

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 24E507	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/22/2026
NAME OF PROVIDER OR SUPPLIER Southside Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2644 Aldrich Avenue South Minneapolis, MN 55408	
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 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review the facility failed to complete a thorough investigation of alleged abuse, provide documentation of an investigation and take action to prevent further abuse for 1 of 3 residents (R1) reviewed for abuse. This resulted in an Immediate Jeopardy (IJ) when the administrator and the director of nursing (DON) were notified of a possible sexual relationship between cook-A and R1 but failed to complete a thorough investigation prior to cook-A returning to work. The IJ began on 7/10/26, when the facility failed to conduct a thorough investigation when alleged abuse was reported. The administrator and owner were notified of the immediate jeopardy at 4:45 p.m. on 7/16/26. The IJ was removed on 7/22/26, but noncompliance remained at a lower scope and severity level D, which indicated no actual harm with potential for more than minimal harm that is not immediate jeopardy. Findings include: R1 R1's quarterly Minimum Data Set (MDS) dated [DATE], indicated she had diagnoses of endocarditis (an infection of the inner lining of heart) anxiety, depression, bipolar disorder, adjustment disorder and was cognitively intact. R1's chart lacked a vulnerability care plan. R1's progress notes lacked documentation of the alleged sexual abuse. R1's chart lacked attempts at communication to investigate alleged abuse. A report submitted to the State Agency (SA) on 7/13/26 at 8:01 a.m., indicated on 7/10/26 two residents informed the director of nursing (DON) that cook-A had a sexual relationship with R1 resulting in R1 becoming upset and then leaving the facility. During an observation on 7/15/26, at 10:45 a.m., cook-A told R2 and R3 told they would be looking for a new place to live if they told the surveyor what occurs at the facility. During an interview on 7/15/26 at 12:03 p.m., R2 stated she shared a room with R1. R2 stated prior to R1 leaving the facility on 7/3/26, R1 was overheard on a phone call with R1's boyfriend. R1 told her boyfriend she was breaking up with him due to having a sexual relationship with cook-A. During an interview on 7/15/26 at 12:04 p.m., R3 stated she also shared a room with R1 and overheard R1 on the phone fighting with her boyfriend because she had a relationship with cook-A. R3 was unsure of the exact date but said it was a few days prior to R1 leaving on 7/3/26. During an interview on 7/15/26 at 12:45 p.m., the administrator stated R1 refused to provide a statement when she did not return his calls on 7/11/26, 7/12/26 and 7/13/26. He stated he interviewed cook-A on 7/14/26 who denied having a relationship with R1. The administrator stated he interviewed two other residents who were severely cognitively impaired and did not interview R1's previous roommates, who reported the allegations. The administrator concluded the allegations were unsubstantiated. The administrator did not suspend cook-A during the investigation as cook-A was not scheduled to work and did not work between 7/10/26 and 7/15/26. During an interview on 7/16/26 at 10:00 a.m., the director of nursing stated on 7/10/26, R2 and R3 reported they overheard R1 fighting with her boyfriend on the phone saying she was breaking up with him because she was in a sexual relationship with cook-A. The DON informed the administrator and the owner via text message on 7/10/26. The DON did not file (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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: 24E507	Facility ID: 24E507
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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	a police report. She made a report to the SA on 7/13/26. She stated the administrator did not interview R2 and R3 who were the witnesses to the phone call and told the DON she was not allowed to interview cook-A, as she was not his supervisor. The DON stated cook-A was never suspended. A facility internal investigation report, dated 7/15/26, indicated two residents alleged cook-A may have had an inappropriate relationship with a former resident. Cook-A was interviewed and denied all allegations. R1 was discharged from the facility before an interview could be conducted. The facility made attempts to contact R1 on 7/11/26, 7/12/26 and 7/13/26 but R1 was unavailable and could not be interviewed. The investigation findings were noted as unsubstantiated due to insufficient evidence. A report to the SA on 7/17/26 at 6:08 p.m., indicated on 7/15/26 at 10:45 a.m., cook-A was observed by surveyor telling residents not to say anything or they would have to move out. The facility Abuse Prevention policy, dated 5/30/25, directed it is the policy of the facility to establish and enforce a system for prompt reporting of abuse or neglect of any resident of the facilities and have systems in place to prevent abuse. It instructed the facility to attempt to interview staff who worked in the previous 48 hours prior to the incident. Residents should also be interviewed and verified they feel safe living at the facility. If an employee is suspected of abuse, the facility may suspend the employee pending results of the investigation. Police will be notified of physician or sexual abuse. Start internal investigation as indicated by the situation. Person in charge can remove from unit/suspend staff involved, interview staff, obtain written summary of the incident, record review, staff/resident interview, resident assessment, etc. Document all actions taken in a confidential file. If an allegation is not substantiated and not to be reported, actions taken and follow-up will be documented with the complaint/grievance form/file. Review a summary of the cases at the next Quality Assessment Performance Improvement (QAPI) meeting. Initiate any procedural, educational, or personnel actions as indicated to prevent the situation from happening again. The IJ began on 7/10/26 and was removed on 7/22/26 when a thorough investigation into allegations made by R2 and R3 was completed, a report of the allegation was made to law enforcement, facility policies related to thorough investigation into allegations of abuse were reviewed and revised, and staff received education for completing a thorough investigation.		

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F 0925 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, observation and document review the facility failed to maintain a clean and sanitary environment, free of pests. This had the potential to affect residents (R5, R4, R2, R6, R8) as well as all residing at the facility. This resulted in Immediate Jeopardy (IJ) when rodent feces were observed in resident rooms, resident common areas, facility kitchen and facility storage areas. The IJ began on 7/16/26, when the facility failed to take necessary action to control rodents and to make structural repairs which resulted in a rodent infestation. The administrator and owner were notified of the immediate jeopardy on 7/16/26 at 4:45 p.m. The immediate jeopardy was removed on 7/22/26, but noncompliance remained at a lower scope and severity level F, which indicated no actual harm with the potential for more than minimal harm that was not immediate jeopardy. Findings include: R5R5's face sheet dated 7/16/26, identified R5's diagnoses included anxiety disorder and schizoaffective disorder (a chronic mental health condition characterized by a combination of psychotic symptoms). R5's admission Minimum Data Set (MDS) dated [DATE], identified R5 had intact cognition, had other behavior symptoms not directed towards others (such as hitting or scratching self, pacing, and rummaging) that occurred for one to three days, and was independent with transfers. During an observation and interview on 7/16/26 at 9:00 a.m., R5 stated rodents had gotten into a bag of her belongings and had urinated on her important papers. R5 then showed the surveyor a plastic bag with a large hole in the bottom of the bag. The papers were located in the trash can and had yellow stains on them. R5 explained she had placed the plastic bag in the bottom of her closet on the day of her admission and must have left pistachio nuts in the bag. The mice must have gotten into it and peed all over it. R5 further explained, I see mice running in groups of four at time at night, and having mice in my room pisses me off. They should not be in my room. R4R4's face sheet dated 7/17/26, identified R4's diagnoses included depressive disorder, anxiety disorder, post-traumatic stress disorder, and chronic cough. R4's quarterly MDS dated [DATE], identified R4 had intact cognition, had other behavioral symptoms not directed at others four to six days, no rejection of care, and was independent with mobility. During an observation and interview on 7/16/26 at 9:07 a.m., R4 stated the rodents chewed up a quilt she had sitting on a bed in her room. R4 had a quilt over the top of the bed, R4 showed the surveyor the quilt had a hole approximately two centimeters (cm) x two cm with the batting pulled out. Rodent feces were observed on the top of the bed near the hole in the quilt. R4 stated the quilt meant a lot to her and, It pisses me off that the mice wrecked it. R4 further explained she had to put all her snacks in a plastic tub to try and keep the rodents from getting in her food and she had to purchase her own traps to try and catch the rodents. R4 stated, I caught around three mice so far. If the mice get in my food and I happen to eat it, that could make me sick. R2R2's face sheet dated 7/16/26, identified R2's diagnoses included diabetes, borderline personality disorder, and post-traumatic stress disorder. R2's quarterly MDS dated [DATE], identified R2 had intact cognition, had verbal behavioral symptoms towards others that occurred one to three days, had other behavioral symptoms not directed towards others that occurred daily, had rejection of cares daily, and was independent with all transfers. During an observation and interview on 7/16/26 at 10:08 a.m., R2 stated she needed to put her food up to try and keep the rodents from getting it. R2 explained, The mice get in the garbage cans and eat the food I throw in there at times. The facility placed sticky traps and bait stations to try and catch the mice, but I still see the mice running around my room at night. Three bait stations were observed: on the floor in R2's room, in an adjoining room in the closet, in the corner and under an empty bed. R2 further explained, I saw the mice sitting on top of the bait (continued on next page)		

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F 0925 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	stations. The mice running all over my stuff can make me sick and I could die. R6R6's quarterly MDS dated [DATE], indicated R6's diagnosis included schizophrenia, adjustment disorder, and diabetes. R6's cognition was intact. During an interview on 7/15/26 at 12:37 p.m., R6 stated, Mice had run over me while I'm sleeping. R8 R8's quarterly MDS, dated [DATE], indicated R8's diagnosis included schizophrenia and depression. R8 had moderately impaired cognition. During an interview on 7/15/26 at 12:39 p.m., R8 stated, Sometimes I see mice. Last week there was a squirrel in the house. During an observation on 7/15/26 at 10:45 a.m., rodent feces were present in resident rooms, dining room, food storage areas, food preparation areas, close to clean dishes, on the kitchen floor, in the medical supply storage areas and in sanitary linen areas. Large cracks were observed in the concrete foundation of the front porch/patio. Window air conditioning (A/C) units were propped in windows with large gaps on either side were observed throughout the facility, in hallways and resident rooms. Fruit, bakery items, leftover meals, crackers and granola bars were observed in resident rooms. Bait stations, glue traps, and snap traps for rodents were observed in resident rooms, on a resident's dresser, on a resident's bed, in closets, hallways, in the dining room, in food storage areas and the basement. During an interview on 7/15/26 at 12:00 p.m., the administrator stated the director of nursing (DON) found a lot of rodent feces. The administrator told the owners about the rodent feces, and the facility had a monthly contract with an exterminator. The administrator was unaware there was rodent trap on a resident bed. The administrator stated he did not review the pest control reports, and the facility did not have a designated maintenance person on staff. During an interview on 7/15/26 at 1:00 p.m., the facility owner stated they had an ongoing rodent problem. She stated the other owner was at the facility on 7/10/26 and observed traces of rodents and found a deceased rodent. Rodent poison was purchased and placed in the basement. During an interview on 7/15/26 at 1:30 p.m., the exterminator from an outside company stated the recommended structural repairs to the facility have not been made, along with residents maintaining food caches in their rooms. He recommended the facility increase the service contract from quarterly to monthly to better control the rodents. Over a year ago, but the facility declined. The severity of the mice infestation is not new and the owners are aware. He stated he documented his recommendations on the service invoice provided to the facility. During an interview on 7/15/26 at 2:40 p.m., the DON stated she made complaints the week of 6/22/26, regarding unsanitary conditions and rodent problems to the administrator and the owners. The owners instructed her to purchase rodent poison and place it in the residents' rooms, but she did not do that because she did not feel it was safe for the residents. The DON stated she had concerns the residents could get sick and die from the rodents. No education had been provided to the residents or staff to reduce or control mice infestation. During an interview on 7/15/26 at 3:25 p.m., licensed practical nurse (LPN)-A stated rodents have been a problem at the facility. He had not received education regarding reducing or controlling the rodents. During an observation on 7/16/26 at 9:45 a.m., shelves in the cabinet used for activity supplies were covered in rodent feces. During an interview on 7/16/26 at 12:08 p.m., registered nurse (RN)-A stated she had worked the night shift a few days prior and was sitting at the desk in the dining room, A mouse had run across my feet while I was working. I've seen evidence of a large number of mice in the facility. I informed the administration of my observations. RN-A was unable to articulate what the facility was doing to reduce the number of rodents. During an interview on 7/16/26 at 12:30 p.m., RN-B stated rodents were everywhere in the facility, and it had been a problem for years. During an interview on 7/16/26 at 2:30 p.m., the administrator stated he had received complaints about rodents in the facility and shared those complaints with the owners. He stated the rodent feces could make residents sick. During a phone interview on 7/16/26 at 2:50 p.m., medical director (MD) stated he was not aware of the rodent (continued on next page)		

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F 0925 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	infestation at the facility and with the large amount of evidence being observed it was really bad. MD explained he could see maybe one or two rodents being seen since the facility was an older building. With the large amount of rodent feces near the resident's food, it put the residents at risk for contracting a communicable disease from the rodents. MD stated the risk in the population at the facility was pretty low, but not zero. MD further explained if a resident had a weakened immune system and was admitted to the facility, this could have the potential to cause serious harm or even death by being exposed to the rodent feces or rodent urine. The Centers for Disease Control (CDC), Controlling Wild Rodent Infestations website https://www.cdc.gov/healthy-pets/rodent-control/index.html document, dated 4/8/24, indicated rodents carry many diseases that can spread directly or indirectly to people. During a phone interview on 7/16/26 at 3:52 p.m., infection preventionist (IP) stated, I am aware of a mice infestation in the facility. Having so many mice could put the residents at risk of contracting a communicable disease from the mice. IP was unable to articulate what the facility was doing to eradicate the rodents. During an interview on 7/16/26 at 4:30 p.m., LPN-A stated the residents complained about the rodents all the time. During an interview on 7/17/26 at 10:00 a.m., housekeeper (HSKP)-A stated, I observed evidence of rodent feces in resident rooms when cleaning. The facility tried to use bait to kill the mice, but I am still seeing evidence of the mice. HSKP-A further explained she thought the rodents were coming through all of the cracks in the building and until that was fixed the mice would still come in. HSKP-A stated, The residents living here do not deserve to have to live with mice getting all over their food or belongings. During an observation on 7/17/26 at 10:32 a.m., the surveyor was sitting at a desk in the basement of the facility. A trash can was observed next to the desk with rodent feces on the top of the trash. A mouse was observed running across floor along a wall, the mouse stopped and then proceeded to run back into a room where the food pantry was located. During an interview on 7/17/26 at 12:18 p.m., DON stated, I just watched a mouse run across the dining room floor as the residents were sitting in there for their noon meal. During an observation and interview on 7/17/26 at 12:55 p.m., the DON had a can of spray foam and was filling holes near the kitchen area. The DON stated, A mouse just tried to come out of the hole while I was filling it. I need to go home, because I cannot handle these mice anymore. During an observation on 7/21/26 at 9:45 a.m., rodent feces was observed on storage shelves in the dining room, on the table next to the phone, in the corner of the dining room, on the shelves of food storage areas in the kitchen, next to the seasonings on the kitchen shelves, next to clean pots and pans, under the appliances, and behind the doors. Repairs to the A/C units in the windows were incomplete. Gray fuzz-like material was observed on a rodent trap located on a resident's dresser. During an interview on 7/21/26, at 10:58 a.m., cook-C stated he had seen rodents here and there. A pest control contract, dated 3/14/24, indicated the facility was on a quarterly service plan for pest control. A pest control service invoice dated 6/8/26, indicated on 6/14/24, immediate repairs were recommended for any hole in the siding or foundation larger than two inches and the front patio area was deteriorated. No suggested repairs have been made at this time. Pest control service was provided. The invoice noted heavy rodent activity in the basement. Three mice removed from trap and bait stations. A pest control invoice dated 7/15/26, indicated recommended repairs had not been made and additional structural repair suggestions included door threshold and window frame. A couple of mice were seen during service. Foundation deterioration, window and door framing are in poor condition. Suggested moving to a monthly service and going through residents' rooms private food storage and items to find potential nesting sites. The facility Pest Control policy, dated 5/2008, directed the facility maintains an on-going pest control program to ensure that the building is kept free of insects and rodents. Windows are screened at all times. (continued on next page)		

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F 0925 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Maintenance services assist, when appropriate and necessary, in providing pest control services. The IJ began 7/16/26 and was removed on 7/22/26 when education was provided to staff regarding proper cleaning methods and instructions to observe for rodent droppings. Education was provided to residents regarding proper storage of personal dry food in plastic bins. A/C unit fittings repaired exterior structural repairs made to control the rodent infestation. An audit of all living, kitchen and storage spaces was conducted. Assessments of all 13 residents were conducted to observe for rodent bites, skin integrity, respiratory symptoms, gastrointestinal symptoms/signs of illness and documented.		

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Keep residents' personal and medical records private and confidential. Based on observation and document review the facility failed to maintain medical record security and confidentiality when contents of the residents' medical records were stored in resident common area space, where residents could access the information. Findings include: During an observation on 7/15/26 at 1:50 p.m., four discharged residents records were located in the corner of the unlocked furnace room. In addition, an open top box, measuring 12 inches x 12 inches x 12 inches, containing residents' health record information was observed in a shared resident room approximately 6 inches from the door on the floor. During an interview on 7/15/26 at 1:55 p.m., the administrator stated the box contained medical records and personal information for residents who were referred to the facility but never admitted. He was unaware the records were in a shared resident room. He stated they were in there because the facility did not have a shredder or method of proper disposal. During an interview on 7/15/26 at 2:40 p.m., the director of nursing (DON) stated she was concerned about the lack of security for the medical records and made the administrator and facility owners aware of the box of health information located in the shared resident room weeks prior. She stated the facility did not have a shredding service or method to store the records securely. A policy regarding the security and confidentiality of medical records was requested but not received.		

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on observation and interview, the facility failed to provide a safe, clean, comfortable and homelike environment when they failed to implement housekeeping and maintenance services to install air conditioning (A/C) units in a manner that would prevent large gaps, failed to repair cracks in the exterior structure, holes in the wall and window coverings and clean the dark gray matter at the base of the walls and bottoms of the doors in the hallway, foyers and kitchen. This had the opportunity to affect all 13 residents. Findings include: During an observation on 7/15/26 at 10:45 a.m., large cracks were observed in the concrete foundation of the front porch/patio. Window A/C units were propped in windows with large gaps on either side observed throughout the facility in hallways and in shared resident rooms: Rooms 101, 203, 205 and in the second floor hallway. The dining room A/C unit had a blanket wrapped around three sides and was hanging down to the dining room floor. Resident rooms appeared cluttered with minimal space for clothing and personal items. Window treatments appeared to be broken. Sheetrock was broken in a shared resident room with a hole measuring approximately four inches x four inches, where R2 and R3 resided. Dark gray matter was built up on the base of the walls and bottoms of doors in the kitchen, hallway, front and back foyer. During an interview on 7/15/26 at 11:25 a.m., R4 stated she had made several requests to the administrator and other staff to have the window A/C unit fitted to her window. During an interview on 7/15/26 at 12:03 p.m., R2 stated the hole in the wall in their shared room had occurred over two weeks prior. She said she had made complaints about the A/C unit in the hall at the top of the stairs being open to the outside, but the facility did not fix it. During an interview on 7/15/26 at 12:00 p.m., the administrator stated the facility did not have designated maintenance staff, the A/C units had been installed in their current status for over a year and he was unaware of the hole in the wall in R2's and R3's room. During an interview on 7/15/26 at 1:00 p.m., the facility owner stated the facility did not have designated maintenance staff but had contractors to contact to complete projects as needed. A policy regarding a safe, clean and home-like environment was requested but not received. A policy regarding building maintenance was requested but not received.		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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 document review, the facility failed to maintain an environment free from fire hazards which had the potential to affect all 13 residents currently residing at the facility. In addition, the facility failed to identify resident risks and implement interventions to reduce risks and monitor a resident (R5) after an incident which included a fall off the facility premises. Findings include: R5's admission Minimum Data Set (MDS) dated [DATE], indicated R5's diagnoses included schizoaffective disorder, psychotic disturbances. R5 was cognitively intact. The MDS indicated R5 had behavioral symptoms and used tobacco, ambulated 10 feet independently and required assistance from staff for showering, putting on footwear, and walking distances over 10 feet. R5 required supervision with stairs. R5 received antipsychotic, antidepressant, antibiotic, diuretic, and hypoglycemic (medications to lower blood sugar) medications. Care area assessments were triggered for cognitive loss/dementia, activities of daily living (ADL) functional/rehabilitation potential, urinary incontinence/catheter, mood state, falls, nutritional status, psychotic drug use, and return to community referral. R5's care plan dated 6/19/26, included nutrition but lacked other areas of care and interventions. R5's progress note dated 7/2/26 at 12:00 a.m., indicated R5 returned to the facility after becoming lost. Around 12:00 a.m., the facility received a phone call from R5. She was disoriented and unable to find her way back. A security guard assisted R5 to make the call and a car service was sent to pick her up. R5 fell while getting into the car and sustained a superficial scrape to the bottom of her foot, denied hitting her head, loss of consciousness, dizziness, or other injuries. Will continue to monitor for any changes in condition. R5's chart lacked an incident report or post-fall observations related to the 7/2/26 incident. During an observation on 7/15/26 at 1:50 p.m., a hospital bed mattress was leaning against the gas furnace and gas water heater in the basement furnace room. There was a large board leaning against the mattress. During an interview and observation on 7/15/26 at 1:50 p.m., the owner stated she did not know who left the mattress leaning against the furnace and water heater. After the surveyor explained the State Fire Marshall was contacted and gave direction to immediately move the mattress, the owner directed the administrator to do so. During an interview on 7/16/26 at 10:20 a.m., the administrator stated his work schedule was 9:00 a.m. to 1:00 p.m. and he worked 16 hours per week which does not allow the opportunity to provide the supervision I need to. The administrator was not aware the mattress was stored in this manner. During an interview on 7/16/26 at 10:57 a.m., the director of nursing (DON) stated on 7/2/26, R5 had an incident where she left the facility independently but was unable to find her way back. She came upon a bus stop security guard who assisted her to call the facility around midnight. The nurse working arranged for a car service to pick R5 up. Upon entering the car, R5 fell to the ground. The DON stated the administrator told her the fall protocol was not necessary since the fall did not occur at the facility. She stated the provider was notified but not R5's emergency contact. She stated R5 did not have a care plan and no new interventions were implemented following the incident. During an interview on 7/22/26 at 10:48 a.m., the administrator stated he was not notified of R5's incident. All falls require nursing to follow the fall protocol which included notifying their emergency contact. During an interview on 7/22/26 at 1:45 p.m., R5 stated she missed the last bus and had to find help to call the facility to find her way back. She fell to the ground as she was getting into the car. The facility Fall Prevention and Fall Management Program, dated 5/30/2018, directed to conduct a fall risk assessment within 24 hours of admission, quarterly, or when a change in health status puts them at (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	increased risk. Any risk should be care planned and treated. Initiate a plan of care within 24 hours of admission based on resident's assessed condition, fall history, needs, behaviors, medications and preferences. Monitor, evaluate and document resident progress and outcomes. When a resident has fallen, the resident will be assessed regarding the nature of the fall and associated consequences, the cause of the fall and the post fall care management needs. Monitor every hour for the first four hours and then every four hours for 24 hours post fall signs of neurological changes. Complete a incident investigation and an incident report including all contributing factors. Redo the fall risk assessment form, review the fall prevention interventions and modify the plan of care in collaboration with the IDT.		

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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 properly prepare and store food in accordance with safe food handling. This had the potential to affect all 13 residents currently residing at the facility. Findings include: During an interview on 7/15/26 at 10:45 a.m., cook-A stated he was aware of the need to wear a beard net to prevent hair from getting into the food, but the facility refused to purchase them. During an observation on 7/15/26 at 11:50 a.m., cook-A was in the kitchen and not wearing a beard net for beard hair approximately one and one-half inches to two inches long. During an interview on 7/15/26 at 10:46 a.m., the administrator stated cook-A's beard was about one and one-half inches to two inches long and required a beard net while in the kitchen. The administrator stated he was aware that beard nets were important to prevent food getting into residents' food. He previously directed cook-A to order beard nets. During an interview on 7/15/16 at 1:05 p.m., the owner stated she was unsure what the temperature of the refrigerator should be to keep food safe and thought it might be under 38 degrees Fahrenheit (F). During an observation on 7/15/16 at 1:50 p.m., the kitchen floor had 6 loose tiles in the middle of the floor with dark brown matter underneath them. The kitchen refrigerator was at 42 degrees F with the following items stored in the refrigerator: a gallon of milk, ketchup, mustard, barbeque sauce, and mayonnaise that was previously opened but were not labeled with the date. In the top drawer of the kitchen freezer, there was a pink-tinged frozen liquid under frozen chicken. On the counter were opened jars of grape jelly and strawberry jelly with approximately 50% remaining in each jar. Both jars of jelly lacked date opened labels. In the kitchen cabinets, the opened paper sacks of flour and sugar were both folded over and were unsecured, without a date opened on them. Two opened bags of chips were folded over and were not secured in a bowl on top of the refrigerator. Neither bag was labeled with date opened. Rodent feces were observed behind the seasonings in the upper cabinet. A dark, brown matter was under the counters, sink, dishwasher, oven, and refrigerator/freezer. A pile of rodent feces was under the front right leg of the oven. There was a yellow matter stuck to a spatula in the drawer. There were rodent feces in the cabinet next to the clean pots and pans and on the shelf where clean plates and bowls were stored. There were rodent feces on the food prep counter. There was a brown residue on the interior and exterior of the toaster. A hairbrush with a moderate amount of hair in it was observed in the middle kitchen drawer where clean spoons, unused hairnets and unused scrubbing pads were stored. There were piles of rodent feces behind both kitchen doors along with a large amount of gray dark matter. During an interview on 7/15/26 at 1:50 p.m., the administrator stated the kitchen refrigerator was not working correctly and the facility was not using it. The milk was purchased that morning so the residents could have milk on their cereal and should have been stored downstairs in the one refrigerator that was working correctly. The food in the kitchen refrigerator at the time was intended for resident consumption but should have been thrown away and would be thrown away. The administrator stated the residents had not received that food since the refrigerator was not functioning correctly. There was a note on the kitchen refrigerator instructing staff not to use it. The freezer should be cleaned to prevent illness. The jelly was not served for breakfast, and he was unsure why it was left on the counter. The administrator stated the cloths used to clean the kitchen were clean, however they appeared worn and soiled. Items should be dated once opened and closed securely to know when to discard the food items. The administrator was unsure why the items were stored improperly as the cooks had received training. The hairbrush should not have been stored in the kitchen. During an interview on 7/15/26 at 2:40 p.m., the director of nursing (DON) stated she (continued on next page)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	reported concerns of the food storage and unsanitary kitchen to the owner and the administrator two weeks prior. No efforts have been made to correct the improper food storage or to clean. The DON was concerned for the health of the residents. During an interview on 7/16/26 at 12:12 p.m., cook-A stated the kitchen refrigerator hadn't worked in a week. He was aware food was to be labeled when it was opened, so staff knew when to discard it. During an observation on 7/21/26 at 9:45 a.m., rodent feces were near the seasonings in the kitchen cabinet. There was a large pile of rodent feces under the front right leg of the oven and piles of rodent feces behind both kitchen doors. During an observation on 7/21/26 at 10:58 a.m., cook-C was in the kitchen, preparing food, without a hairnet. During an interview on 7/21/26 at 10:58 a.m., cook-C stated he was aware he was supposed to wear a hairnet in the kitchen. During an observation on 7/22/26 at 2:25 p.m., cook-C was in the kitchen without wearing a hairnet. The facility Food Receiving and Storage policy, dated 11/2022, directed food shall be stored in a manner that complies with safe handling practices. Food services, or other designated staff, maintain clean and temperature/humidity appropriate food storage at all times. Dry food storage area must be kept free of insects and rodents and kept clean. Dry foods and goods are stored in a manner that maintains the integrity of the packaging until they are ready to use. All foods in the refrigerator or freezer and covered, labeled and dated. Potentially hazardous foods are stored at or below 41 degrees F, unless otherwise specified by law. The facility Food Storage and Procurement policy, dated 3/30/25, directed if a bag of food is opened but some food remains in the bag, the bag or box must be labeled with an additional label of the date the food was opened. Open packages of food must be closed with tape or label to prevent contamination of the food.		

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Administer the facility in a manner that enables it to use its resources effectively and efficiently. Based on observation, interview, and document review the facility failed to provide oversight and management for the facility when there was a severe rodent infestation, lack of food, and the facility was in disrepair. This had the potential to affect all 13 residents currently residing at the facility as well as all staff and visitors. Findings include: A pest control service invoice, dated 6/8/26, indicated on 6/14/24 immediate repairs recommended for hole in siding or foundation larger than two inches and front patio deteriorated. No suggested repairs have been made at this time. Pest control service was provided. It indicated heavy rodent activity in the basement. Three mice removed from trap and bait stations. A pest control invoice, dated 7/15/26, indicated recommended repairs had not been made and additional structural repair suggestions included door threshold and window frame. A couple of mice were seen during service. Foundation deterioration, window and door framing are in poor condition. Suggested moving to a monthly service and going through residents' rooms private food storage and items to find potential nesting sites. During an observation on 7/15/26 at 10:45 a.m., evidence of rodent feces was present in residents' rooms, the dining room, food storage areas, food preparation areas, near clean dishes, on the kitchen floor, in medical supply storage areas and in sanitary linen areas. Large cracks were observed in the concrete foundation of the front porch/patio. Window air conditioning (A/C) units were propped in windows with large gaps on either side (open to the outdoors) were observed throughout the facility in hallways and residents' rooms. Fruit, bakery items, leftover meals, crackers and granola bars were stored in residents' rooms. During an interview on 7/15/26, at 11:25 a.m., R4 stated she had recently trapped three mice in her room. I purchased my own mouse traps, and the mice had chewed on my quilt. During an interview on 7/15/26 at 12:00 p.m., the administrator stated the director of nursing (DON) found a lot of rodent feces and the facility had a monthly contract with an exterminator. He was unaware there was a rodent trap on a resident's bed. The administrator did not review the pest control reports, and the facility did not have a designated maintenance person on staff. The administrator stated he should have reviewed them but they were sent directly to the owners. During an interview on 7/15/26 at 12:03 p.m., R2 stated the facility lacked healthy food options. When cold cereal with water was provided for breakfast on 7/15/26, R2 opted to eat snacks in her room instead. R2 stated cereal was not on the menu, but the facility rarely followed the menu. The administrator was aware of the rodent problem but did nothing to resolve the concerns. During an interview on 7/15/26 at 12:04 p.m., R3 stated the facility did not follow the menu. When R3 asked for an alternative, cook-A became angry and retaliated by making food that was not palatable such as a stale hot dog bun, covered in wilted lettuce and a large amount of mustard. During an interview on 7/15/26 at 12:37 p.m., R6 stated rodents had run over her while she was sleeping. During an interview on 7/15/26 at 12:39 p.m., R8 stated sometimes she saw rodents and, Last week there was a squirrel in the house. During an interview on 7/15/26 at 1:00 p.m., the facility owner stated they had an ongoing rodent problem. She stated the other owner was at the facility on 7/10/26 and observed traces of rodents and found a deceased mouse. Rodent poison was purchased to place in the basement. During an interview on 7/15/26 at 1:30 p.m., the contracted exterminator stated the recommended structural repairs to the facility have not been made, along with residents maintaining food caches in their rooms. He stated he recommended the facility increase the service contract from quarterly to monthly to better control the rodents over a year ago, but they declined. He stated the severity of the rodent infestation was not new and the owners were aware. He documented his recommendations on the invoices provided to the facility. During an observation on 7/15/26 at 1:50 p.m., four discharged residents' records were located in the corner of the unlocked furnace room. An (continued on next page)		

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	open top box, measuring 12 inches x 12 inches x 12 inches, containing health information, was observed on the floor in a shared resident room approximately six inches from the door. A plastic covered hospital bed mattress was leaning against the gas furnace and gas water heater in the basement furnace room. There was a large board leaning against the mattress. During an interview on 7/15/26, at 1:55 p.m., the administrator stated the box in the shared resident room contained medical records and personal information for residents who were referred to the facility but never admitted. He stated he was unaware the records were in a shared resident room. He stated they were in there because the facility did not have a shredder or method of proper disposal. He stated the DON informed the owners the facility needed a paper shredder. During an interview on 7/15/26 at 2:40 p.m., the DON stated she made complaints the week of 6/22/26, regarding unsanitary conditions and the rodent problem to the administrator and owners. The DON had concerns the residents could get sick and die from the rodents. The owners directed the DON to purchase mouse poisoning and place it in resident rooms, but she refused as she felt this was unsafe for the residents. The DON stated on the morning of 7/15/26, when she saw cook-A serve cold cereal with water to R7, she immediately asked another staff person to go buy milk. Cold cereal was not on the menu for 7/15/26. The DON made the administrator and facility owners aware of the box of health information located in the shared resident room weeks prior. The facility did not have a shredding service or method to store the records securely. The owners told her they would purchase a shredder and there was no further direction regarding the storage of the box of health information. The facility had not provided education to the staff or the residents to reduce or control the rodent infestation. The DON did not feel the administrator could appropriately supervise the facility as he was in the facility only 16 hours per week. During an interview on 7/15/26 at 3:25 p.m., licensed practical nurse (LPN)-A stated rodents have been a problem at the facility, and they had even trapped some of them. The facility had not provided education regarding reducing or controlling the rodents. During an observation on 7/16/26 at 9:45 a.m., shelves in cabinet used for activity supplies were covered in rodent feces. During an interview on 7/16/26 at 10:20 a.m., the administrator stated his work schedule was 9:00 a.m. to 1:00 p.m. and he worked 16 hours per week which does not allow the opportunity to provide the supervision I need. He shared this concern with the owners. He stated his reduced hours were due to the facility's budget. During an interview on 7/16/26 at 12:12 p.m., cook-A stated the facility often had expired food and did not have the ingredients to make what was on the menu. The refrigerator in the kitchen had not been functioning since 7/10/26. One of the two refrigerators in the basement was in operating condition. The administrator was aware and working on obtaining a replacement refrigerator for the basement and repairing the kitchen refrigerator. Cook-A was not sure how long obtaining the replacement and the repairs would take. During an interview on 7/16/26 at 12:30 p.m., registered nurse (RN)-B stated rodents were everywhere in the facility and it had been a problem for years. During an interview on 7/16/26 at 2:30 p.m., the administrator stated he had received complaints about rodents in the facility and shared those complaints with the owners. He stated the rodents could leave feces and urine which could cause the residents to get sick. During an interview on 7/16/26 at 4:30 p.m., licensed practical nurse (LPN)-A stated he had worked at the facility for seven months and the residents complained about the rodents all the time. He stated he did not do anything in response to this concern. During an observation on 7/21/26 at 9:45 a.m., rodent feces was observed on storage shelves in dining room, on the table next to the phone, in the corner of the dining room, on shelves of food storage areas in the kitchen, next to the seasonings on the kitchen shelves, next to clean pots and pans, under appliances, and behind the kitchen doors. Repairs to the A/C fit in the windows was incomplete. Gray fuzz-like material was observed on a rodent trap located on a (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	resident's dresser. The facility Pest Control policy, dated 5/2008, directed the facility maintains an on-going pest control program to ensure that the building is kept free of insects and rodents. Windows are screened at all times. Maintenance services assist, when appropriate and necessary, in providing pest control services. A policy for building maintenance was requested but not received. A policy regarding the security and confidentiality of medical records was requested but not received.		

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. Based on interview and document review the facility failed to establish a system to address, monitor and take actions for a known rodent problem. This had the potential to affect all 13 residents at the facility, staff and visitors. Findings include: The facility's Quality Assessment Performance Improvement (QAPI) committee notes, dated 7/14/26, lacked documentation addressing a plan for the rodent infestation, monitoring the progress of the identified rodent issue or infection concerns related to the rodent infestation. The QAPI notes lacked plans for structural repairs recommended by the pest control service. The document indicated the owner, administrator, director of nursing (DON) and infection preventionist (IP) were present at the meeting. During an observation on 7/15/26, at 10:45 a.m., evidence of rodent feces was present in resident rooms, dining room, food storage, food preparation, clean dishes, kitchen floor, medical supply storage areas and sanitary linen areas. Bait boxes, glue traps, and snap traps for rodents observed in resident rooms, on a resident's dresser, on a resident bed, in closets, hallways, dining room, food storage areas and basement. During an interview on 7/15/26, at 11:25 a.m., R4 stated she had recently trapped three rodents in her room. She stated she had purchased her own rodent traps. During an interview on 7/15/26, at 12:00 p.m., the administrator stated the director of nursing (DON) found a lot of rodent feces and the facility had a monthly contract with an exterminator. He did not review the pest control reports, and the facility did not have a designated maintenance staff person. During an interview on 7/15/26 at 1:00 p.m., the facility owner stated they had an ongoing rodent problem. She stated the other owner was at the facility on 7/10/26 and observed traces of rodents and found a deceased rodent. During an interview on 7/15/26, at 1:30 p.m., the exterminator stated recommended structural repairs to the facility have not been made, along with residents maintaining food caches in their rooms over a year ago. He stated he recommended the facility increase the service contract from quarterly to monthly to better control the rodents, but they declined. He stated the severity of the rodent infestation was not new. During an interview on 7/15/26, at 2:40 p.m., the DON stated she made complaints the week of 6/22/26, regarding unsanitary conditions and the rodent problem to the administrator and owners. The rodent problem was not addressed at the QAPI committee meeting on 7/14/26. The DON stated that was her first time in attendance at a QAPI meeting and she was still learning about the process and purpose of the QAPI program. She stated she had concerns the residents could get sick and die from the rodents. No education had been provided to the residents or staff to reduce or control rodent infestation. During an interview on 7/16/26, at 2:30 p.m., the administrator stated he had received complaints about rodents in the facility and shared those complaints with the owners. He stated the rodents could leave feces and residents could get sick. He stated the rodent infestation was not addressed at the facility's QAPI meeting on 7/14/26. (This is April's interview below:) During an interview on 7/16/26 at 3:52 p.m., the infection preventionist (IP) stated she was aware of the rodent infestation at the facility, however, did not do any audits to determine the location of the rodents or if they had been present in care/food areas. The IP explained that the administrator and/or the director of nursing should have been doing the monitoring. The IP was responsible for tracking resident illnesses and did not monitor the environment for pest infestation. The IP further explained that having rodents in the facility near resident areas and food areas can put the residents at risk of contracting a communicable disease and would fall into infection prevention, however, she had not identified any illness at the facility that would have been caused by rodent infestation. A pest control invoice, dated 7/15/26, indicated recommended repairs had not been made and additional structural (continued on next page)		

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	repair suggestions included door threshold and window frames. A couple of rodents were seen during service. Foundation deterioration, window and door framing are in poor condition. Suggested moving to a monthly service and going through residents' rooms private food storage and items to find potential nesting sites. The facility Infection Prevention and Control Program (IPCP) and The Role of the Infection Preventionist policy, dated 10/20/25, directed the IPCP will provide a safe, sanitary and comfortable environment to help prevent the development and transmission of communicable diseases and infections. The QAPI committee, through the Infection Control Committee, shall oversee the implementation of infection control policies and procedures, and help department directors and managers ensure that they are implemented and followed. The facility Quality Assurance and Performance Improvement (QAPI) Program policy, dated 2/2020, directed the objective of the QAPI program to provide a means to establish and implement performance improvement projects to correct identified negative or problematic indicators and establish systems through which to monitor and evaluate corrective actions. The owner/governing board is ultimately responsible for the QAPI program. The administrator is responsible for assuring that the facility's QAPI program complies with federal, state and local regulatory agency requirements.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. Based on interview and document review the facility failed to ensure a sanitary environment when the facility was noted to have and failed to respond to a rodent infestation. This had the potential to affect all 13 residents currently residing at the facility as well as staff and visitors. Findings include: A pest control invoice, dated 7/15/26, indicated recommended repairs had not been made and additional structural repair suggestions included door threshold and window frame. A couple of mice were seen during service. Foundation deterioration, window and door framing are in poor condition. Suggested moving to a monthly service and going through residents' rooms private food storage and items to find potential nesting sites. During an observation on 7/15/26 at 10:45 a.m., evidence of rodent feces was present in resident rooms, dining room, food storage, food preparation, clean dishes, kitchen floor, medical supply storage areas and sanitary linen areas. Bait boxes, glue traps, and snap traps for mice observed in resident rooms, on resident dresser, on a resident bed, in closets, hallways, dining room, food storage areas and basement. During an interview on 7/15/26 at 12:00 p.m., the administrator stated the director of nursing (DON) found a lot of rodent feces and the facility had a monthly contract with an exterminator. The administrator was unaware there was rodent trap on a resident bed. He did not review the pest control reports, and the facility did not have a designated maintenance person on staff. During an interview on 7/15/26 at 1:00 p.m., the facility owner stated they had an ongoing rodent problem. She stated the other owner was at the facility on 7/10/26 and observed traces of mice and found a deceased rodent. During an interview on 7/15/26 at 1:30 p.m., the contracted exterminator stated recommended structural repairs to the facility have not been made, along with residents maintaining food caches in their rooms. He stated he recommended the facility increase the service contract from quarterly to monthly to better control the mice, but they declined. He stated the severity of the mice infestation was not new. During an interview on 7/15/26 at 2:40 p.m., the DON stated she made complaints the week of 6/22/26, regarding unsanitary conditions and rodent problem with the administrator and owners. She stated she had concerns the residents could get sick and die from the mice. No education had been provided to the residents or staff to reduce or control mice infestation. During an observation on 7/16/26 at 9:45 a.m., shelves in cabinet used for activity supplies were covered in rodent feces. During an observation on 7/21/26 at 9:45 a.m., rodent feces were observed on storage shelves in dining room, on table next to phone, on the in the corner of the dining room, on shelves of food storage areas in the kitchen, next to the seasonings on the kitchen shelves, next to pots and pans and under the appliances, and behind the doors. Repairs to A/C fit in the windows was incomplete. Gray (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 24E507	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/22/2026
NAME OF PROVIDER OR SUPPLIER Southside Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2644 Aldrich Avenue South Minneapolis, MN 55408	
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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	fuzz-like material was observed on a rodent trap located on a resident's dresser. During an interview on 7/16/26, at 2:30 p.m., the administrator stated he had received complaints about mice in the facility and shared those complaints with the owners. He stated the mice could leave feces and residents could get sick. During an interview on 7/16/26 at 3:52 p.m., infection preventionist (IP) stated she was aware of the rodent infestation at the facility, however, did not do any audits to determine the location of the rodents or if they had been present in care/food areas. IP explained that the administrator and/or the director of nursing should have been doing the monitoring. The IP was responsible for tracking resident illnesses and did not monitor the environment for pest infestation. The IP further explained that having rodents in the facility near resident areas and food areas can put the residents at risk of contracting a communicable disease and would fall into infection prevention, however, she had not identified any illness at the facility that would have been caused by a rodent infestation. The facility Infection Prevention and Control Program (IPCP) and The Role of the Infection Preventionist policy, dated 10/20/25, directed the IPCP will provide a safe, sanitary and comfortable environment to help prevent the development and transmission of communicable diseases and infections. The QAPI committee, through the Infection Control Committee, shall oversee the implementation of infection control policies and procedures, and help department directors and managers ensure that they are implemented and followed.		

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F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow resident to participate in the development and implementation of his or her person-centered plan of care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review the facility failed to offer an interdisciplinary care conference, involve resident in the plan of care, allow the resident to share preferences or ask if they had any concerns with the care provided for 1 of 3 (R5) residents reviewed for the right to participate in care planning. Findings include: R5's admission Minimum Data Set (MDS) dated [DATE], indicated R5's diagnoses included schizoaffective disorder, psychotic disturbances. R5 was cognitively intact. The MDS indicated R5 had behavioral symptoms and used tobacco, ambulated 10 feet independently and required assistance from staff for showering, putting on footwear, and walking distances over 10 feet. R5 required supervision with stairs. R5 received antipsychotic, antidepressant, antibiotic, diuretic, and hypoglycemic (medications to lower blood sugar) medications. Care area assessments were triggered for cognitive loss/dementia, activities of daily living (ADL) functional/rehabilitation potential, urinary incontinence/catheter, mood state, falls, nutritional status, psychotic drug use, and return to community referral. R5's care plan dated 6/19/26, lacked resident preferences. R5's care plan only included nutrition. R5's chart included a care conference note dated 6/29/26, with the director of nursing (DON) and R5 present. It included goals, R5's medical history and orders but lacked addressing R5's preferences, R5's goals for herself, and addressing any concerns. During an interview on 7/16/26 at 10:57 a.m., the DON stated R5 was admitted to the facility over one month prior but had never had a care conference and did not have a care plan. The DON stated care was directed by the physician orders. During an interview on 7/22/26 at 10:48 a.m., the administrator stated care plans were established by the admitting nurse sitting down with the resident and having a conversation with the resident. He stated care conferences were set up on a calendar for the nurses to conduct them within the first 14 days, then quarterly or as needed. During an interview on 7/22/26 at 1:31 p.m., registered nurse (RN)-B stated care is directed by the physician using ordered treatments and the DON was responsible to set up care conferences. During an interview on 7/22/26 at 1:45 p.m., R5 stated the facility had not asked her about her personal, cultural or religious preferences. R5 was not offered a care conference, but a nurse did an assessment. The facility did not ask her if she had other providers or medical needs. R5 stated she had other providers and needed to schedule medical procedures and establish transportation to the appointments. The facility had not offered her a meeting to discuss concerns or needs. She was not provided with a copy of a care plan. The facility Care Plans, Comprehensive Person-Centered policy, dated 3/2022, directed the resident is informed of his or her right to participate in his or her treatment, and provided advance notice of care planning conferences. Each resident's comprehensive person-centered care plan is consistent with the resident's rights to participate in the development and implementation of his or her plan of care, including the right to: a. participate in the planning process; b. identify individuals or roles to be included; c. request meetings; d. request revisions to the plan of care; e. participate in establishing the expected goals and outcomes of care; f. participate in determining the type, amount, frequency and duration of care; g. receive the services and/or items included in the plan of care; and h. see the care plan and sign it after significant changes are made.		

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F 0572 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents a notice of rights, rules, services and charges. Based on interview and document review the facility failed to provide 1 of 3 (R5) residents with the Resident [NAME] of Rights (RBoR) orally or in writing upon admission to the facility. Findings include: R5's chart lacked documentation that R5 received a copy of the RBoR. During an interview on 7/16/26 at 10:57 a.m., the director of nursing (DON) stated the administrator was responsible to review the [NAME] of Rights and explain the grievance process to new residents upon admission to the facility. During an interview on 7/22/26 at 10:48 a.m., the administrator stated the admitting nurse was responsible to ensure new residents were informed of the RBoR when they moved into the facility and the DON was responsible to verify all steps of the admission process were complete. The admission process was not in written form. The administrator stated R5's chart lacked evidence she was provided with the RBoR but there was a full listing of the RBoR posted on a facility wall. During an interview on 7/22/26 at 1:55 p.m., R5 stated was not provided with a written copy of the RBoR when she admitted to the facility and did not know if they were posted in the facility. R5 stated the staff did not verbally educate her or review the RBoR with her. The facility Resident Rights and Responsibilities policy, undated, listed resident rights and provided grievance information. The policy lacked direction to provide the resident with the [NAME] of Rights prior to or upon admission. The facility Abuse Prevention policy, dated 5/30/25, directed residents and families are informed on admission how to report concerns, incidents, and grievances. A copy of the Resident [NAME] of Rights is provided and its content is covered upon every admission.		

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review the facility failed to notify the resident's representative following an incident involving 1 of 3 residents (R5) reviewed for notification of change. Findings include: R5's admission Minimum Data Set (MDS) dated [DATE], indicated she had diagnoses of schizoaffective disorder, psychotic disturbances and was cognitively intact. R5's chart indicated her friend was her emergency contact. R5's progress note dated 7/2/26 at 12:00 a.m., indicated R5 returned to the facility after becoming lost. Around 12:00 a.m., the facility received a phone call from the resident. She was disoriented and unable to find her way back. A security guard assisted her to make the call, and a car service was sent to pick her up. R5 fell while getting into the car and sustained a superficial scrape to the bottom of her foot. During an interview on 7/16/26 at 10:57 a.m., the director of nursing (DON) stated on 7/2/26, R5 had an incident where she left the facility independently but was unable to find her way back. She came upon a bus stop security guard who assisted her to call the facility around midnight. The nurse working arranged for a car service to pick R5 up. Upon entering the car, R5 fell to the ground. The DON stated the administrator told her the fall protocol was not necessary since the fall did not occur at the facility. R5's provider was notified but not R5's emergency contact. During an interview on 7/22/26 at 10:48 a.m., the administrator stated he was not notified of R5's incident. All falls require nursing to follow the fall protocol which included notifying their emergency contact. During an interview on 7/22/26 at 1:45 p.m., R5 stated she missed the last bus and had to find help to call the facility to find her way back. She fell to the ground as she was getting into the car service. She said her daughter should have been notified. During an interview on 7/22/26 at 3:42 p.m., R5's friend stated she was not informed of R5 having any incidents at the facility but wished she had been notified. The facility Fall Prevention and Fall Management Program, dated 5/30/2018, directed to notify the registered nurse (RN) and the physician when falls occur. The policy lacked direction to notify the resident's representative when accidents occur.		

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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 interviews and document review the facility failed to document, track and follow up with grievances filed by residents for 3 of 3 residents (R4, R2 and R3) reviewed for complaints. Findings include: R4 R4's face sheet dated 7/17/26, identified R4's diagnoses included depressive disorder, anxiety disorder, post-traumatic stress disorder, and chronic cough. During an interview on 7/15/26 at 11:25 a.m., R4 stated she had complained about rodents chewing on her quilt to the director of nursing (DON) over the past couple weeks but no action had been taken to resolve R4's concern. R2 R2's quarterly MDS dated [DATE], indicated R2's diagnoses included post-traumatic stress disorder (PTSD), and anxiety. R2's cognition was intact. During an interview on 7/15/26 at 12:03 p.m., R2 stated she made complaints directly to the administrator over the past few months regarding food portion sizes, being fearful of kitchen staff due to their behavior, and stated nothing gets done. R3 R3's quarterly MDS dated [DATE], indicated R3's diagnoses included panic disorder, traumatic brain injury (TBI), anxiety, depression, and PTSD. R3 had moderate cognitive impairment. During an interview on 7/15/26 at 12:04 p.m., R3 stated she told the administrator and the DON she was scared of the two kitchen staff because they slammed things around and made her feel uncomfortable. She stated she complained about the food that was served and the amount of food they were served. R3 stated the administrator did not make any changes or follow up with her regarding her complaints. During an interview on 7/15/26 at 2:40 p.m., the DON stated she made complaints about unsanitary conditions to the administrator and owners during her first week at the facility, the week of 6/15/26. During her second week of employment, she shared her concerns regarding a mouse problem with the administrator and owners. The DON stated she talked to the administrator regarding the kitchen staff playing very loud music with explicit language and them slamming things around in the kitchen, making loud noises and how it bothered the residents. She complained about the amount of food served, not following the menu, expired food being served, and lack of activities at the facility. The administrator and owners of the facility failed to follow-up with her regarding her concerns. She stated the facility didn't have a formal grievance process that she knew of. During an interview on 7/16/26 at 2:30 p.m., the administrator stated the facility only had one complaint in the last year and it was yesterday. He said he had not received any concerns about staff behavior but had received complaints regarding building maintenance issues, including rodents. He also stated some residents had complained there was too much pork on the menu. The administrator stated he was the grievance officer. The grievance forms were kept in the wall pocket near the front door. During an observation on 7/16/26 at 3:30 p.m., there were no grievance forms in the designated location, in the wall pocket near the front door. During an interview on 7/16/26 at 4:30 p.m., licensed practical nurse (LPN)-A stated the facility did not have a formal process to handle complaints. He informed the administrator and DON if there were complaints. The residents complained about the rodents and kitchen staff behavior frequently and LPN-A shared the complaints with the facility administrator many times. During an observation on 7/21/26, at 9:45 a.m., there were no grievance forms in the designated location, in the wall pocket near the front door. During an interview on 7/21/26 at 3:23 p.m., cook-B stated there was not a specific complaint form and complaints should be directed to the administrator. During an observation on 7/22/26 at 1:25 p.m., there were no grievance forms in the designated location, in the wall pocket near the front door. During an interview on 7/22/26 at 1:45 p.m., R5 stated she admitted to the facility on [DATE], and was not informed of the facility's (continued on next page)		

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	grievance and complaint procedure. She was not informed there were complaint forms. The facility Quality Assessment Performance Improvement (QAPI) committee meeting notes, dated 7/14/26, indicated management discussed resident grievance documentation procedures for recent conduct issues regarding cook-A and the administrator would complete a grievance form. The facility grievance complaint log indicated there was one complaint made on 7/15/26 by R2 when intimidating comments were made by cook-A. The facility policy Resident Rights and Responsibilities policy, undated, directed residents may file grievances verbally or in writing without fear of retaliation. The policy lacked direction to notify residents of right to file grievances through postings in prominent locations and notifying residents individually, right to file a complaint anonymously, reasonable expected time frame for completing review of the complaint, identification of the facility grievance official, contact information for the Beneficiary and Family Centered Care Quality Improvement Organizations (BFCC-QIO), the state Survey Agency (SA). The policy lacked direction to take immediate action to prevent further violations while investigating the allegations, immediately report abuse, the process of handling the grievance and following up with the resident, and maintain records of all grievances for at least three years. The facility Abuse Prevention policy, dated 5/30/25, directed residents and families to be informed on admission how to report concerns, incidents, and grievances. A copy of the Resident [NAME] of Rights is provided, and its content is covered upon every admission. Upon hire, all staff are informed to report concerns and/or incidents. This is reviewed in annual in-services as required. After initial investigation a complaint is determined not willful treatment /abuse, this report may be filed on the complaint/grievance form and not reported to the SA. Appropriate follow up will be documented on the form.		

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review the facility failed to protect residents' rights to be from verbal abuse, mental abuse and neglect when cook-A verbally threatened R2 and R3, and when the facility lacked administrative supervision of staff performance. Findings include: R2R2's quarterly Minimum Data Set (MDS) dated [DATE], indicated she had diagnoses of post-traumatic stress disorder (PTSD), anxiety and her cognition was intact. R2's care plan dated 2/16/26, indicated she had diagnoses of borderline personality disorder, depression and diabetes. It directed to encourage resident to express feelings, allow her time to talk and discuss concerns, fears, or issues regarding health or other subjects. It directed a dietary consult should be provided for nutritional regimen. R2's nurse practitioner (NP) note dated 6/29/26, indicated a carbohydrate-conscious diet was recommended. R3R3's quarterly MDS dated [DATE], indicated she had diagnoses of panic disorder, traumatic brain injury (TBI), anxiety, depression, PTSD and had moderate cognitive impairment. R3's care plan dated 10/17/25, directed to discuss concerns, fears, or issues regarding health or other subjects. During an observation on 7/15/26 at 10:45 a.m., cook-A told R2 and R3 they would be, looking for a new place to live, if they told the surveyor what occurs at the facility. During an interview on 7/15/26 at 12:04 p.m., R3 stated she had agoraphobia (anxiety disorder characterized by an intense fear of situations where escape might be difficult or help unavailable, often leading to avoidance of public places or situations that trigger anxiety) and cook-A's threat to not to talk to the surveyor would make her want to stay in her room to avoid him. R3 stated she reported to the administrator when cook-A and cook-B slam things around in the kitchen, it made her feel uncomfortable and unsafe. She told the administrator and director of nursing (DON) but nothing was done. During an interview on 7/15/26 at 12:45 p.m., the administrator stated he was unaware residents felt uneasy with cook-A and cook-B. He stated cook-A cooked lunch and dinner and the administrator left facility by 1:00 p.m. each day, so he did not witness the behavior the residents reported. During an interview on 7/15/26 at 2:40 p.m., the DON stated she also heard cook-A threaten R2 and R3 to not tell the surveyor what occurs in the facility. She told the administrator some residents had complained about cook-A and cook-B's behavior including slamming things around in the kitchen and playing music with explicit language loudly in the kitchen disrupting the peaceful home-like environment. During an interview on 7/16/26, at 10:00 a.m., the DON stated the facility did not initiate abuse education for staff following alleged employee to resident sexual abuse on 7/10/26 or the witnessed verbal threat on 7/15/26. The facility Abuse Prevention policy, dated 5/30/25, directed the facility to have systems in place to prevent abuse. All resident incidents are reviewed to determine whether there is reasonable evidence to suspect abuse and/or neglect of vulnerable adults. Incidents are reviewed by the program director or administrator.		

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review the facility failed to immediately report abuse and abuse allegations to the State Agency (SA) within two hours for 3 of 3 (R1,R2,R3) residents reviewed for abuse.R1R1's quarterly Minimum Data Set (MDS) dated [DATE], indicated she had diagnoses of endocarditis (an infection of the inner lining of heart) anxiety, depression, bipolar disorder, adjustment disorder and was cognitively intact.R1's chart lacked a vulnerability care plan.R1's progress notes lacked documentation of the alleged sexual abuse.R1's chart lacked attempts at communication to investigate alleged abuse.R2R2's quarterly MDS dated [DATE], indicated R2's diagnoses included post-traumatic stress disorder (PTSD), and anxiety. R2's cognition was intact.R3R3's quarterly MDS dated [DATE], indicated R3's diagnoses included panic disorder, traumatic brain injury (TBI), anxiety, depression, and PTSD. R3 had moderate cognitive impairment.A report to the State Agency (SA) on 7/13/26 at 8:01 a.m., indicated on 7/10/26 two residents informed the director of nursing (DON), cook-A had a sexual relationship with R1 resulting in R1 becoming upset and then leaving the facility.During an observation on 7/15/26 at 10:45 a.m., cook-A told R2 and R3 they would be, looking for a new place to live, if they told the surveyor what occurs at the facility.During an interview on 7/15/26, at 12:03 p.m., R2 stated R1 had shared a room with her. R2 stated prior to R1 leaving the facility on 7/3/26, R1 was overheard on a phone call with her boyfriend whom she was breaking up with due to having a sexual relationship with cook-A.During an interview on 7/15/26, at 12:04 p.m., R3 stated she also shared a room with R1 and overheard R1 on the phone fighting with her boyfriend because she [R1] had a relationship with cook-A. R3 was unsure of the exact date but said it was a few days prior to R1 leaving on 7/3/26.During an interview on 7/15/26, at 12:45 p.m., the administrator stated R1 refused to provide a statement when she did not return his calls on 7/11/26, 7/12/26 and 7/13/26. He stated he interviewed cook-A on 7/14/26, who denied having a relationship with R1. The administrator stated he interviewed two other residents who were severely cognitively impaired and did not interview R1's previous roommates, who reported the allegations. The administrator concluded the allegations were unsubstantiated. The administrator stated he was aware abuse must be reported to the SA immediately but thought the DON reported the alleged abuse.During an interview on 7/16/26 at 10:00 a.m., the director of nursing stated on 7/10/26, R2 and R3 reported they overheard R1 fighting with her boyfriend on the phone saying she was breaking up with him because she was in a sexual relationship with cook-A. The DON informed the administrator and the owner via text message on 7/10/26. The DON did not file a police report. She made a report to the SA on 7/13/26. She stated the administrator did not interview R2 and R3 who were the witnesses to the phone call and told the DON she was not allowed to interview cook-A, as she was not his supervisor. The DON stated she was not aware of the requirement to report immediately but thought the administrator was responsible for reporting the alleged abuse.A report to the SA on 7/17/26 at 6:08 p.m., indicated on 7/15/26 at 10:45 a.m., cook-A was observed by surveyor telling residents not to say anything or they would have to move out.The facility Quality Assessment Performance Improvement (QAPI) committee meeting notes, dated 7/14/26, lacked review of report of allegation of sexual relationship between cook-A and R1.The facility Abuse Prevention policy, dated 5/30/25, directed it is the policy of the facility to establish and enforce a system for prompt reporting of abuse or neglect of any resident of the facilities and have systems in place to prevent abuse. We are required to report any allegations regarding abuse, neglect, exploitation or mistreatment, including (continued on next page)		

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	injuries of unknown source an misappropriation of resident property immediately, but not later than 2 hours after the allegation is made if the events that cause the allegation involve abuse or results in serious bodily injury or suspicion of a crime, or not later than 24 hours if the events that cause the allegations do not involved abuse and do not result in bodily injury, to the administrator and SA. Immediately make an oral report to the staff nurse. The program director, DON and administrator must be notified immediately / as soon as possible of any allegations of mistreatment. Staff may gather some initial information to determine whether an incident potentially meets one or more of the reporting criteria. If so, then report to the SA via on-line reporting. After initial investigation a complaint is determined not willful mistreatment/abuse, this report may be filed on the complaint/grievance form and not reported to the SA. If the event involved allegation of abuse, serious bodily injury or suspicion of a crime it must be reported to the SA and local police within 2 hours. Review summary of cases at the next QAPI committee meeting.		

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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 document the discharge for 1 of 3 residents (R1) reviewed for discharge process. Findings include: R1's quarterly Minimum Data Set (MDS) dated [DATE], indicated diagnoses of endocarditis (an infection of the inner lining of heart) anxiety, depression, bipolar disorder, adjustment disorder. R1 was cognitively intact. R1's care plan dated 4/27/26, lacked discharge planning. R1's progress notes lacked coordination and communication of discharge with primary physician or receiving provider. R1's chart lacked documentation of R1's discharge or coordination of care with R1's primary physician or receiving provider. During an interview on 7/15/26 at 12:45 p.m., the administrator stated R1 left the facility on 7/3/26, with her case worker, to move to another facility without providing advanced notice to the facility. He stated the director of nursing (DON) was responsible for documenting discharges. During an interview on 7/15/26 at 2:40 p.m., the DON stated she did not complete a discharge summary or coordinate R1's care with the receiving facility as she was unaware of where R1 went when she discharged. The DON stated R1 was provided with most of her medications upon discharge on [DATE]. The DON notified R1's physician and nurse practitioner (NP) of the discharge on [DATE]. The facility Discharging the Resident policy, dated 12/2016, directed if the resident is being discharged to a hospital or another facility, ensure that a transfer summary is completed and telephone report is called to the receiving facility. The following information should be recorded in the resident's medical record: The date and time the discharge was made, the name and title of the individual(s) who assisted in the discharge, all assessment data.		

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review the facility failed to establish a baseline care plan within 48 hours of admission for 1 of 3 residents (R5) reviewed for baseline care plan. Findings include: R5's face sheet indicated she admitted to the facility on [DATE]. R5's admission Minimum Data Set (MDS) dated [DATE], indicated R5's diagnoses included schizoaffective disorder, psychotic disturbances. R5 was cognitively intact. The MDS indicated R5 had behavioral symptoms and used tobacco, ambulated 10 feet independently and required assistance from staff for showering, putting on footwear, and walking distances over 10 feet. R5 required supervision with stairs. R5 received antipsychotic, antidepressant, antibiotic, diuretic, and hypoglycemic (medications to lower blood sugar) medications. Care area assessments were triggered for cognitive loss/dementia, activities of daily living (ADL) functional/rehabilitation potential, urinary incontinence/catheter, mood state, falls, nutritional status, psychotic drug use, and return to community referral. R5's progress note dated 6/16/26, indicated she was admitted and was alert and oriented to self, time, place, and situation. R5's care plan dated 6/19/26, included nutrition but lacked other areas of care and interventions. During an interview on 7/16/26, at 10:57 a.m., the director of nursing (DON) stated R5 was admitted to the facility over one month prior but did not have a care plan because she was not trained how to enter care plans into the resident's chart. She stated she knew all residents should have an initial care plan and care was directed by physician orders. During an interview on 7/22/26 at 10:48 a.m., the administrator stated care plans were established by the admitting nurse sitting down with the resident and having a conversation with the resident. During an interview on 7/22/26 at 1:31 p.m., registered nurse (RN)-B stated care is directed by their ordered treatments and the DON was responsible to establish the resident's care plan. During an interview on 7/22/26 at 1:45 p.m., R5 stated the facility had not asked her about her personal, cultural or religious preferences. She stated she had not been offered a care conference but a nurse completed an assessment. R5 stated she had never met the dietician. R5 stated the facility failed to ask her if she had other providers or medical needs. R5 stated had other providers and needed to schedule medical procedures and establish transportation to the appointments. The facility Care Plans - Baseline policy, dated 3/2022, directed the baseline care plan to meet the resident's immediate health and safety needs is developed for each resident within 48 hours of admission. The baseline care plan includes instructions to provide effective, person-centered care of the resident that meet the professional standards of quality of care and must include the minimum healthcare information necessary to properly care for the resident. A baseline care plan is used until the staff can conduct the comprehensive assessment and develop an interdisciplinary person-centered care plan (no later than 21 days after admission). The resident and/or representative are provided with a written summary of the baseline care plan.		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review the facility failed to develop and implement a care plan for 1 of 3 residents (R5) reviewed for care plans. Findings include: R5's face sheet indicated she admitted to the facility on [DATE]. R5's admission Minimum Data Set (MDS) dated [DATE], indicated R5's diagnoses included schizoaffective disorder, psychotic disturbances. R5 was cognitively intact. The MDS indicated R5 had behavioral symptoms and used tobacco, ambulated 10 feet independently and required assistance from staff for showering, putting on footwear, and walking distances over 10 feet. R5 required supervision with stairs. R5 received antipsychotic, antidepressant, antibiotic, diuretic, and hypoglycemic (medications to lower blood sugar) medications. Care area assessments were triggered for cognitive loss/dementia, activities of daily living (ADL) functional/rehabilitation potential, urinary incontinence/catheter, mood state, falls, nutritional status, psychotic drug use, and return to community referral. R5's care plan, dated 6/19/26, included nutrition but lacked other areas of care and interventions. R5's progress notes lacked evidence of care planning. During an interview on 7/16/26 at 10:57 a.m., the director of nursing (DON) stated R5 was admitted to the facility over one month prior but did not have a care plan because she was not trained how to enter care plans into the chart. The DON she knew all residents should have a care plan and care was directed by physician orders. During an interview on 7/22/26 at 9:45 a.m., the dietician stated she interviewed residents to determine their likes and dislikes and reviewed their medical history to establish care plans. She was not included in care conferences and did not collaborate with nursing or any other disciplines. The dietician stated, I have my own notes, but did not share them with the interdisciplinary team (IDT). During an interview on 7/22/26 at 10:48 a.m., the administrator stated care plans were established by the admitting nurse sitting down with the resident and having a conversation with the resident. During an interview on 7/22/26 at 1:31 p.m., registered nurse (RN)-B stated care is directed by their ordered treatments and the DON was responsible to set up care conferences and establish their care plan. During an interview on 7/22/26 at 1:45 p.m., R5 stated the facility had not asked her about her personal, cultural or religious preferences. She stated she had not been offered a care conference, but a nurse did an assessment. R5 stated she had never met the dietician. The facility did not ask R5 if she had other providers or medical needs. R5 stated she had other providers and needed to schedule medical procedures and establish transportation to the appointments. The facility Care Plans - Baseline policy, dated 3/2022, directed a baseline care plan is used until the staff can conduct the comprehensive assessment and develop an interdisciplinary person-centered care plan (no later than 21 days after admission). The facility Care Plans, Comprehensive Person-Centered policy, dated 3/2022, directed a comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. The IDT, in conjunction with the resident and his/her family or legal representative, develops and implements a comprehensive, person-centered care plan for each resident. The comprehensive, person-centered care plan is developed within seven (7) days of the completion of the required MDS assessment (Admission, Annual or Significant Change in Status), and no more than 21 days after admission. The care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment. The comprehensive, person-centered care plan includes measurable objectives and timeframes; describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	psychosocial well-being, includes the resident's stated goals upon admission and desired outcomes; builds on the resident's strengths; and reflects currently recognized standards of practice for problem areas and conditions.		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and document review, the facility failed to maintain a complete, accurate and readily accessible medical record was maintained for 2 of 3 residents (R5, R6) whose records were reviewed for completeness and accuracy. Findings include: R5 R5's face sheet indicated R5 admitted to the facility on [DATE]. R5's admission Minimum Data Set (MDS) dated [DATE], indicated R5's diagnoses included schizoaffective disorder, psychotic disturbances. R5 was cognitively intact. The MDS indicated R5 had behavioral symptoms and used tobacco, ambulated 10 feet independently and required assistance from staff for showering, putting on footwear, and walking distances over 10 feet. R5 required supervision with stairs. R5 received antipsychotic, antidepressant, antibiotic, diuretic, and hypoglycemic (medications to lower blood sugar) medications. Care area assessments were triggered for cognitive loss/dementia, activities of daily living (ADL) functional/rehabilitation potential, urinary incontinence/catheter, mood state, falls, nutritional status, psychotic drug use, and return to community referral. R5's care plan, dated 6/19/26, included nutrition but lacked other areas of care and interventions. R5's progress notes lacked evidence of care planning, care coordination with providers, 7/2/26 fall when away from facility, and response to interventions. R5's chart lacked resident's preferred emergency contact information, as it listed her friend and per R5 it should have been her daughter, contact information for R5's providers physician/nurse practitioner (NP) visit notes, physician/NP orders, assessments following 7/2/26 fall and lab results During an interview on 7/22/26 at 1:45 p.m., R5 stated her daughter should have been notified following an incident on 7/2/26. R6 R6's face sheet dated 7/17/26, identified diagnoses of schizophrenia, bipolar disorder, and diabetes. R6's quarterly MDS dated [DATE], identified R6 was cognitively intact and was independent for all transfers. Review of R6's electronic health record (EHR) from 6/16/26 through 7/16/26 did not include physician visit notes/orders. During an interview on 7/16/26 at 12:41 p.m., the director of nursing (DON) stated R6 had been (continued on next page)		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	refusing medication at times and the physician had been notified and gave an order on 7/10/26 to discontinue some medications. DON explained she would need to go onto the outside facility EHR to find the notes as they were not located in the R6's facility chart. DON explained she had been informed by upper management that she did not need to download a copy of the physician notes/orders in any of the resident's EHR records because they could be found in the clinic/hospital EHR. However, not every nurse had access to the clinic/hospital EHR to see the records. The DON further explained that the clinic/hospital records did not belong to the facility and facility nurses only had access to view the records. In the event of an emergency, such as an evacuation, not having the records complete and accurate could cause a delay in care for the residents. During an interview on 7/17/26 at 1:21 p.m., the administrator stated the facility does not have a policy on maintaining a complete and accurate medical record and the physician orders/notes are not placed into the EHR due to being in the outside clinic/hospital records. The facility does not own the records that are in the clinical/hospital record system. The facility can only view the records. Administrator explained by not having all of the physician visit notes/orders in the resident's chart, this had the potential to cause a delay in care in the event the facility had an emergency and needed to transfer the resident to another facility. A policy for complete and accurate medical record was requested but was not received.		

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F 0803 Level of Harm - Potential for minimal harm Residents Affected - Many	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review the facility failed to follow the established menus. This had the potential to affect all 13 residents currently residing at the facility. Findings include: R4 R4's quarterly Minimum Data Set (MDS) dated [DATE], indicated R4's diagnoses included depression, anxiety, post-traumatic stress disorder (PTSD), and diabetes. R4's cognition was intact. R4's care plan dated 5/4/26, directed staff to provide and serve diet as ordered. Registered dietician (RD) to evaluate and make diet change recommendations as needed and to provide and serve diet as ordered (regular diet). R4's care plan lacked information regarding R4's food preferences. During an interview on 7/15/26 at 11:25 a.m., R4 stated cereal with water was served for breakfast this morning. The facility frequently ran out of food that was on the menu and did not serve what was on the menu. R4 stated the residents did not know what to expect for each meal. R2 R2's quarterly MDS dated [DATE], indicated R2's diagnoses included PTSD, diabetes, and anxiety. R2's cognition was intact. R2's care plan dated 2/16/26, directed staff to encourage the resident to express feelings, allow her time to talk and discuss concerns, fears, or issues regarding health or other subjects. A dietary consult should be provided for nutritional regimen. R2's care plan lacked information regarding R2's dietary preferences. During an interview on 7/15/26 at 12:03 p.m., R2 stated the facility had served cold cereal with water on it for breakfast that morning and no fruit. She stated that is not what was on the menu and the facility frequently did not follow the menu. During an interview on 7/16/26 at 10:15 a.m., R2 shared a photo of supper from 7/15/26, which included a slice of pizza and garden salad. R3 R3's quarterly MDS dated [DATE], indicated R3's diagnoses included panic disorder, traumatic brain injury (TBI), anxiety, depression, and PTSD. R3 had moderate cognitive impairment. R3's care plan dated 10/17/25, directed staff to provide and serve diet as ordered (regular diet), and directed the RD to evaluate and make diet change recommendations as needed. R3's care plan lacked information regarding R3's dietary preferences. During an interview on 7/15/26 at 12:04 p.m., R3 stated pork is frequently served, but you won't see it on the menu. R3 stated, They never serve what's on the menu. R7 R7's quarterly MDS dated [DATE], indicated R7's diagnoses included schizoaffective disorder and psychotic disorder. R7's cognition was intact. R7's care plan dated 1/5/26, directed staff to provide and serve diet as ordered (regular diet), and directed the RD to evaluate and make diet change recommendations as needed. R7's care plan lacked information regarding R7's dietary preferences. During an interview on 7/15/26 at 12:30 p.m., R7 stated he was served cold cereal with water over it for breakfast this morning. He stated it was his only option and it was better than nothing. R7 stated this was the only option because the facility refrigerator was broken and the food on the menu was tossed out. The facility breakfast menu for 7/15/26, directed staff to serve turkey sausages, fruit muffin, and a banana. The facility lunch menu for 7/15/26, directed staff to serve an Italian sub sandwich, whole wheat sub roll, lettuce, tomato, pepper, and apple crisp. The facility dinner menu for 7/15/26, directed staff to serve roast beef, stewed potatoes, carrots and berries. Alternative menu options for lunch and dinner included a peanut butter and jelly sandwich or a deli meat sandwich. During an interview on 7/15/26 at 9:22 a.m., the director of nursing (DON) stated the facility served cold cereal with water for breakfast this morning. She stated the refrigerator was broken and the facility did not have milk or the items on the menu for this morning's breakfast. During an observation on 7/15/26 at 11:45 a.m., residents were served a turkey and cheese sandwich and chips for lunch. During an interview on 7/15/26 at 12:45 p.m., the administrator stated the kitchen (continued on next page)		

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F 0803 Level of Harm - Potential for minimal harm Residents Affected - Many	refrigerator broke on 7/10/26 so the cook could not prepare breakfast. The one operating refrigerator in the basement was to be used for all cold storage. The milk was left in the kitchen refrigerator and tossed out due to not being cold enough. The administrator did not expect the cook to serve cold cereal with water on it. He expected the cooks to prepare what was on the menu and the cooks were responsible for ordering the food. The administrator stated for the noon meal today, the facility did not have the ingredients to make the food on the menu, so he made turkey sandwiches. During an interview on 7/15/26 at 2:40 p.m., the DON stated she had asked another staff person to go buy milk for breakfast after she saw cook-A serve cold cereal with water on it. The cooks rarely followed the menu. She stated pork was served twice on 7/14/26, without an alternative option for residents who did not eat pork. The DON stated some residents ate peanut butter and jelly sandwiches as an alternate and they had them frequently due to the facility not considering resident preferences. The facility lunch menu for 7/16/26 indicated they were to serve turkey muffins, tabouleh salad, roasted zucchini, and brownie. During an interview on 7/16/26 at 10:20 a.m., the administrator stated he planned to cooked meatloaf because the facility did not have the ingredients to make what was on the menu and he did not know what turkey muffins were. During an observation on 7/16/26 at 11:45 a.m., residents were served meatloaf and mashed potatoes. During an interview on 7/16/26 at 12:12 p.m., cook-A stated the facility was always serving the wrong food and stated the person in charge of ordering the food kept ordering the wrong food. The dietician created the menus but didn't ever talk to the cooks. Cook-A stated the refrigerator in the kitchen and one of the refrigerators in the basement was broken. Both refrigerators had broken within the last week. The administrator and the owners were aware, and he was not aware of the plan to address the non-operating refrigerators. Cook-A stated he was directed to use the only operating refrigerator in the basement until the other two refrigerators were either repaired or replaced. During an interview on 7/16/26 at 2:30 p.m., the administrator stated he was not aware pork was being served frequently and would not expect it to be served twice on the same day. Residents had complained there was too much pork on the menu. The administrator state the dietician was responsible for creating the menus. The facility lunch menu for 7/21/26 indicated they were to serve a ham and Swiss sandwich on whole wheat bread, side salad, and oranges. During an observation on 7/21/26 at 11:45 a.m., residents were served barbeque chicken, boiled potatoes and mixed vegetables. During an interview on 7/22/26 at 9:45 a.m., the dietician stated she met with residents and asked about their preferences. She did not share this information with the facility staff but kept her own notes. She established the menu and expected the cooks to follow that menu as it was based on dietary guidelines and resident needs/preferences. The dietician stated she did not review the menu with the cooks. She was not informed when the facility did not follow the menu, the cooks ordered the food, and she was not aware of the broken refrigerators. The dietician stated the facility should have food on hand if a resident chooses not to eat the main meal on the menu. She would not expect the facility to serve pork twice on the same day. A policy regarding establishing and following menus was requested but not provided.		

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F 0806 Level of Harm - Potential for minimal harm Residents Affected - Many	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. Based on interview and document review the facility failed to communicate residents' food preferences to the interdisciplinary team (IDT) and failed honor residents' food preferences once those preferences were known. This had the potential to affect all 13 residents currently residing at the facility. Findings include: During an interview on 7/15/26 at 12:03 p.m., R2 stated the facility served cold cereal with water on it for breakfast that morning and no fruit. R2 stated she is diabetic; she did not wish to eat sugary cereal. She stated that is not what was on the menu and the facility frequently did not follow the menu. During an interview on 7/15/26 at 12:04 p.m., R3 stated pork is frequently served, but you won't see it on the menu. R3 stated, They never serve what's on the menu. R3 stated she told the director of nursing (DON) and the administrator of her food preferences. R3 told the cooks what her food preferences were but they don't care. R3 stated she did not eat pork because she didn't like it and for religious reasons as she was Buddhist. During an interview on 7/15/26 at 12:39 p.m., R8 stated she did not eat pork and they always make pork. She stated she had told the cooks, the administrator and DON at the facility of her preference. During an interview on 7/15/26 at 2:40 p.m., the DON stated the cooks rarely followed the menu. Pork was served twice on 7/14/26, without an alternative option for residents who did not eat pork. The facility did not have a system to communicate resident food preferences. The DON stated the dietician was responsible to discuss preferences with residents but did not share those with facility staff. During an interview on 7/16/26 at 12:12 p.m., cook-A stated the facility was always serving the wrong food and stated the person in charge of ordering the food kept ordering the wrong food. Cook-A shared his concerns with the administrator and the owners but they don't care. Cook-A stated the dietician created the menus but didn't ever talk to the cooks and there was not a system to communicate resident likes and dislikes. He said the cooks just know everyone. During an interview on 7/16/26 at 2:30 p.m., the administrator stated he was not aware pork was being served frequently and would not expect it to be served twice on the same day. Residents had complained there was too much pork on the menu. Alternatives are always available and were posted outside the kitchen. The administrator stated resident food preferences should be documented in each resident's electronic health record. During an interview on 7/21/26 at 3:23 p.m., cook-B stated he was unaware of residents' food preferences. He stated, I just make what they [dietician] tell me to make. He stated the residents were aware they could always get a sandwich as an alternative. Cook-B frequently needed to request the administrator or activity staff to go to the store to purchase necessary ingredients to make food on the menu. During an interview on 7/22/26 at 9:45 a.m., the dietician stated she established the menu and expected the cooks to follow that menu as it was based on dietary guidelines and resident needs/preferences established in her assessments. She stated she was not informed when the facility did not follow the menu. The dietician would not expect the facility to serve pork twice on the same day. The dietician interviewed residents to determine their likes and dislikes and reviewed their medical history to establish care plans. She was not included in care conferences and did not collaborate with nursing or any other disciplines. She stated, I have my own notes, but did not share them with the interdisciplinary team (IDT). She stated it was up to the cooks to get to know the residents' preferences. During an interview on 7/22/26 at 10:48 a.m., the administrator stated care plans were established so the staff know how to provide care for the residents. The nurse and the dietician developed each resident's care plan by reviewing the residents' history, orders and preferences. The administrator expected food dislikes would be listed under each resident's allergies in their medical (continued on next page)		

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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 0806 Level of Harm - Potential for minimal harm Residents Affected - Many	record.Policies regarding resident food preferences and dietary assessments were requested but were not received.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 24E507	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/22/2026
NAME OF PROVIDER OR SUPPLIER Southside Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2644 Aldrich Avenue South Minneapolis, MN 55408	
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 0813 Level of Harm - Potential for minimal harm Residents Affected - Many	Have a policy regarding use and storage of foods brought to residents by family and other visitors. Based on interview and document review the facility lacked a policy for personal food storage. This had the opportunity to affect all 13 residents currently residing at the facility. Findings include: During an observation on 7/15/26 at 10:45 a.m., evidence of rodent feces was present in resident rooms and throughout the facility. Fruit, bakery items, leftover meals, crackers and granola bars were stored in residents' rooms. During an interview on 7/15/26 at 1:00 p.m., the facility owner stated they had an ongoing rodent infestation. During an interview on 7/15/26 at 1:30 p.m., the contracted exterminator stated he had concerns with residents maintaining food caches in their rooms related to the rodent infestation. During an interview on 7/15/26 at 2:40 p.m., the DON stated she made complaints the week of 6/22/26, regarding unsanitary conditions and the rodent problem to the administrator and owners. No education had been provided to the residents or staff to reduce or control rodent infestation, including food storage in residents' rooms. During an interview on 7/15/26 at 3:25 p.m., licensed practical nurse (LPN)-A stated the facility had not provided education regarding reducing or controlling the rodent infestation. During an interview on 7/16/26 at 2:17 p.m., the administrator stated the facility did not have a policy on personal food storage. A pest control invoice dated 7/15/26, indicated the exterminator suggested going through residents' rooms, private food storage and residents' items to find potential nesting sites. A policy for personal food storage was requested but not received.		