple routes of transmission, including contact precautions. Contact or touch was the most common and significant mode of transmission of infectious agents and residents in contact precautions included those infected with C. diff.Facility policy titled Clostridium Difficile Infection dated 4/3/24, identified C. diff was a spore-forming bacteria found in feces and health care workers could spread the bacteria to other residents or contaminate surfaces through hand contact. Residents would be placed on contact or enhanced barrier precautions. Enhanced barrier precautions were only to be used if the resident was continent of bowel or the diarrhea could be contained in an incontinence product. Residents with acute diarrhea would be in contact precautions. A contact or enhanced barrier precautions sign was to be placed on the resident's door. Gloves would be worn prior to entering the room and removed before exiting with hand hygiene performed before putting on gloves, after