STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245028	A. Building B. Wing	04/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Highland Chateau Health and Rehabilitation Center	2319 West Seventh Street Saint Paul, MN 55116

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50764 Based on observation, interview, and document review the facility failed to provide a dignified experience for 2 of 2 residents (R30 and R1) who did not have clothing to wear and were spoken to in an undignified manner by staff. Findings include: R30's face sheet printed 4/24/25, indicated diagnoses of weakness, adult failure to thrive, morbid obesity, and bipolar disorder with psychotic features. R30's significant change minimum data set (MDS) assessment dated [DATE], indicated intact cognition, no rejection of care, use of a wheelchair, substantial assistance with upper body dressing, and dependence on staff for lower body dressing. R30's care plan printed 4/24/25, indicated R30 required extensive assistance of one staff for dressing, and limited assistance of one staff for bed mobility and eating. During interview on 4/21/25 at 3:27 p.m., R30 stated one of the nursing assistants had a terrible attitude and scolded her for accidentally getting vomit on her shirt. R30 stated she did not think it was abuse, but did not appreciate being scolded like a little kid. R30 further stated she had reported this incident to a nurse but could not recall which nurse. R30 identified the nursing assistant who scolded her as a nursing assistant with letters HCAC in her name, but did not know her actual name. R30 further stated this nursing assistant had continued to work with her since the incident. During interview on 4/23/25 at 11:51 a.m., R30 stated she knew the assistant director of nursing (ADON) was notified of the scolding event because a nurse had R30 write up a note to give to the ADON. R30 stated she could not write, so she dictated the note describing the event to the nurse and the nurse was supposed to give it to the ADON. R30 thought the incident happened two weeks ago. During interview on 4/23/25 at 8:15 a.m., nursing assistant (NA)-K stated she was not aware of R30 being scolded by a nursing assistant but that should not have happened. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 4/24/25 at 10:10 a.m., NA-M stated she did not recall scolding R30 and maybe R30 did not understand her or maybe she was talking too loud. NA-M further stated she would not scold a resident. During interview on 4/23/25 at 8:47 a.m., social services (SS)-A stated she was not aware of a nursing assistant scolding R30. SS-A further stated if she had heard that she would have reported it because nursing assistants should not scold residents. During interview on 4/23/25 at 12:23 p.m., ADON stated she recalled a nurse reporting R30 being scolded by a nursing assistant and had asked the nurse to complete a grievance form. ADON was not able to recall name of nurse or nursing assistant. ADON did not recall receiving the grievance form and had not followed up on the report from R30. ADON stated she was trying to make the nurses more accountable. ADON stated the incident likely would not have been addressed if R30 had not brought it up again but it was addressed today. During interview on 4/24/25 at 8:45 a.m., director of nursing (DON) stated nursing assistants should not scold residents, and she expected the ADON to follow up on the reported grievance. DON further stated the grievance had been reported today and would be investigated. R1's face sheet printed 4/24/25, indicated an admitted [DATE], diagnoses of non-pressure chronic ulcer of left ankle, depression, chronic kidney disease, and adult failure to thrive. R1's quarterly MDS assessment dated [DATE], indicated moderately impaired cognition, verbal behavioral symptoms directed at others four to six days, rejection of care one to three days, use of a walker, supervision for bathing, and independent with upper and lower body dressing. R1's care plan dated 3/28/25, indicated resident independent with dressing, resistive to cares related to poor impulse control with intervention of encourage to participate and provide interaction. During interview and observation on 4/21/25 at 5:55 p.m., R1 was naked on her bed and stated she did not have any clothes at the facility and her only clothing was a robe and a pair of slippers. A blue robe was observed hanging on a chair in R1's room. No other clothing was observed. R1 stated she came from the hospital and did not have anyone to bring her clothing. R1 further stated she used to wear gowns provided by the facility, but the facility no longer provided gowns. During observation on 4/22/25 at 1:03 p.m., R1 was in the common dining room in a blue robe and slippers. During observation on 4/24/25 at 8:40 a.m., R1 was in the common dining room in a blue robe and slippers. During interview on 4/23/25 at 8:15 a.m., nursing assistant (NA)-K stated R1 was very particular and wanted her own clothing. During interview on 4/23/25 at 9:15 a.m., licensed practical nurse (LPN)-C stated R1 did not have any clothes. LPN-C stated she recalled social services (SS)-A tried to contact someone to bring R1's personal belongings but had not heard anything since then. LPN-C further stated R1 used to wear gowns provided by the facility but the facility no longer provided gowns so R1 only wore her robe. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 4/23/25 at 8:47 a.m., SS-A stated R1 had no clothing other than a robe due to her clothing being at her previous group home. SS-A stated she knew R1 wanted her clothing here at the facility and she had tried to work with the previous group home when R1 admitted to the facility but the previous group home did not bring the clothes. SS-A stated she was unaware R1 did not have facility provided gowns and was only wearing a robe with no clothing underneath. SS-A stated that would be a dignity concern to not have any clothing to wear. During interview on 4/23/25 at 12:23 p.m., assistant director of nursing (ADON) stated she knew R1's belongings were at her previous group home and did not know why her belongings were not at the facility yet. ADON stated she would expect after nine months of R1 being at the facility someone would have figured out how to get her clothing. ADON further stated R1 wore facility provided gowns as her clothing prior to the facility no longer providing gowns. During interview on 4/24/25 at 9:15 a.m., R1 stated she had asked someone to get her clothes, and they brought her sweatpants and a button up shirt. R1 stated she did not want to wear those facility provided clothes and preferred her own slacks and blouses. R1 further stated she was told someone would get her clothes a long time ago. During interview on 4/24/25 at 11:07 a.m., administrator stated the facility provided gowns to the first floor residents who were there for short term rehabilitation stays, but no longer provided gowns to second floor residents if residents used them as regular clothing. Administrator stated the facility offered to assist residents who chose to wear gowns as regular clothing with purchasing gowns if they desired them and further stated she could not confirm whether R1 had replacement gowns or clothing prior to facility gowns being taken away. Facility Dignity policy reviewed 4/24/25, indicated the following: 1. Residents are treated with dignity and respect at all times. 2. The facility culture supports dignity and respect for residents by honoring resident goals, choices, preferences, values, and beliefs. This begins with the initial admission and continues throughout the resident's facility stay. 5. When assisting with care, residents are supported in exercising their rights. For example, residents are: c. encouraged to dress in clothing that they prefer. 8. Staff speak respectfully to residents at all times.

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F 0576 Level of Harm - Potential for minimal harm Residents Affected - Many	Ensure residents have reasonable access to and privacy in their use of communication methods. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42073 Based on interview and document review, the facility failed to ensure mail was delivered to residents on Saturdays for 4 of 4 residents (R16, R47, R32, R42) who attended the resident council meeting, who verbally confirmed mail was not delivered on Saturdays. This had the potential to affect all 47 residents residing in the facility. Findings include: During an interview on 4/23/25 at 10:05 a.m., R16, R47, R32, R42 stated they had never seen mail delivered on Saturdays. R32 stated the business office manager was not there on Saturdays, and she usually delivered it. R16's annual Minimum Data Set (MDS) assessment dated [DATE], indicated intact cognition. R47's quarterly MDS assessment dated [DATE], indicated intact cognition. R32's quarterly MDS assessment dated [DATE], indicated intact cognition. R42's quarterly MDS assessment dated [DATE], indicated intact cognition. During an interview on 4/23/25 at 3:52 p.m., business office manager (BOM)-D stated she delivered mail to residents during the week, but no one was assigned to deliver mail on Saturdays. During an interview on 4/24/25 at 12:21 p.m., the director of nursing (DON) stated mail was not delivered on Saturdays since BOM-D, who delivered mail during the week did not work on Saturdays. Facility Mail and Electronic Communication policy dated 4/23/25, indicated mail and packages would be delivered to the resident within twenty-four (24) hours of delivery on premises or to the facility's post office box (including Saturday deliveries).

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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** 48065 Based on interview and document review, the facility failed to provide timely notification to a family member for change of condition and hospitalization for 1 of 1 resident (R22) reviewed for change in condition. Findings include, R22's quarterly Minimum Data Set (MDS) assessment dated [DATE], indicated R22 was severely cognitively impaired, had no behaviors and did not refuse personal cares. R22's MDS indicated diagnoses of cerebral infarction, quadriplegia, essential hypertension, and seizure disorders. A review of R22's progress notes contained the following information: - Progress noted dated 2/4/25, indicated R22 was coughing more than usual, and blood was coming out of his mouth. R22 had bitten his lower lip. Progress note indicated the nurse practitioner was updated and gave an order for cough medication as needed. - Progress note dated 2/5/25, indicated change in health condition. Progress note indicated the nurse practitioner was updated and ordered to send R22 to the hospital for further evaluation. - Progress notes lacked documentation regarding R22's family being notified about the change in condition, new orders, and/or transfer to the hospital. During interview on 4/21/25 at 5:23 p.m., family member (FM)-A indicated R22 was sent to the hospital in February, and she was not notified. FM-A learned R22 was sent to the hospital when she received a call from a hospital doctor who called her to discuss treatment options for R22. FM-A stated R22 had been at the hospital for one hour and forty-five minutes. FM-A called the facility and asked why she was not notified about R22's change of condition and transfer to the hospital. FM-A stated the facility stated they didn't have time. During interview on 4/23/25 at 11:10 a.m., the director of nursing (DON) stated the family or responsible party should be notified about change in condition as soon as we know, and before sending the resident to the hospital. The DON verified the facility didn't notify FM-A about his change of condition or transfer. A facility policy about notification of change in condition and transfer to a hospital was requested but not received.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50764 Based on observation, interview, and document review the facility failed to investigate a report of missing clothing for 1 of 1 resident (R30) who reported missing clothing items to nursing staff. Findings include: R30's face sheet printed 4/24/25, indicated diagnoses of weakness, adult failure to thrive, morbid obesity, and bipolar disorder with psychotic features. R30's significant change Minimum Data Set (MDS) assessment dated [DATE], indicated intact cognition, no rejection of care, use of a wheelchair, substantial assistance with upper body dressing, and dependence on staff for lower body dressing. R30's care plan printed 4/24/25, indicated R30 required extensive assistance of one staff for dressing, and limited assistance of one staff for bed mobility and eating. During interview on 4/21/25 at 3:32 p.m., R30 stated she was missing clothing and had told a nurse about it but could not recall the nurse's name. R30 stated the nurse responded that she would look into the missing clothing, but R30 had not heard anything further. R30 further stated she thought the clothing had been missing for a few months. During interview on 4/23/25 at 11:51 p.m., R30 stated she recalled which clothing was missing and listed a green shirt, light green pullover sweatshirt, and navy blue sweatshirt. R30 stated she told an unknown nurse about the missing clothing but did not fill out a formal grievance form. During interview on 4/23/25 at 8:47 a.m., social services (SS)-A stated she was not aware of R30's missing clothing items, R30 was a reliable reporter, and if a nurse was made aware of missing clothing items a grievance form should have been filled out. During interview on 4/23/25 at 12:23 p.m., assistant director of nursing (ADON) stated she had not heard about R30's missing clothing items prior to this week. ADON further stated if R30 had reported the missing items to a nurse, the nurse should have completed a grievance form so it could get to the right people for an investigation. ADON stated recently there had been more complaints of missing clothing. During interview on 4/23/25 at 1:38 p.m., director of nursing (DON) stated she would have expected a grievance form to be completed about R30's missing clothing items. Facility Personal Property reviewed 10/18/22, stated the following: 7. The facility will promptly investigate any complaints of misappropriation or mistreatment of resident property.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48065 Based on interview and document review, the facility failed to ensure the Minimum Data Set (MDS) was accurately coded for 1 of 2 residents (R16) reviewed for MDS accuracy. Findings include: R16's annual MDS assessment dated [DATE], indicated R16 had limited range of motion of upper extremities and was cognitively intact with diagnoses including renal insufficiency, amputation, diabetes, heart failure and atrial fibrillation. Section N0415 indicated R16 was taking an antidepressant, an antibiotic but didn't indicate taking an anticoagulant. A section of the RAI labeled, Section N-Medications, outlined directions for coding the subsequent sections including N0415: High-risk Drug Classes. High-risk drug classes included antipsychotics, antianxiety, antidepressant, hypnotic, anticoagulant, antibiotic, diuretic, opioid, antiplatelet, hypoglycemic or none of the above. During interview on 4/24/25 at 2:59 p.m., director of nursing (DON) stated the MDSs were completed by a person at the corporate office. DON stated she was the MDS coordinator prior to assuming her current position as DON and was knowledgeable of the RAI process. The DON verified R16 received an anticoagulant medication during the MDS review period but was not coded. DON stated we [facility] will have to redo the assessments or make a correction. DON stated the MDS was the base for payment and care planning and needed to be accurate. Facility MDS Error Correction policy dated 12/9/21, indicated: If an error is discovered after the encoding period and the record in error is an OBRA assessment, determine if the error is major or minor. a. A minor error is one related to the coding of the MDS. For minor errors, correct the record and submit to the QIES ASAP system. b. A major error is one that inaccurately reflects the resident's clinical status and/or may result in an inappropriate plan of care. For major errors: (1) correct the original assessment to reflect the resident's status as of the original assessment reference date and submit the record; AND (2) perform a new significant change in status (if this has occurred) OR a new significant correction to a prior assessment with a new observation period and assessment reference date.

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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** 48065 Based on interview and document review, the facility failed to offer/provide a summary of the baseline care plan to the resident and/or resident's representative for 1 of 1 resident (R36) reviewed for baseline care plan. Findings include: R36's Clinical Profile dated 4/23/25, identified an admitted [DATE], with diagnoses of infection and inflammatory reaction due to unspecified internal joint prosthesis. R36''s admission Minimum Data Set (MDS) assessment dated [DATE], indicated R36 was admitted to the facility on [DATE], was cognitively intact, and had no behaviors or delusions. MDS indicated resident was on a pain management program, received medications for pain as needed, had a surgical wound, had oxygen, and received occupational and physical therapy services. R36's Electronic Medical Record (EMR) lacked evidence of a baseline care plan had been provided to R36. R36's EMR included a progress note authored by social services (SS)-A dated 4/4/25, indicating R36 wished to discharge to a sober house once he meets his goal . care conference will be scheduled quarterly and as needed. During interview on 4/21/25 at 7:03 p.m., R36 stated he didn't remember receiving a care plan or having a care conference. During interview on 4/23/25 at 2:28 p.m., social services (SS)-A indicated initial care conferences were scheduled 48 to 72 hours after admission. During the initial care conference residents received a copy of their baseline care plan. SS-A verified R36 was admitted on [DATE]. SS-A stated the progress note dated 4/2/25, was a late entry and added, perhaps I was out that week, maybe we didn't have the care conference, and the 72 hours base line care plan was not given. SS-A stated she will look for a copy of the signed care conference form and the copy of R36's baseline care plan. During interview on 4/24/25 at 10:13 a.m., SS-A stated she was unable to provide documentation of a care conference held with the resident, therapist, nurse and SS. Furthermore, SS-A was unable to provide a copy of R36's baseline care plan. SS-A stated baseline care plans were usually provided to residents at the initial care conference. During interview on 4/24/25 at 2:41 p.m., director of nursing (DON) stated initial care conferences were scheduled 48 to 72 hours after a resident was admitted to the facility. The residents meet with the Interdisciplinary Team (IDT) which included SS, therapies, recreational therapist, nursing, dietary manager, resident, and family. DON stated residents should receive a copy of the baseline care plan during the initial care conference. DON added baseline care plans help to determine residents' care goals, discharge planning, community services and equipment needs. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Facility Baseline Care Plans dated 4/24/25, indicated a baseline plan of care to meet the resident's immediate health and safety needs is developed for each resident within forty hours of admission. The policy also indicated the resident and/or representative is provided a written summary of the baseline care plan, and the provision of the summary to the resident and/or resident representative is documented in the medical record.

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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** 40614 Based on observation, interview and document review the facility failed to ensure a comprehensive care plan was developed and maintained for 2 of 2 residents reviewed, (R7) who was assessed for facility acquired pressure ulcers and (R4) for respiratory cares. Findings include: R7's face sheet printed 4/24/25, indicated R7 had diagnoses including fracture of shaft of right tibia (main long bone of lower leg), type 2 diabetes mellitus, morbid obesity and pulmonary embolism (blood clot that blocks blood flow in the lung). R7's admission Minimum Data Set (MDS) assessment dated [DATE], indicated R7 was cognitively intact, had no behaviors, had a Foley catheter present and was always incontinent of stool. Activities of daily living assessment indicated not assessed. Risk of pressure ulcers (PU) was answered no and R7 had no unhealed pressure ulcers. A Braden Scale (risk assessment tool for patient's risk of developing pressure injuries) completed for R7 on 2/14/25, indicated a score of 13 which indicates moderate risk of PU. Repeat Braden Scales were completed 4/9/25 and 4/21/25, and both indicated moderate risk for PU. R7's plan of care, dated 2/21/25, indicated wound management as a problem. Interventions included notify provider if no signs of improvement on current wound regimen and provide wound care per treatment order. A current functional performance included bed mobility, dressing, toilet use were independent/one-personal physical assist, with transfers of a total assist of two persons using full body lift. R7's plan of care did not include a risk for skin breakdown or interventions to prevent skin breakdown. On interview 4/23/25, at 10:30 a.m., nurse practitioner (NP)-K stated R7 has been a high risk for pressure ulcer development since she started seeing her at the facility in March 2025. NP-K indicated she does wound rounds weekly and R7 is always laying on her back which is concerning. NP-K stated R7 requires assistance to reposition and is not able to turn herself. NP-K indicated she made recommendations to the facility to have her on a repositioning program at least every 2 hours and to keep her off her back. NP-K added she requested a heel protector boots for both feet also. On 4/23/25 at 2:22 p.m., licensed practical nurse (LPN)-B indicated R7 has a plan of care to reposition every 2 hours. LPN-B stated they were getting R7 up once a day but since she returned from the hospital, they don't have order to get her out of bed. LPN-B stated it takes 2 staff to turn R7 which has not changed since her admission in February. On 4/23/25 at 2:24 p.m., LPN-A indicated R7 should be repositioned every 2 hours and believes that is part of her plan of care. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R4's face sheet printed 4/24/25, indicated R4 had diagnosis including morbid (severe) obesity, chronic pain, reduced mobility, and obstructive sleep apnea (breathing repeatedly stops and starts during sleep due to obstruction in upper airway). R4's admission MDS assessment dated [DATE], indicated R4 had intact cognition, no behaviors including refusal of care. Special treatments included non-invasive mechanical ventilator. Oxygen was not checked as being used. Activities of daily living section was not completed and included not assessed. On observation 4/22/25 at 8:24 a.m., an oxygen concentrator was present in R4's room. R4 had a nasal cannula in her nose and oxygen concentrator was set at 2 liters oxygen flow. There was a non-invasive mechanical ventilator present in the room but was not on the resident at this time. R4's plan of care dated 1/14/25, included functional performance requiring total assist of two persons for bed mobility, dressing and personal hygiene. Transfer included total assist using 600 pound full body lift with 4 persons to transfer. The care plan did not include R7 was risk or had a potential for impairment of the respiratory system. Physician orders dated 1/9/25, included Noninvasive Ventilator (NIV) Trilogy PC/AVAPS PC01 > or = to 52 mm HG, target tidal volume 550 with rate at 14 IPAP min: 10IPAP max: 30 EPAP 08 and full face mask every shift. The physician orders did not include an order for oxygen. On interview 4/24/25 at 10:17 a.m., LPN-A stated R4 has been on oxygen since she came here in January 2025. LPN-A indicated R4 had a plan of care addressing R4's respiratory issues that included the NIV, oxygen and inhalers R4 uses. LPN-A upon review of R4's medical record and stated there was not an order for oxygen and there was not a plan of care addressing R4's respiratory issues which she should have. On interview 4/24/25 at 12:03 p.m., the director of nursing (DON) confirmed R7 did not have a plan of care to prevent skin breakdown but stated she should have one. The DON confirmed R4 did not have a respiratory plan of care and indicated she would expect one with R7's current medical conditions and using NIV and oxygen. Facility Care Plans, Comprehensive Person-Centered policy dated 1/20/25, included: -The comprehensive, person-centered care plan: a. includes measurable objectives and timeframes; b. describes the services that are to be furnished to attain or maintain the resident ' s highest practicable physical, mental, and psychosocial well-being, including: (1)services that would otherwise be provided for the above, but are not provided due to the resident exercising his or her rights, including the right to refuse treatment; (2) any specialized services to be provided as a result of PASARR recommendations; and (3) which professional services are responsible for each element of care; (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	c. includes the resident ' s stated goals upon admission and desired outcomes; d. builds on the resident ' s strengths; and e. reflects currently recognized standards of practice for problem areas and condition -Care plan interventions are chosen only after data gathering, proper sequencing of events, careful consideration of the relationship between the resident ' s problem areas and their causes, and relevant clinical decision making. a. When possible, interventions address the underlying source(s) of the problem area(s), not just symptoms or triggers. b. Assessments of residents are ongoing and care plans are revised as information about the residents and the residents ' conditions change.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48065 Based on interview and document review, the facility failed to ensure a care conference was conducted for 3 of 3 residents (R31, R3 and R36) reviewed for care planning. Findings include: R3's quarterly MDS assessment dated [DATE], indicated R3 had moderate cognitive impairments, needed set up for eating, required substantial assistance with dressing and was dependent for oral hygiene, toileting, personal hygiene, bed mobility and transfers. MDS indicated diagnoses of lumbar spinal stenosis, heart failure, hypertension, renal insufficiency, diabetes, and depression. R3's electronic medical record (EMR) report of care conferences indicated resident had care conferences on 6/19/24 and 5/14/24. During interview on 4/23/25 at 12:11 p.m., family member (FM)-B indicated a care conference (CC) was scheduled in March 2025 for R3. FM-B stated he was not available and requested to change the CC to be moved to the following week. FM-B talked to social services (SS)-A who informed him the CC couldn't be scheduled the following week but was going to call him later to re-schedule the CC. FM-B stated SS-A never followed up and the CC was never rescheduled. During interview on 4/24/25 at 10:21 a.m., SS-A stated R3 conference was scheduled on 3/13/25, but it was canceled because family was unable to attend. SS-A stated R3's family asked if the CC could be rescheduled the following week, but the CC schedule for the following week was full. SS-A stated she had not talked to the R3's son again and had not scheduled a new CC. SS-A stated she needed to prioritize CC and if it's urgent a new CC would be re-scheduled. During interview on 4/24/25 at 2:47 p.m., director of nursing DON stated we (facility) needed to accommodate CCs to facilitate residents and family participation. R36's admission MDS assessment dated [DATE], indicated R36 was admitted to the facility on [DATE], was cognitively intact, and had no behaviors or delusions. MDS indicated resident was on a pain management program, received pain medications as needed, had a surgical wound, had oxygen, and received occupational and physical therapy services. R36's Clinical Profile dated 4/23/25, identified an admitted [DATE], with diagnosis of infection and inflammatory reaction due to unspecified internal joint prosthesis. During review of R36's Care Conference Summary section of the electronic medical record (EMR), R36's MR lacked evidence of any care conference since 3/12/25, despite MDS data submitted on 3/20/25. R36's EMR included a progress note titled care conference, dated 4/4/25, and authored by SS-A indicated R36 wished to discharge to a sober house once he meets his goal . care conference will be scheduled quarterly and as needed. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 4/21/25 at 7:03 p.m., R36 stated he didn't remember having a care conference, not like other places. R36 stated I talk to the therapists during the therapy sessions and maybe I talked to the SW. R36 added he did not meet as a group with SS, therapist, and a nurse to talk about his care plan or rehabilitation goals. During interview on 4/23/28 at 2:28 p.m., SS-A stated she scheduled the initial, quarterly, significant changes and discharge care conferences. SS-A indicated initial care conferences are scheduled 48 to 72 hours after admission and during the initial care conference residents receive a copy of their baseline care plan. SS-A stated the progress note dated 4/2/25, was a late entry and added maybe she was out that week, maybe we didn't have the care conference. SS-A stated R36 did not meet with the interdisciplinary team which includes a nurse, therapist, and SS. During interview on 4/24/25 at 10:13 a.m., director of nursing (DON) stated initial care conferences were scheduled 48 to 72 hours after a resident was admitted to the facility. The residents meet with the Interdisciplinary Team (IDT) which included SS, therapies, recreational therapist, nursing, dietary manager, resident, and family. DON stated when a care conference was canceled or missed, a new care conference should be rescheduled as soon as possible. 42073 R31's face sheet received on 4/24/25, included diagnoses of left below the knee amputation, diabetes, protein calorie malnutrition, and depression. R31's quarterly Minimum Data Set (MDS) assessment dated [DATE], indicated R31 was cognitively intact, had clear speech, could understand and be understood. R31 was able to transfer from bed to wheelchair independently and self-propel wheelchair throughout the facility. R31's care plan with revised date of 1/7/25, indicated R31's preferences would be considered when providing care. During an interview on 4/22/25 at 9:42 a.m., R31 stated she did not recall having had a care conference. A care conference was explained to her, and she still did not recall having had one. During an interview on 4/23/25 at 12:19 p.m., social services (SS)-A stated care conferences were conducted quarterly, as needed, or at family or resident request. SS-A provided two care conference notes for R31 titled Social Services Care Conference - one dated 6/5/24, and one dated 4/18/25. Both notes indicated R31 was in attendance as well as members of the IDT (interdisciplinary team). During an interview on 4/24/25 at 12:06 p.m., SS-A stated when a resident was due for a care conference, she asked the resident if he/she wanted her to schedule one. SS-A stated sometimes R31 stated she did not want a care conference in which case a care conference was not conducted. Further, SS-A stated when a resident declined their care conference, the IDT team did not always meet without the resident or resident representative to review various areas such as nursing, dietary, activities and/or therapy. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview at 4/24/25 at 12:45 p.m., the director of nursing (DON) stated SS-A spoke to her about this and stated SS-A misunderstood the requirement about frequency of care conferences. The DON stated SS-A thought care conferences should be conducted every 92 days IF needed, or IF the resident wanted one. The DON stated she expected care conferences to be conducted every 92 days, regardless if the resident attended. Facility Resident Care Conference/Care Plan Review policy dated 6/27/22, indicated the purpose of the care conference was to develop a plan of care and to ensure that the resident goals and preferences were discussed and established. The overall care conference goal process would aid in better resident care outcomes for our long-term, and safe discharge to the community for our short-term residents. Once a conference date and time was established, an email invite would be sent to the IDT team members, including therapy alerting of this meeting. During conferences, the following items would be discussed: resident diagnosis, review of the comprehensive care plan, therapy course, and any other care areas (wound, medication therapy, psychotropic therapy, diet, appointments, etc.) along with the code status and POLST (Physician Orders for Life Sustaining Treatment). If the resident refused to meet, this would be noted in the resident chart. Quarterly care conferences would include a review of the care plan by the IDT team prior to the conference to ensure focuses, goals and interventions are accurate. In addition, the resident orders should be reviewed and updated as needed for accuracy.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48065 Based on observation, interview, and document review, the facility failed to ensure routine personal hygiene care (i.e., nail care) was provided for 1 of 1 resident (R22) reviewed for activities of daily living (ADLs) who was dependent on staff for his care. Findings include: R22's quarterly Minimum Data Set (MDS) assessment dated [DATE], indicated R22 was severely cognitively impaired, had no behaviors and did not refuse personal cares. R22's MDS indicated diagnoses of cerebral infarction (stroke), quadriplegia (paralysis of arms and legs), essential hypertension, and seizure disorders. R22's care plan printed 4/24/25, indicated R22 had a self-care deficit with bathing, dressing and feeding. This care plan directed staff to assist R22 with activities of daily living (ADL). A care plan titled Current Functional Performance identified R22 needed total assist with personal hygiene. During observation on 4/21/25 at 4:10 p.m., resident was sleeping in bed. R22's fingernails were about half an inch long and had black debris underneath his fingernails. During observation and interview on 4/21/25 at 4:13 p.m., nursing assistant (NA)-D verified R22's fingernails were long and had black debris underneath his fingernails. NA-D stated he usually worked overnight shifts and didn't know when or who trims R22's nails. During interview on 4/21/25 at 12:38 p.m., family member (FM)-A stated she visited R22 on 4/13/25, and observed his fingernails were long and dirty. FM-A stated on 4/13/25 she left a voice mail for who she believed was the charge nurse. FM-A stated she left a voice mail to request R22's nails be cleaned and trimmed. During interview on 4/22/25 at 12:38 p.m., NA-E verified R22's nails were long. NA-E stated she gave a sponge bath to R22 this morning and planned to trim his nails before the end of her shift. During observation on 4/23/25 at 8:24 a.m., R22's fingernails were long and had black debris underneath them. During interview on 4/23/25 at 1:55 p.m., licensed practical nurse (LPN)-C stated residents nails are checked on their bath day and trimmed as needed. LPN-C stated R22 is a diabetic, therefore nurses are responsible to trim his nails. During interview on 4/23/25 at 2:56 p.m., director of nursing (DON) stated she expected the facility's residents' nails will be cut on bath days or on a weekly basis. DON added. if a resident had contractures there was a risk to produce skin alterations, and was an infection and dignity issue. Facility Care of Fingernails/Toenails policy dated 4/24/25, indicated the purpose was to clean the nail bed, to keep nails trimmed, and to prevent infections. Activities of Daily Living

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48065 Based on observation, interview and document review, the facility failed to properly transcribe and implement physician orders for a resident requiring edema and surgical incision monitoring for 1 of 1 resident (R36) reviewed for edema and skin conditions. Findings include, R36's Clinical Profile dated 4/23/25, identified an admitted [DATE]. R36's Clinical Diagnoses report printed 4/23/25, indicated diagnoses of infection and inflammatory reaction due to unspecified internal joint prosthesis, presence of right artificial knee joint, acute on chronic diastolic heart failure, cellulitis of right lower extremity, and acute and chronic respiratory failure. R36's admission Minimum Data Set (MDS) assessment dated [DATE], indicated R36 was admitted to the facility on [DATE]. R36 was cognitively intact, had no behaviors or delusions. MDS indicated resident was on pain management, received medications for pain as needed, received intravenous antibiotics, had a surgical wound, used oxygen, and received occupational and physical therapy services. R36's Clinical Orders report printed 4/23/25, included the following orders: - Below the knee [NAME] hose stocking for compression. On in the morning, off at night. Order dated 3/12/25, no end date. - Dressing change with gauze, ABD (large, highly absorbent sterile gauze pad used for managing heavily draining wounds) and Ace wrap. Keep incision dry. Let steri-strips fall off on their own. As needed (PRN). Order dated 3/12/25 at 10 p.m., and discontinued on 3/12/25 at 9:25 p.m. R36's medication administration record (MAR) and treatment administration record TAR) for March 2025 indicated: - Leave wound dressing in place for two weeks or until orthopedic follow-up appointment. Call surgeon if significant cloudy, blood or malodorous drainage, redness or warmth around incision. Every shift for wound maintenance. Order starting date 3/12/25 at 10 p.m. and was discontinued on 4/15/25. It was documented as done between 3/12/25 and 3/31/25. - Daily dressing change with gauze, tape, and Ace wrap for compression. Keep incision dry, one time a day. Order starting date 3/20/25, and ending date 3/26/25. Documented as done. - Dressing change with gauze, ABD and Ace wrap. Keep incision dry. Let Steri strips fall off on their own. PRN. Order starting date 3/26/25, no ending date. No dressing changes were documented. - March's MAR or TAR did not included the order for [NAME] stockings. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R36's medication administration record (MAR) and treatment administration record TAR) for April 2025 indicated: - Leave wound dressing in place for two weeks or until orthopedic follow up appointment. Call surgeon if significant cloudy, blood or malodorous drainage, redness or warmth around incision. Every shift for wound maintenance. Order starting date 3/12/25 at 10 p.m. and was discontinued on 4/15/25. Documented as done. - Dressing change with gauze, ABD and Ace wrap. Keep incision dry. Let Steri strips fall off on their own. PRN. Order starting date 3/26/25, no ending date. No dressing changes were documented. - Below the knee [NAME] hose stockings for compression. On in the morning, off at night. Space for documentation was crossed out. No documentation was done. R36's care plan titled Wound Management Post-Surgical dated 3/12/25, indicated the wound will be free of signs or symptoms of infections. The care plan also indicated Administer antibiotic therapy as prescribed. Wound dressing to remain intact until ortho visit. Do not get dressing wet. No reviews or updates to the care plan were done since 3/12/25. R36's edema and order for ted stockings was not addressed in his care plan. During interview on 4/21/25 at 7:16 p.m., R36 stated he was at the facility after his 7th right knee surgery. R36 was not wearing ted stockings. R36's left shin skin color was darker with some red and dry spots, but the skin was intact. R36 stated A few weeks ago I removed my ted stockings and pulled off some of the skin. It's healed now. R36 had a gauze present below his right knee. R36 stated he had problems with edema and was supposed to wear ted stockings during the day and remove them at night before going to bed. R36 stated the staff did not put on the ted stockings or remove them. R36 added never done it for me. I do it by myself. During interview on 4/22/25 at 12:33 p.m., R36 was not wearing ted stockings and had a dressing present below his left knee. R36 stated he probably scratched a little scab and the area was draining so he put a gauze over the affected area. R36 stated he kept some gauze and dressings in his room, and he took care of his wounds. R36 stated he was admitted to the facility on [DATE], and had a surgical dressing on for 2 weeks. R36 stated on 3/26/25, the surgeon removed the surgical dressing and for a week or so the nurses changed my dressings every day. R36 added after that week I had taken care of my wounds. During observation and interview on 4/22/25 at 2:47 p.m., R36's lower leg was swollen and red. R36 stated his right leg didn't hurt, but compared to his left leg, it felt warmer. R36 was not wearing ted stockings. During interview on 4/23/25 at 8:41 a.m., the assistant director of nursing (ADON) verified R36 had orders for ted stockings and wound care. ADON stated the orders can be seen under physician orders but not under the Point Click Care (PCC) TAR or MAR used every shift by the nurses. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 4/23/25 at 1:37 p.m., LPN-C stated she didn't know R36 had ted stockings or current wound care orders. LPN-C stated this morning the ADON asked her to investigate. LPN-C stated the ted stocking order was transcribed on 3/12/25, but was not properly processed and the nurses couldn't see the order as a daily assignment. LPN-C stated the only way to know was to look at the physician orders. LPN-C verified R36's order for PRN (as needed) wound care. LPN-C stated the order for wound care dated 3/26/25 was transcribed, but was not appropriately processed and was not included in the nurses' daily assignments. LPN-C stated Yesterday, I put a dressing on his [R36] knee because he had a small wound and he is taking antibiotics. During interview on 4/23/25 at 2:50 p.m., director of nursing (DON) stated the ted stockings and wound care orders were not properly carried over PCC for nurses to follow orders. DON stated the mistake was done by the nurse transcribing the orders. DON stated R36 had a history of infection on the right leg and edema. DON stated not putting the ted stockings on to help with the fluid built up, not doing dressing changes and assessing his wounds could be a risk for infection and decline in condition for R36. Facility Comprehensive Person-Centered Care Plans dated 1/20/25, indicated a comprehensive, person centered care plan that includes objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. The care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40614 Based on observation, interview, and document review, the facility failed to implement interventions to prevent the development of new pressure ulcers for 1 of 3 residents (R7) who were reviewed for pressure ulcers. Findings include: R7's Face Sheet printed 4/24/25, indicated R7 had diagnoses including fracture of shaft of right tibia (main long bone of lower leg), type 2 diabetes mellitus, morbid obesity and pulmonary embolism (blood clot that blocks blood flow in the lung). R7's admission Minimum Data Set (MDS) assessment dated [DATE], indicated R7 was cognitively intact, had no behaviors, had a Foley catheter present and was always incontinent of stool. Activities of daily living assessment indicated not assessed. Risk of pressure ulcers (PU) was no and R7 had no unhealed pressure ulcers. A Care Area Assessment (CAA) dated 2/14/25 included a risk for wound care plan will be initiated. A PU/injury will not be addressed in the plan of care. Diagnosis and condition putting patient at increase risk includes diabetes and chronic end stage renal liver, heart disease, depression and pain. Meds affecting potential skin injury include antipsychotics and antidepressants. In addition R7 has come cognitive loss and is incontinent. Needs special mattress or seat cushion. A Braden Scale (risk assessment tool for patient's risk of developing pressure injuries) completed for R7 on 2/14/25, indicated a score of 13 which indicates moderate risk of PU. Repeat Braden Scales were completed 4/9/25 and 4/21/25, and both indicated moderate risk for PU. R7's plan of care dated 2/21/25, indicated wound management as a problem. Interventions included notify provider if no signs of improvement on current wound regimen and provide wound care per treatment order. A current functional performance included bed mobility, dressing, toilet use were independent/one-person physical assist, with transfers of a total assist of two persons using full body lift. R7's plan of care did not include a risk for skin breakdown or interventions to prevent skin breakdown. Weekly bath audit forms included: 2/13/25: R7 had an open area above the coccyx (fissure) and an open area on the right breast due to dampness. 2/27/25: No new alterations in skin noted during this observation. 3/7/25: No new alternation in skin noted during this observation. 3/9/25: No new alternation in skin noted during this observation. 3/13/25: No new alternation in skin noted during this observation. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3/20/25: No new alternation in skin noted during this observation. 3/27/25: No new alternation in skin noted during this observation. 4/3/25: No new alternation in skin noted during this observation. Resident refused shower/bath. Resident said will take shower/bath at another time. An Integrated Wound Care note from 3/12/25, included R7 is being seen for evaluation and treatment recommendations for a fissure (small tear in thin tissue) to the gluteal fold (fold of the buttock horizontal crease) and open lesion to the right breast. She is incontinent of urine and bowel and her mobility is limited by her body habitus (shape and size), weakness and recent surgery to repair a fracture of the right tibia. R7's Braden score is 12 high risk for pressure injury. Recommendations included pressure relief/off loading to include facility pressure ulcer prevention protocol, pressure redistribution mattress, heel offloading and turn and reposition per facility protocol. Other orders included incontinence care and optimize nutrition. An Integrated Wound Care note dated 3/19/25 and 3/26/25, included a Braden score of 12 which is high risk for pressure injury and requires assistance with bed mobility. Recommendations included pressure relief/off loading to include facility pressure ulcer prevention protocol, pressure redistribution mattress, heel offloading and turn and reposition per facility protocol. Other orders included incontinence care and optimize nutrition. An Integrated Wound Care note dated 4/4/25, included R7 is incontinent of urine and bowel and her mobility is limited by her body habitus, weakness and recent surgery to repair a fracture of the right tibia. Her Braden score is 12 which is high risk for pressure injury. New wound was noted on this visit which is an unstageable pressure ulcer to left heel. Treatment orders were placed. Plan of care was discussed with facility staff and the patient. Heel unstageable ulcer was 100% eschar (hardened, dry, black or brown crust caused by dead tissue) and measured 1.5 x 0.7 x 0 centimeter (cm). Treatment recommendation included paint pressure ulcer on heel with Betadine (antiseptic medicine use to treat skin infections) every day. Wound evaluation dated 4/16/25, included abrasion measuring 4.5 cm x 1.7 cm., new wound, in house acquired. Granulation (indicates wound healing) 100% of wound with light serous (serum, the clear watery part of liquid in the body) exudate (body fluid) present. Foam dressing applied. An Integrated Wound Care note dated 4/23/25 included unstageable pressure ulcer left heel was 1.3 x 0.9 x 0 cm with 100% eschar present. Progress improving. No drainage present. Pressure ulcer left gluteus (group of muscles that make up area commonly known as the buttocks) - stage 3 (wound that affects the top two layers of skin, as well as fatty tissues) measured 0.8 x 0.5 x 0.1 cm with scant serosanguinous (serous fluid and blood) drainage. 30% granulation with 70% slough (dead tissue yellow or white appearance) present. Periwound (skin around the wound) is fragile. Wound treatment to left heel included cleanse wound and surrounding area with saline. Do not dry the wound surface. Spread Iodosorb (substance that helps clean and heel wounds) in 1/8-1/4 thickness over wound bed and cover with super absorbent pad. Change three times a week and as needed. Plan is to address factors affecting wound healing include incontinence care as needed, turn and reposition, offload pressure per facility protocol, air mattress and heel offloading. (continued on next page)

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	245028	A. Building B. Wing	04/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Highland Chateau Health and Rehabilitation Center	2319 West Seventh Street Saint Paul, MN 55116

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On interview and observation 4/22/25 at 8:09 a.m., R7 was lying on her back in her bed with head of bed at 20 degrees. R7 stated she got back from the hospital yesterday and has been having problems with abdominal pain and loose stools. R7 stated her Foley catheter was removed over a month ago. R7 stated she does have some wounds on her bottom and one on her heel. R7 stated she has one wound on her bottom since she came in that she has had off and on for a long time. The other wound on her bottom is new as is the heel wound in the past month. R7 stated she isn't able to move or position herself in the bed and requires assistance to reposition. R7 stated prior to her going to the hospital she was getting up in her chair at least once a day. R7 had a heel protector on her left leg. On interview 4/23/25 at 10:30 a.m., nurse practitioner (NP)-K stated R7 has been at high risk for pressure ulcer development since she started seeing her at the facility in March 2025. NP-K stated it was hard to determine if the 2 new pressure ulcers were preventable or not. NP-K added she does wound rounds weekly and R7 is always laying on her back which is concerning. NP-K stated R7 requires assistance to reposition and is not able to turn herself. NP-K stated she made recommendations to the facility to have her on a repositioning program at least every 2 hours and to keep her off her back and has educated the resident of this also. NP-K added she had seen on past visits the staff were placing a pillow under R7's lower legs in attempt to float her heels but the heels were often times resting on the pillow. NP-K added she recommended heel protector boots for both of her heels after her left heel ulcer was discovered. On observation and interview 4/23/25 at 10:35 a.m., NP-K, registered nurse (RN)-G, also identified as assistant director or nursing (ADON), and nursing assistant (NA)-A entered the room to complete wound evaluation, care and treatment. See above 4/23/25 Integrated Wound note above for wound descriptions. NP-K educated R7 and all staff in the room on importance of offloading and staying off her back. Also recommended heel protector for the right heel as one wasn't present and the heel was resting on a pillow. R7 did have a heel protector on her left heel. Continuous observation started on 4/23/25 at 10:38 a.m. for R7: 10:38 a.m., NA-A positioned R7 on her left side using a pillow. 10:56 a.m., no change in position. R7 is dozing off and on. 11:08 a.m., no change in position. 11:26 a.m., no change in position. No staff into her room. 11:45 a.m., no change in position. 12:07 p.m., no change in position. No staff into her room. 12:19 p.m., no change in position. 12:29 p.m., NA-A into room with lunch tray. NA-A raised the head of the bed but did not reposition R7. Pillow remains tucked behind R7 positioned slightly on her left side. 12:33 p.m., P7 is awake and eating lunch. R7 states she has not been repositioned since after the wound care this morning. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. Supplement the use of a risk assessment tool with assessment of additional risk factors. -Skin Assessment: 1. Conduct a comprehensive skin assessment upon (or soon after) admission, with each risk assessment, as indicated according to the resident ' s risk factors, and prior to discharge. 2. During the skin assessment, inspect: a. Presence of erythema; b. Temperature of skin and soft tissue; and c. Edema. 3. Inspect the skin on a daily basis when performing or assisting with personal care or ADLs. a. Identify any signs of developing pressure injuries (i.e., non-blanchable erythema). For darkly pigmented skin, inspect for changes in skin tone, temperature, and consistency; b. Inspect pressure points (sacrum, heels, buttocks, coccyx, elbows, ischium, trochanter, etc.); c. Wash the skin after any episodes of incontinence, using pH balanced skin cleanser; d. Moisturize dry skin daily; and e. Reposition resident as indicated on the care plan. - Mobility/Repositioning 1. Reposition all residents with or at risk of pressure injuries on an individualized schedule, as determined by the interdisciplinary care team. 2. Choose a frequency for repositioning based on the resident ' s risk factors and current clinical practice guidelines. 3. Teach residents who can change positions independently the importance of repositioning. Provide support devices and assistance as needed. Remind and encourage residents to change positions.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42073 Based on observation, interview and document review, the facility was unaware of and failed to comprehensively assess a resident for safe vaping practices for 1 of 1 resident (R37) reviewed for accidents. Findings include: R37's face sheet received on 4/24/25, included diagnoses of malignant cancer of the bladder, chronic pain due to cancer, anxiety, and insomnia. R37's quarterly Minimum Data Set (MDS) assessment dated [DATE], indicated R37 had moderately impaired cognition, clear speech, could understand and be understood. R37 was dependent on staff for some activities of daily living and could walk short distances with the aid of a walker. R37 had pain almost constantly which interfered with sleep and day to day activities. R37's physician orders did not indicate use of medical marijuana or vaping THC (tetrahydrocannabinol). R37's care plan did not indicate use of medical marijuana or vaping THC. Smoking assessments dated 8/21/24, 11/25/24, and 2/24/25, indicated R37 was a non-smoker. Vaping was listed as an option on the electronic assessment tool but had not been checked. Consequently, an assessment for safe vaping had not been conducted. During an interview on 4/23/25 at 11:05 a.m., with R37 and family member (FM)-L, while lying in bed, R37 started vaping with a pen; smoking coming out of his mouth as he exhaled. R37 stated it was weed (marijuana). FM-L stated R37 was on a cannabis program and had a medical marijuana card. FM-L brought the supplies to the facility and R37 stated he vaped multiple times daily. During an interview on 4/23/25 at 4:26 p.m., the director of nursing (DON) and assistant director of nursing (ADON) stated they were not aware of any residents who vaped. The DON stated she knew R37 had a medical marijuana card due to cancer pain. The DON stated, We all knew he was using it (marijuana) but did not know how he ingested it. The DON stated when R37 was admitted (in August 2024), he was given a locked box to store his marijuana supplies, but she never looked at the supplies nor asked how he planned to ingest it. The DON stated she was instructed not to put marijuana use on R37's care plan, and stated the facility did not do anything with the marijuana or supplies -- it was up to the resident and family to manage it. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Nursing progress note dated 4/23/25 at 4:50 p.m., was written as follows by the DON: Writer was informed that resident was vaping medical cannabis in his bed while talking with a surveyor. Resident was admitted with a medical cannabis card and the terms of use were initially explained. Writer approached resident after learning about resident vaping in his bed and asked to speak with him about facility medical cannabis policy. Writer explained to resident that he is not allowed to vape the cannabis within the facility or on facility grounds. Writer encouraged resident to use manual wheelchair and leave facility property if he feels like he needs to use the medication. Resident voiced understanding and stated he would not use the cannabis within the facility nor on facility grounds. Writer left resident with facility policy. In an email request on 4/23/25, at 7:38 p.m., the DON was asked if R37's provider was aware of R37 vaping marijuana, and if so, provide that documentation. Documentation was not received. During an interview on 4/24/25 at 12:16 p.m., the DON stated she talked to R37 late yesterday afternoon (4/23/25), about the facility policy on vaping. In addition, the DON informed R37's provider last night via email of R37's marijuana use and did not know if the provider was aware. The DON stated, we won't know if R37 continued to vape in his room, stating we are hands off; the supplies are in his locked box. The DON stated the facility would have to monitor R37 for vaping in his room. A note in R37's electronic medical record indicated the facility should have been aware R37 was vaping THC in his room. The note was documented by physician assistant certified (PA-C)-M and indicated date of service of 4/17/25, and included R37 had a primary hospice diagnosis of malignant neoplasm of the bladder with metastases. Within this note were three other dates: --10/17/24, indicated R37 seemed to be heavily under the influence of THC and was holding his vape pen in his hand and noted to be quite comfortable. --11/7/24, indicated R37 was resting, and FM-L via telephone stated it [vaping THC] helped relieve R37's anxiety and gave him a break from everything. It helps a lot with his pain, too. --12/4/24, indicated R37's THC continued to help. Facility Medical Cannabis policy dated 7/28/23, indicated: 1. The resident's physician must support the resident's use of medical cannabis. 2. The resident and/or the resident's representative must provide documentation of confirmation that the resident is on the State Medical Cannabis Patient Registry. 3. Confirmation of the resident's certified qualifying medical condition. 4. Confirmation that any individual who intended to assist the resident with administration of the medical cannabis was identified as a Registered Designated Caregiver. 5. If the resident's supply of medical cannabis was to be stored within the facility, it must be stored in a locked secured storage. The facility would provide the resident with a lockable container and secure it within the room if requested. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	6. If the resident intended to administer the medical cannabis independently, the resident would be assessed for safe self-administration of medication by the interdisciplinary team. This assessment would be maintained within the resident's medical record. 7. Vaporizing medical cannabis or smoking dried cannabis flower was not allowed within the facility or on facility grounds. Only liquid (oral suspensions, tincture, sublingual spray), pills/capsules, or topicals (balms or oils), or gummies or chews were permitted. 8. Documentation - The use of medical cannabis would not be documented in the resident's medication administration record. However, the resident's plan of care would be updated to reflect that he/she was authorized to use medical cannabis and had been educated on and met the facility's restriction for use of medical cannabis as outlined by this policy. Facility Residents Smoking Policy with reviewed date of 1/20/22, indicated: Prior to, and upon admission, residents would be informed of the facility smoking policy, including designated smoking areas, and the extent to which the facility can accommodate their smoking or non-smoking preferences. Smoking was only permitted in designated resident smoking areas, which were located outside of the building. Electronic cigarettes would be permitted outside in designated areas only. Otherwise, smoking was not allowed inside the facility under any circumstances. The resident would be evaluated on admission to determine if he or she was a smoker or non-smoker. If a smoker, the evaluation would include method of tobacco consumption (traditional cigarettes; electronic cigarettes; pipe, etc.); ability to smoke safely with or without supervision (per a completed Smoking Observation). The staff would consult with the attending physician and the director of nursing services to determine if safety restrictions need to be placed on a resident's smoking privileges. A resident's ability to smoke safely would be evaluated upon admission/readmission, quarterly, upon a significant change (physical or cognitive) and as determined by the staff. Any smoking-related privileges, restrictions, and concerns (for example, need for close monitoring) would be noted on the care plan, and all personnel caring for the resident shall be alerted to these issues .

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40614 Based on observation, interview, and document review, the facility failed to have a comprehensive incontinence care plan and provide timely assistance with toileting for 1 of 1 resident (R21) reviewed for bladder incontinence. Findings include R21's face sheet printed 4/24/25, included diagnoses of orthopedic aftercare (hip replacement), mixed incontinence, pressure ulcer of right buttock and muscle weakness. R21's admission Minimum Data Set (MDS) assessment dated [DATE], identified R21 was cognitively intact and did not have rejection/refusal of care behaviors. The MDS identified R21 required substantial to maximum assistance for lower body dressing and footwear. R21 requires supervision or touching assistance for toilets transfers. The MDS indicated R21 was always incontinent of urine and bowel. MDS identified no toileting program had been or is currently being attempted. A Care Area Assessment (CAA) dated 3/30/25 included R21 is always incontinent of bowel and bladder. R21 requires assist with transfers needed with toileting tasks. Several skin alterations noted including surgical incision and pressure ulcers present. Will address in care plan. R21's plan of care did not include an incontinence care plan. R21's current functional performance plan of care last updated 4/16/25, included limited to assist of one person for personal hygiene and toilet use. Transfers included extensive assist of one person physical assist. On review of R21's medical record, no bladder/bowel incontinence assessment was found. On observation 4/23/25 at 9:05 a.m., R21 placed call light on. At approximately 9:10 a.m., nursing assistant (NA)-A entered the room and R21 requested to be changed as his pad was wet. NA-A stated she would be back soon. On observation on 4/23/25 at 10:44 a.m., R21 placed his call light on and licensed practical nurse (LPN)-A was in the hallway. R21 was yelling at the nurse that he has been sitting in a wet pad for hours and no one comes and answers his call light. R21 stated the NA said she would be back hours ago. LPN-A stated she would get him some help. R21 stated he has been sitting in wet stuff for over 2 hours and that is ridiculous and was going to contact state senators to stop all funding for the facility. LPN-A stated she would help him shortly and R21 stated this is ridiculous, you shouldn't have to, where are the aides? LPN-A entered R21's shortly after and assisted with changing his wet pad. On observation 4/23/25 at 11:53 a.m., R21 placed call light on while NA-A was walking past his room. R21 told NA-A he needed to get dressed before lunch and NA-A still in the hallway, stated she would be there soon. NA-A continued to walk down the hallway towards the nurses station and then back towards R21's room. R21 again stated he needed to get dressed and has an appointment at 1:00 p.m., and NA-A stated she needed to help someone else and would be right back from the hallway. R21 stated all you are doing is wandering around. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On interview and observation on 4/23/25 at 11:59 a.m., R21 stated he was left laying in a wet pad for 2 hours this morning and that just isn't right. R21 was in a hospital gown in his bed. R21 stated this happens almost every day and gets nothing but excuses over and over. R21 stated again I layed in a wet pad for over 2 hours this morning and added the nurse had to change the pad because the NA never did come into his room and he saw her wandering the halls. R21 stated they never toilet him and he just has to go in his pad. On observation on 4/23/25 at 12:12 p.m., NA-A entered R21's room and closed the door. On interview 4/23/25 at 12:43 p.m., LPN-A indicated R21 was upset this morning and she did change his wet pad. LPN-A stated R21 is incontinent of urine and requires assist of one to change his pad. LPN-A stated she was not aware R21 had been waiting for assistance for over 2 hours until R21 told her. On interview 4/23/25 at 1:30 p.m., NA-A indicated R21 had his call light on multiple times this morning but she was assisting other residents at the times he was requesting assistance. NA-A indicated she informed him she would assist him as soon as she could. NA-A stated she was the only NA down this hallway. On interview 4/24/25 at 9:09 a.m., the director of nursing (DON) stated staff should go into the room once a call light is activated and should not have conversations with them from the hallway. The DON stated residents should not have to wait over an hour to get assistance for toileting or dressing and should never lay in a wet pad for two hours. Facility Urinary Continence and Incontinence - Assessment and Management policy, last reviewed 10/18/22 included: 1. The staff and practitioner will appropriately screen for, and manage, individuals with urinary incontinence. 2. Management of incontinence will follow relevant clinical guidelines. 3. The physician and staff will provide appropriate services and treatment to help residents restore or improve bladder function and prevent urinary tract infections to the extent possible. 4. As part of its assessment, nursing staff will seek and document details related to continence. Relevant details include the following: a. Voiding patterns (frequency, volume, nighttime or daytime, quality of stream, etc.); b. Associated pain or discomfort (dysuria); and c. Type of incontinence 8. The staff and physician will identify individuals with complications of existing incontinence, or who are at risk for such complications (e.g., skin maceration or breakdown, or perineal dermatitis). (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	16. The physician and staff will address treatable causes or contributing factors related to urinary incontinence, including: a. tapering, stopping, or changing medications that may be causing or exacerbating incontinence; b. managing pain and/or providing adaptive equipment to help mobilize individuals suffering from arthritis, contractures, neurological impairments, etc.; c. incorporating environmental interventions and assistive devices (e.g., grab bars, raised toilet seats, bedside commodes, urinals, bed rails, restraints, and/or walkers) to facilitate toileting; d. treating underlying conditions that may impair continence (e.g., delirium causing urinary incontinence related to acute confusion); and e. implementing a fluid and/or bowel management program to meet assessed needs. 18. As indicated, and if the individual remains incontinent despite treating transient causes of incontinence, the staff will initiate a toileting plan. a. As appropriate, based on assessing the category and causes of incontinence, the staff will provide scheduled toileting, prompted voiding, or other interventions to try to manage incontinence. b. Toileting programs will start with a 3- to 5-day toileting assistance trial. c. If the individual requires assistance from more than one person to transfer to the toilet, staff will address his or her mobility problems before attempting a toileting assistance trial. d. Incontinence care should be individualized at night in order to maintain comfort and skin integrity, and minimize sleep disruption. e. Prompted voiding is not helpful at night (e.g., between the hours of 10 p.m. and 5 a.m.) and has been shown to disrupt sleep.

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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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50764 Based on observation, interview, and document review, the facility failed to ensure 1 of 1 resident (R46) reviewed for nutrition and weight loss had received ice cream to increase calorie intake and weight per provider order. Findings include: R46's face sheet printed 4/24/25, included diagnoses of unspecified severe protein-calorie malnutrition, chronic kidney disease, depression, and repeated falls. R46's significant change Minimum Data Set (MDS) assessment dated [DATE], indicated intact cognition, no rejection of care, weight loss of five percent or more in the last month or loss of ten percent or more in the last six months, and setup assistance for eating. R46's care plan revised 2/16/25, indicated resident has a nutritional problem related to diagnosis of adult failure to thrive with goal of maintaining adequate nutritional status as evidenced by maintaining weight within five percent of 124 pounds or gain three to four pounds per month to reach 130 pounds and consume 50 percent of meals. Interventions included provide, serve diet as ordered. R46's physician's orders printed 4/24/25, failed to include an order for ice cream three times per day in between meals to increase calorie intake. During interview on 4/21/25 at 6:30 p.m., R46 stated he had lost weight. R4 further stated he was offered a supplement but declined and had agreed to ice cream three times per day but had not received ice cream yet. During interviews on 4/22/25 at 1:14 p.m. and 3:17 p.m., R46 stated he still had not been offered ice cream and he would eat some if someone would give him some. A dietary note dated 4/1/25, stated registered dietician (RD) met with resident regarding ongoing weight loss. Resident stated he would prefer to weigh 180 pounds. He does not want any supplements such as Ensure or Boost but would agree to ice cream. RD recommends offering ice cream three times per day between meals to help with weight maintenance/gain. A review of R46's electronic medical record (EMR) on 4/23/25, indicated the following weights: 4/23/25-141.0 4/1/25-142.8 3/21/25-148.1 3/10/25-140.4 3/1/25-143.9 (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2/22/25-150.9 1/25/25-151.6 1/4/25-149.7 12/27/24-161.4 11/30/24-160.8 11/6/24-161.0 During interview on 4/23/25 at 7:50 a.m., licensed practical nurse (LPN)-D stated he had not given R46 ice cream and did not have an order to give R46 ice cream. LPN-D further stated he was unaware of any discussion about ice cream for R46. During interview on 4/23/25 at 8:15 a.m., nursing assistant (NA)-K stated she had not seen R46 offered ice cream and was not aware he was supposed to get ice cream three times per day. During interview on 4/23/25 at 9:15 a.m., LPN-C stated she was not aware R46 was supposed to be getting ice cream three times per day. LPN-C further stated usually if there was something the dietician ordered it would be put on the medication administration record (MAR) for the nurses to give. LPN-C stated an order for ice cream was not on the MAR for R46. During interview on 4/23/25 at 1:15 p.m., assistant director of nursing (ADON) stated she was unsure why R46 had not received ice cream and did not know how the orders from the RD were processed. ADON further stated she did not handle dietician orders. During interview on 4/23/35 at 1:38 p.m., director of nursing (DON) stated she did not know the order for ice cream from the RD had not been implemented. DON further stated she would expect diet recommendations to be implemented as soon as possible, and not a month later. DON stated she would need to look at the facility's process for diet orders. During interview on 4/23/25 at 1:45 p.m., RD stated he recalled a discussion with R46 regarding weight loss and R46 agreed to eat ice cream three times per day. RD stated he emailed the recommendation to the DON. RD further stated he expected diet orders implemented timely and would have expected R46's order for ice cream to be implemented by now to prevent further weight loss. Facility Medication Orders policy reviewed 4/19/24, stated the following: 2. A current list of orders must be maintained in the clinical record of each resident. 7. Dietary Supplements- When recording orders for dietary supplements, specify the type, amount, and frequency.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48065 Based on observation, interview, and document review the facility failed to ensure staff provided cares according to standard of practice for gastrostomy tube care for 1 of 1 resident (R22) reviewed for tube feeding. Findings include: R22's quarterly Minimum Data Set (MDS) assessment dated [DATE], indicated R22 was severely cognitively impaired, had no behaviors and did not refuse personal cares. R22's MDS indicated diagnoses of cerebral infarction (stroke), quadriplegia, essential hypertension, moderate protein-calorie malnutrition, and seizure disorders. R22's Clinical orders printed 4/23/25, indicated Jevity 1.5 feeding at 65 milliliters (ml) per hour for 22 hours daily. R22's care plan dated 10/25/24, indicated R22 required a tube feeding and was NPO (nothing per mouth). Care plan indicated R22 will be free of aspiration through the review date and maintain adequate nutritional and hydration status. R22's care plan indicated R22's head of bed (HOB) needed to be elevated 45 degrees during and thirty minutes after tube feeding. R22's medical record indicated three hospitalization s within the last 12 months. On 2/5/25, R22 was hospitalized with a diagnosis of influenza A, pneumonia and sepsis. On 12/12/ 24, R22 was hospitalized with a diagnosis of acquired community pneumonia. On 10/12/24, R22 was hospitalized with a diagnosis of sepsis of unknown source with suspected pulmonary versus oropharyngeal source. During observation on 4/21/25, at 4:10 p.m., R22 was laying in bed in supine position and the head of the bed was not elevated. A tube feeding pump was infusing Jevity 1.5 at 65 ml per hour. During interview on 4/21/25 at 4:13 p.m., NA-D entered R22's room and stated the bed is flat, and it shouldn't be flat. The HOB should be elevated at least 30 degrees. We don't want him to aspirate. NA-D approached and elevated R22's HOB to about 45 degrees. During interview on 4/23/25 at 2:04 p.m., licensed practical nurse (LPN)-C stated R22's HOB should be elevated at least 30 degrees during TF infusion to prevent aspiration. During interview on 4/23/25 at 3:05 p.m., director of nursing (DON) stated the HOB of a resident receiving a tube feeding infusion had to be up at least 30 degrees to prevent aspiration. Facility Safety Precautions Enteral Feedings policy dated 4/24/25, indicated Always elevate the head of the bed (HOB) at least 30 - 45 during tube feeding and at least 1 hour after.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40614 Based on observation, interview and document review, the facility failed to ensure non-invasive ventilator (uses positive pressure to increase lung volume and decrease work of breathing, and allows for support of breathing without breathing tube) was used in accordance with physician orders to meet the individual needs for 1 of 1 resident (R4) reviewed for respiratory care and services. In addition, the facility failed to have an oxygen administration order for R4 who was on continuous oxygen. Findings include: R4's face sheet printed 4/24/25, indicated R4 had diagnoses including morbid (severe) obesity, chronic pain, reduced mobility, and obstructive sleep apnea (breathing repeatedly stops and starts during sleep due to obstruction in upper airway). R4's admission Minimum Data Set (MDS) assessment dated [DATE], indicated R4 had intact cognition, no behaviors including refusal of care. Special treatments included non-invasive mechanical ventilator. Oxygen was not checked as being used. Activities of daily living section was not completed and included not assessed. R4's plan of care dated 1/14/25, included functional performance requiring total assist of two persons for bed mobility, dressing and personal hygiene. Transfer included total assist using 600 pound full body lift with 4 persons to transfer. The care plan did not include R7 was risk or had a potential for impairment of the respiratory system. Physician orders dated 1/9/25 included Noninvasive Ventilator (NIV) Trilogy PC/AVAPS PC01 > or = to 52 mm HG, target tidal volume 550 with rate at 14 IPAP min: 10IPAP max: 30 EPAP 08 and full face mask every shift. The physician orders did not include an order for oxygen. Standing Orders for Skilled Nursing Facilities, last revised for 2025 included: - Initiate and titrate supplemental oxygen from 1-4 L/min via nasal cannula prn for dyspnea (shortness of breath), hypoxia (O2 saturation < 90% or <88% for COPD) or acute angina to keep O2 saturations >90%; immediately update provider with nursing assessment. - May wean supplemental oxygen per nursing judgment to maintain oxygen saturation > 90%; monitor O2 saturations three times a day and 3 days after oxygen is discontinued, including one oxygen saturation during night-time sleep. -Orders initiated should be communicated to the provider the next business day. On observation 4/22/25 at 8:24 a.m., an oxygen concentrator was present in R4's room. R4 had a nasal cannula in her nose, and oxygen concentrator was set at 2 liters oxygen flow but tubing was not connected to the concentrator. There was a NIV present in the room but was not on the resident at this time. Registered nurse (RN)-A was asked to check oxygen saturation which was 87%. RN-A stated the tubing needs to be connected to the concentrator for R4 to receive oxygen and proceeded to connect the tubing. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On observation and interview 4/23/25 at 12:39 p.m., R4 had nasal cannula at 2 liters of oxygen flow. R4 stated she hasn't worn her NIV for the past four or five nights because they ran out of fluid for the machine. R4 added staff told her the state told them she can't have 2 machines in the room, pointing at her oxygen concentrator and her NIV. On interview 4/24/25 at 8:50 a.m., licensed practical nurse (LPN)-A stated R4 hasn't used the NIV for the past few nights and stated they ran out of fluid for the machine some time over the past weekend, but she wasn't aware about it until Tuesday, 4/22/25. LPN-A stated she needed to get an order from the provider, who is coming today, before she can order the fluid for the machine. LPN-A stated R4 does refuse to use the NIV or sometimes only wears it for a few hours before requesting to have it taken off and then requests oxygen by nasal cannula. LPN-A indicated she was not sure if the provider was aware R4 was not wearing the NIV every shift. On interview 4/24/25 at 10:06 a.m., physician assistant (PA-C)-M stated R4 needs her NIV at night due to hypercapnia (abnormally high level of carbon dioxide in the blood, which occurs when the body can't effectively exhale it) and obstructive sleep apnea. PA-C-M was not aware R4 was refusing her NIV and stated he should be notified if she refuses to wear it. PA-C-M stated he was unaware they ran out of fluid for the machine but added, the order she came with from the hospital should cover the need for reordering the fluids or any supplies needed. PA-C-M stated he has not ordered oxygen use for R4 but was aware from previous visits that she was using 2 liters of oxygen via a nasal cannula. On interview 4/24/25 at 10:17 a.m. LPN-A reviewed R4's record and confirmed that there was no oxygen order present and R4's record lacked a plan of care for respiratory care related to oxygen use, NIV and inhaler use. On interview 4/24/25 at 10:30 a.m., nursing assistant (NA)-I stated R4 usually wears her nasal cannula with oxygen throughout the day. NA-I states he hasn't seen her wear her NIV mask in awhile. Review of Trilogy NIV machine use indicated 4/21/25, was left blank and lacked documentation. 4/22 and 4/23/25 were documented as not used due to bag of sterile water for hydration to use with the NIV was not available. Review of use of oxygen lacked documentation in the medical record. On interview 4/24/25 at 11:57 a.m., the director of nursing (DON) stated oxygen can be implemented up to 2 liters per nasal cannula per standing orders but is temporary and a provider order is required within 72 hours. The DON would expect staff to contact the provider for the resident's need for oxygen and get an order. The DON stated she would expect staff to have adequate supplies on hand for the NIV and if not available to resolve the problem right away and not wait. The DON stated the provider should be notified if R4 is refusing to wear the NIV. Facility Oxygen Administration policy dated 11/1/21, included: -Purpose: The purpose of this procedure is to provide guidelines for safe oxygen administration. -Preparation 1. Verify that there is a physician's order for this procedure. Review the physician's orders or facility protocol (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	for oxygen administration. 2. Review the resident's care plan to assess for any special needs of the resident. -Assessment: Before administering oxygen, and while the resident is receiving oxygen therapy, assess for the following: 1. Signs or symptoms of cyanosis (i.e., blue tone to the skin and mucous membranes); 2. Signs or symptoms of hypoxia (i.e., rapid breathing, rapid pulse rate, restlessness, confusion); 3. Signs or symptoms of oxygen toxicity (i.e., tracheal irritation, difficulty breathing, or slow, shallow rate of breathing); 4. Vital signs; 5. Lung sounds; 6. Arterial blood gases and oxygen saturation, if applicable; and 7. Other laboratory results (hemoglobin, hematocrit, and complete blood count), if applicable. -After completing the oxygen setup or adjustment, the following information should be recorded in the resident's medical record: 1. The date and time that the procedure was performed. 2. The name and title of the individual who performed the procedure. 3. The rate of oxygen flow, route, and rationale. 4. The frequency and duration of the treatment. A Mechanical Ventilation: Setup and Monitoring policy dated 4/23/25 included: - Review the resident's care plan to assess for any special needs of the resident. - Documentation: After initiating mechanical ventilation, the following information should be recorded in the resident's medical record: 1.The date and time that the procedure was performed. 2.The name and title of the individual who performed the procedure. 3. The mechanical ventilator settings, including: (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	a. Tidal volume; b. Ventilatory rate; c. Peak flow rate; d. Pressure limit; e. Sensitivity; f. Oxygen concentration; g. Mode (assist control or rate control); and h. Special parameters such as positive end expiratory pressure (PEEP) settings. 4. All assessment data obtained before, during, and after the procedure. 5. How the resident tolerated the procedure. 6. If the resident refused the procedure, the reason(s) why and the intervention taken. 7. The signature and title of the person recording the data. -Reporting: 1. Notify the supervisor if the resident refuses the procedure. 2. Report other information in accordance with facility policy and professional standards of practice.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42073 Based on observation, interview, and document review, the facility failed to provide sufficient staffing and/or oversight of non-licensed nursing staff to ensure 7 of 7 residents (R16, R37, R12, R38, R8, R4, R21) received care and assistance as needed and in a timely manner. These deficient practices had the potential to affect all 47 residents who resided in the facility. Findings include: Refer to F677: The facility failed to ensure routine personal hygiene care (i.e., nail care) was provided for 1 of 1 resident (R22) reviewed for activities of daily living (ADLs) who was dependent on staff for his care. Refer to F690: The facility failed to have comprehensive incontinence care plan and provide timely assistance with toileting for 1 of 1 residents (R21) reviewed for bladder incontinence. Refer to F726: The facility failed to ensure agency nursing assistants (NA's) received appropriate orientation, training and supervision. Refer to F807: The facility failed to provide water, consistent with the resident needs and preferences, and sufficient to maintain hydration for 1 of 1 resident (R31) reviewed for hydration. RECORD REVIEW: R4's face sheet received on 4/24/25, indicated R4 had diagnoses including morbid (severe) obesity, chronic pain, reduced mobility. R4's admission minimum data set (MDS) assessment dated [DATE], indicated R4 had intact cognition. R4's care plan dated 1/14/25, included functional performance requiring total assist of two persons for bed mobility, dressing and personal hygiene. Transfers required total assist using 600 pound full-body lift with 4 persons to transfer. R8's face sheet received on 4/24/25, included diagnosis of stroke affecting his non-dominate left side. R8's significant change MDS assessment dated [DATE], indicated intact cognition, clear speech, could understand and be understood. R8 was dependent upon staff for toileting and most ADL's. R8 was always incontinent of urine and occasionally incontinent of bowel. R8's care plan dated 3/27/25, indicated R8 required extensive physical assist for most ADL's. R12's face sheet received on 4/24/25, included diagnosis of stroke affecting his non-dominate left side. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	R12's quarterly MDS assessment dated [DATE], indicated intact cognition, clear speech, he could understand and be understood. R12 required supervision with toileting transfers, and was dependent upon staff for toileting hygiene. R12 was frequently incontinent of bowel and bladder. R12's care plan dated 3/28/25, indicated R12 required extensive physical assist for most ADL's. R16's annual MDS assessment dated [DATE], indicated R16 was cognitively intact, had clear speech, could understand and be understood. R16 required partial to substantial staff assist with dressing and substantial assist with toileting; was occasionally incontinent of urine and always incontinent of bowel. Diagnoses including renal insufficiency, amputation, diabetes, heart failure and atrial fibrillation. R16's care plan dated 4/25/25, indicated R16 required extensive assistance with dressing, bed mobility, toileting and transfers. R16's care plan also indicated risk for skin impairment and directed staff to apply barrier cream after each incontinent episode. R21's face sheet received on 4/24/25, included diagnoses of orthopedic aftercare for left hip replacement, pressure ulcer of right heel stage 3, and pressure ulcer of right buttocks stage 2. R21's admission MDS assessment dated [DATE] indicated R21 was cognitively intact, had clear speech, could understand and be understood. No behaviors or delirium; was always incontinent of bowel and bladder and required assistance of staff for toileting. R21's care plan dated 3/24/25 and updated 4/16/26 did not include a plan for bowel and bladder incontinence. R31's face sheet received on 4/24/25, included diagnosis of left below the knee amputation. R31's quarterly MDS assessment dated [DATE], indicated R31 was cognitively intact, had clear speech, could understand and be understood. R31 was frequently incontinent of bowel and bladder, used briefs for toileting and was dependent upon staff for toileting hygiene. R31's care plan with revised date of 3/27/25, indicated R31 was incontinent of bladder and bowel related to immobility and would remain free from skin breakdown due to incontinence and brief use. Care plan dated 10/29/24, indicated R31 was a total assist/one-person physical assist. R33's face sheet received on 4/24/25, included chronic venous hypertension of bilateral lower legs (persistent high blood pressure in veins of legs). R33's quarterly MDS assessment dated [DATE], was cognintively intact, had clear speech, could understand and be understood. R33 was independent with activities of daily living R37's face sheet received on 4/24/25, included diagnoses of malignant cancer of the bladder, chronic pain due to cancer, anxiety, and insomnia. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	R37's quarterly MDS assessment dated [DATE], indicated R37 had moderately impaired cognition, clear speech, could understand and be understood. R37 was dependent upon staff for most activities of daily living (ADL's) and could walk short distances with the aid of a walker. R37 was occasionally incontinent of bladder and bowel. R37 had pain almost constantly which interfered with sleep and day to day activities. R37's care plan dated 9/24/24, indicated R37 received hospice care, would be comfortable and would not have an interruption in normal activities due to pain. R37's care plan with revised date of 3/27/25, indicated R37 required one-person physical assist for most ADL's. R38's face sheet received on 4/24/25, included diagnosis of stroke affecting her non-dominate left side. R38's significant change MDS assessment dated [DATE], indicated intact cognition, clear speech, could understand and be understood. R38 was dependent upon staff assist for most ADL's including toileting. R38 was always incontinent of bowel and bladder. R38's care plan with revised date of 3/27/25, indicated R38 required extensive physical assist for most ADL's. RESIDENT OBSERVATIONS: R4 On observation 4/23/25 at 11:30 a.m., nursing assistant (NA)-A entered R4's room and R4 told her she needed the bed pan and NA-A stated she needed to get more help. At 11:32 a.m. NA-B entered R4's room and R4 told her she needed to use the bed pan NA-B informed her she needed to get more assistance and left the room. R4 called the front desk of the facility stating she needed help and to send some as I don't want anyone to have to clean up my mess. At 11:36 a.m. licensed practical nurse (LPN)-A went into R4's room but was not able to locate NA-A or NA-B and told R4 she couldn't get her on the bed pan alone and would have to wait until she could get help. LPN-A remained in the room until 11:41 a.m. At 11:37 a.m., social services (SS)-A entered the room. At 11:52 a.m., SS-A remained in the room with the door closed and NA-A entered the room and then exited the room. NA-B and NA-A both entered the room at 11:55 a.m., and LPN-A entered the room shortly after. At 12:10 p.m., all staff exited the room. On interview and observation on 4/23/25 12:39 p.m., R4 stated she needed to use the bed pan and they told me they needed more help. R4 stated it took them over an hour to finally get her on the bed pan. R4 stated she was really worried she was going to soil herself so she called the front desk for help but that didn't help either. R4 stated she was able to hold her bowel movement until they got her on the bedpan, but it was close. At 12:43 p.m., LPN-A entered the room and R4 complained of how she was laying in her bed with her feet touching the bottom footboard and stated she is not comfortable. LPN-A stated she can't move R4 alone and R4 asked if they had a male NA working today. LPN-A stated no and added we can't always have a male NA on duty. R4 then stated see, this is what happens all the time. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On observation and interview 4/23/25 at 1:21 p.m., R4 continued to have her feet touching the foot board with head of bed elevated at 60 degrees. R4 stated I am so uncomfortable, and someone needs to do something about it. R4 put on her call light. On observation and interview 4/23/25 at 1:34 p.m., NA-H and NA-A entered R4's room to boost R4 up in her bed. NA-H stated they called him from 2nd floor to assist. NA-H added it is just physics with putting her feet up and head down and then sliding her. NA-H stated he can boost R4 up in bed himself when doing this. On interview 4/23/25 at 1:35 p.m., NA-A stated it takes three staff to move R4 and she has to call another NA from another wing or floor to come and assist her and then find the nurse also. On interview 4/24/25 at 9:09 a.m., the director of nursing (DON) stated residents should not have to wait 30-45 minutes to be assisted onto a bedpan or to be repositioned. The DON stated the staff need better ways to communicate and coordinate patient care activities. R21 On observation 4/23/25 at 9:05 a.m., R21 placed call light on. At approximately 9:10 a.m., nursing assistant (NA)-A entered the room. R21 requested to be changed as his pad was wet. NA-A stated she would be back soon. On observation on 4/23/25 at 10:44 a.m., R21 placed his call light on, and licensed practical nurse (LPN)-A was in the hallway. R21 was yelling at the nurse that he has been sitting in a wet pad for hours and no one comes and answers his call light. R21 stated the NA said she would be back hours ago. LPN-A stated she would get him some help and R21 stated he has been sitting in wet stuff for over 2 hours and that is ridiculous and was going to contact state senators to stop all funding for the facility. LPN-A stated she would help him shortly and R21 stated this is ridiculous, you shouldn't have to, where are the aides? LPN-A entered R21's shortly after and assisted with changing his wet pad. On 4/23/25 at 11:53 a.m., R21 placed call light on, and NA-A was walking past his room. R21 told NA-A he needed to get dressed before lunch and NA-A stated she would be there soon. NA-A continued to walk down the hallway towards the nurses station and then back towards R21's room. R21 again stated he needed to get dressed and has an appointment at 1:00, and NA-A stated she needed to help someone else and would be right back. R21 stated all you are doing is wandering around. On interview and observation on 4/23/25 at 11:59 a.m., R21 stated he had been left lying in a wet pad for 2 hours this morning and that just isn't right. R21 was in a hospital gown in his bed. R21 stated this happened almost every day and gets nothing but excuses over and over. R21 stated again, I laid in a wet pad for over 2 hours this morning and the nurse had to change that because the NA never did come into my room and I saw her wandering the halls. R21 stated they never toilet him and he just has to go in his pad. On interview 4/24/25 at 9:09 a.m., the DON stated staff should go into the room once a call light is activated and should not have conversations with them from the hallway. The DON stated residents should not have to wait over an hour to get assistance for toileting or dressing and should never lay in a wet pad for two hours. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	CALL LIGHT RESPONSE INTERVIEWS AND OBSERVATIONS: During an interview on 4/21/25 at 4:53 p.m., R33 stated agency staff had no get up and go. R33 stated there were no standards; no one holding them accountable to make sure they were doing their job. R33 stated for example, there were signs around the building indicating staff were not supposed to be on their cell phones, but they were often seen on their cell phones. R33 provided another example on 4/20/25, at around 7:00 p.m. , R31 was screaming because her call light wasn't working - she was screaming for help - she needed to be changed. After about a half hour and no one helping her, R33 walked to the dining room and saw the nursing assistant sitting at the nurses station on her phone. R33 stated he told her to get off her phone and help R31 and slapped the sign about not being on cell phones in front of her. During observations during survey from 4/21/25, to 4/24/25, on both first and second floors, multiple staff, primarily NA's were observed on cell phones multiple times, both while at the nurses station and while in common areas on the units. During document review, a written grievance filed by R8 on 4/6/25, indicated he had turned his call light on at noon and someone came in and turned the light off saying they would get to him. No one came for 3.5 hours. The DON's written response indicated, Call lights answered promptly. Staff reported they went to assist as soon as able. There was no indication in the review/response that R8's call light log had been reviewed for the date and time of R8's complaint. During an interview on 4/24/25 at 1:36 p.m., R8's grievance was reviewed with the DON, including R8's call light log data from 4/1/25, to 4/24/25. R8 had two call light response times of 42 and 60 minutes on 4/6/25. The DON stated that was not acceptable and would expect call lights to be answered sooner than that. The DON believed she received wrong call light data for R8, otherwise would not have written on the grievance form that R8's call lights had been answered promptly. CALL-LIGHT RESPONSE REVIEW: Call light response times were reviewed for a one-month time frame from 3/23/25, to 4/22/25, which indicated many call light response times greater than 20 minutes: FIRST FLOOR: R21: During an interview on 4/21/25 at 4:43 p.m., R21 stated it was not uncommon for his call light to be on for 30 minutes and no one answered it. When his call light wasn't answered, R21 stated he sometimes called the facility on his cell phone for help and half the time no one answered the phone. R21 stated he thought the NA's were drastically understaffed. R21 had 474 activations with call light response times of: > 20 minutes = 13 x > 30 minutes = 22 x (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	> 40 minutes = 5 x > 50 minutes = 4 x > 60 minutes = 10 x R4: During an interview on 4/22/25 at 8:08 a.m., R4 stated she has had to wait hours for her call light to be answered. R4 had 76 activations with call light response times of: > 20 minutes = 8 x > 30 minutes = 1 x > 40 minutes = 1 x > 50 minutes = 1 x > 60 minutes = 11 x SECOND FLOOR: R16: During an interview on 4/21/25 at 3:34 p.m., R16 stated he waited a long time for his call light to be answered, depending on the shift. R16 stated about a week ago, around 9:00 p.m., he put his call light on, and no one took care of him until the next morning. R16 had 66 call light activations with call light response times of: > 20 minutes = 5 x > 30 minutes = 7 x > 40 minutes = 1 x > 50 minutes = 1 x > 60 minutes = 7 x R37: During an interview on 4/22/25 at 9:14 a.m., R37 stated sometimes staff answered his call light in a few minutes and sometimes they didn't come at all. R37 stated, What I'm scared about the most, is when my pain gets worse -- am I going to have to suffer? (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	R37 had 240 activations with call light response times of: > 20 minutes = 17 x > 30 minutes = 9 x > 40 minutes = 1 x > 50 minutes = 1 x > 60 minutes = 7 x R12: During an interview on 4/21/25 at 2:32 p.m., R12 stated he had his call light on for four hours one night when he had a bowel movement. R12 stated his call light was on for 45 minutes most of the time before anyone responded. R12 had 72 activations with call light response times of: > 20 minutes = 6 x > 30 minutes = 3 x > 40 minutes = 3 x > 50 minutes = 3 x > 60 minutes = 9 x R38: During an interview on 4/21/25 at 5:36 p.m., R38 stated it took a long time for someone answer her call light -- sometimes up to 3 hours. R38 had 23 activations with call light response times of: > 20 minutes = 2 x > 30 minutes = 3 x > 40 minutes = 1 x > 50 minutes = 0 x > 60 minutes = 5 x R8 (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During document review, a written grievance filed by R8 on 4/6/25, indicated he had turned his call light on at noon and someone came in and turned the light off saying they would get to him. No one came for 3.5 hours. Call lights response log for 4/1/25, to 4/24/25, were reviewed. R8 had 36 activations with call light response times of: > 20 minutes = 3 x > 30 minutes = 1 x > 40 minutes = 2 x (one occurred on 4/6/25) > 50 minutes = 1 x > 60 minutes = 2 x (one occurred on 4/6/25) During an interview on 4/24/25 at 10:52 a.m., the assistant director of nursing (ADON) whose office was on second floor, stated she had been in her role for almost a year. ADON stated resident call light response times often came up in conversation. ADON stated she could hear when a call light was not being answered in a timely manner due to the continued beeping sound outside of her office. The ADON stated sometimes she got up to see what was going on, or staff or residents brought it to her attention. The ADON stated she typically touched base with residents when there were long call light response times to discuss circumstances. In addition, the ADON stated call light audits were done when a concern was identified by a resident. The ADON stated a manager conducted the audit by sitting in a residents room and activating the call light and waiting for staff to respond. The ADON stated she did not look at call light response time reports; that maybe the DON and/or administrator did. The ADON was informed by the surveyor that call light response time reports for multiple residents on second floor for the past month indicated many call lights were over 20, 30, 40, 50 and 60 minutes. The ADON stated she was not aware of that, and stated call lights should be answered within 10-15 minutes. The ADON stated licensed nursing staff on duty had accountability over the NA's to ensure they were doing their work in a timely manner. Further, the ADON stated staff cell phones were not permitted on the units - only when on break. During an interview on 4/24/25 at 12:21 p.m., the DON stated call lights response times were discussed at QAPI (quality assurance and performance improvement) meetings. The DON stated call light response times were discussed in terms of average call light response times rather than looking at and investigating outliers. The DON stated managers conducted call light audits where a manager went into a residents room and pressed the call light. The DON stated sometimes a call light could be long if staff went into the room and forgot to shut the light off. The DON stated it wasn't an issue of not having enough staff, adding they were adequately staffed for their census. The DON was informed by the surveyor of the call light response times noted on reports received from the administrator. The DON stated, That is not acceptable on any level. The DON stated she would expect licensed nursing staff on duty to hold NA's accountable for completing their work in a timely manner, but acknowledged staff nurses didn't have the time, and it could place them in an uncomfortable position. The DON stated the facility did not utilize walkie talkies to communicate with other staff across wings .adding that if a NA on one wing needed help, he/she would have to go look for someone to help. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an observation on 4/24/25 at 2:47 p.m., three NA's were standing in the common area on the first floor all on their cell phones. NA-A immediately put her phone away when observed. The other two unidentified NA's did not. The ADON was informed. During an interview on 4/24/25, at 2:50 p.m., (LPN)-C stated staff came to her about NA's being on their cell phones while on duty and stated she had told the ADON and DON, but nothing happened .I can only do so much. 40614 Facility Resident Call System policy dated 3/5/25, indicated calls for assistance were answered as soon as possible, but no later than 5 minutes. Urgent requests for assistance are addressed immediately. Call light response times were reviewed as part of the QAPI program.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42073 Based on interview and document review, the facility failed to ensure employed and agency nursing assistants (NA's) received appropriate orientation, training and supervision. In addition, the facility failed to ensure 2 of 5 nursing assistants (NA-A and NA-C) received and demonstrated required competency skills for resident cares. Further, NA-C had not completed all in-service trainings upon hire. This had potential to affect all 47 residents who resided in the facility. Findings include: R33's quarterly Minimum Data Set (MDS) assessment dated [DATE], indicated R33 was cognitively intact. R47's quarterly MDS assessment dated [DATE], indicated R47 was cognitively intact. During an interview on 4/21/25 at 4:53 p.m., R33 stated agency staff had no get up and go. R33 stated there were no standards; no one holding them accountable to make sure they were doing their job. Reviewed binder provided by the administrator which was used for new employee and agency orientation. Review of the binder indicated one or two pages on various topics, primarily focused on topics licensed nursing staff would need to know/utilize, and little job-specific for non-licensed nursing staff (NA's). The topics included: pharmacy, oxygen, the electronic medical record (EMR) Point Click Care with a screen shot of how to locate the Kardex and care plan, infection control, emergency procedures, wounds, new admissions, risk management and assistance scoring. The administrator indicated new employee and agency orientation was conducted by the assistant director of nursing (ADON). Via email on 4/22/25, at 4:23 p.m., when asked if the binder was used for NA's too, the administrator replied, yes, but rarely did they have any agency NA's. Via email on 4/23/25, at 8:29 p.m. when asked to see certain NA orientation checklists, the administrator replied agency staff did not have a checklist; they only reviewed and signed the orientation binder. An undated document titled Agency Orientation -- provided by the administrator, listed printed name, signature and title of 13 registered nurses and NA's, but unable to determine when this training had occurred. A list of agency NA's for payroll cycle 4/14/25, through 4/27/25, provided by the director of nursing (DON) to identify agency staff working during survey week, identified 12 agency NA's having worked hours during that time period, working a total of 102.25 hours. During an interview on 4/23/25 at 10:05 a.m., at resident council meeting, R47 stated agency NA's needed proper training; That's my biggest concern. R47 stated agency NA's were not doing their work, didn't know what to do when they come here; were not properly trained. R47 stated agency NA's asked him what they were supposed to do and asked him where supplies were kept. R47 stated they didn't know how to use the [mechanical] lifts. Residents at the resident council meeting stated they could not always tell who was agency versus employed staff, adding not all staff wore name tags or often name tags were backwards. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 4/24/25 at 9:17 a.m., human resource director (HRD)-C stated he had been employed at the facility for one month. HRD-C stated a lot of money was going to agencies for staffing. HRD-C stated the ADON provided orientation for new employed and agency staff. HRD-C stated he was not able to find documentation of agency or employed staff orientation/training. During an interview on 4/24/25 at 10:52 a.m., the ADON stated she had been in her role since June 2024. The ADON stated she was responsible for new employee staff orientation, including agency staff, and utilized an orientation binder for guidance. ADON stated there were no orientation checklists or other such documentation tools to ensure employed or agency NA's received orientation and training consistent with resident care requirements and expectations of the facility. There were no documentation to ensure NA's were shown were resident supplies were kept, no documentation to ensure NA's were competent in the use of the facility mechanical lifts, no documentation to ensure NA's were informed of expectations about checking resident preferences and transfer status (e.g., level of assistance needed) prior to providing care, nothing to ensure NA's were informed of providing fresh water to residents, of expected call light response times, or expectations about personal cell phone use. The ADON stated the only orientation NA's received regarding individualized resident care was how to access the Kardex (a quick reference guide that provided a summary of patient information) in the EMR which was one screen shot of how to access the Kardex. The ADON stated she did not ensure agency NA's had access to the Kardex, stating they should have the same access as employed NA's but did not follow up with agency NA's to ensure they had access and knew how to utilize the Kardex. The ADON stated licensed nursing staff on duty were accountable for ensuring NA's performed their job duties. During an interview on 4/24/25 at 12:21 p.m., the director of nursing (DON) stated she expected NA's to know about the individual resident care needs and how a resident transferred before caring for the resident, and expected NA's to use the Kardex to determine this. The DON was informed of resident concerns regarding the perceived lack of orientation, training and oversight for NA's. The DON stated she expected licensed nursing staff on duty to hold NA's accountable for performing their job duties. 48299 NURSE AIDE TRAINING NA-A was hired 5/26/21. NA-A's employee file lacked skill competencies completed within the past year. NA-C was hired 2/4/25. NA-C's employee file contained undated competency exams related to HIPAA (The Health Insurance Portability and Accountability Act; federal stands to protect health information from disclosure without patient's consent), workplace emergencies, resident rights, abuse and neglect and elder justice, fire safety, and hazardous chemicals. NA-C's employee file lacked skill competencies. NA-C's Relias (platform which provides online training) transcript printed 4/24/25, indicated NA-C completed the following trainings: -Emergency Preparedness Requirements with completion date of 4/10/25. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-Behavioral Management in the SNF (skilled nursing facility) with completion date of 4/8/25 and 4/10/25. -Cultural Awareness and Humility with completion date of 4/8/25. -Abuse, Neglect, and Exploitation with completion date of 4/8/25. -Basics of Tuberculosis with completion date of 4/8/25. -About Infection Control and Prevention with completion date of 4/8/25. -The Facts on COVID-19 (respiratory illness caused by the SARS-CoV-2 virus, a type of coronavirus) with completion date of 4/8/25. During interview on 4/24/25 at 1:59 p.m., HRD-C stated new hires completed general onboarding through a PowerPoint (software to create and deliver presentations using slides, texts, images, and multimedia elements) presentation and completed skill competencies during shadow shifts on the floor. HR stated new hires completed some Relias training upon hire and had more Relias trainings during annual training. HR stated employees received annual competency training through a skills fair directed by the assistant director of nursing (ADON) and director of nursing (DON). During follow-up interview on 4/24/25 at 3:03 p.m., HRD-C reviewed NA-C's completed Relias trainings and was unsure if more training was required than what was completed. HRD-C expected Relias training to be completed within two weeks after orientation date. During interview on 4/24/25 at 3:22 p.m., the DON reviewed NA-C's Relias training transcript and stated NA-C was not signed up for all the required new hire Relias trainings. The DON was given opportunity to look for NA-C's new hire skill competencies. DON stated staff completed an annual skills fair which included hand washing, infection control, abuse, and other specific skills. The DON stated the last skills fair was August 2024, and had sign-in sheets for the staff. The DON stated they were not sure where the sign-in sheets were located. The DON stated skill competencies were important to ensure staff understood and were able to effectively perform their necessary job duties. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The facility assessment dated [DATE], indicated current strategies for recruitment and retention of nursing staff included competitive compensation and benefits by offering competitive salaries, comprehensive benefits, and incentives like bonuses or tuition reimbursement to attract and retain top talent. Replace agency with full-time facility employees. The facility utilized a comprehensive educational program with the goal of having the most competent and satisfied care givers. All new staff attended a classroom experience that covered the information all staff need to complete their jobs effectively. Completion of an extensive checklist (developed by the clinical leadership) in the care setting ensured the nursing staff had the opportunity to demonstrate knowledge and skill for required tasks. There was person centered care education via unit meetings, one to one with clinical managers or staff development. The facility provided annual education that covered required regulatory education as well as facility specific education which can occur in the classroom or online, depending on associate's preference, availability, and learning style. The agenda, power point, and checklist for General Orientation were available within the shared drive, located under Administration/General Orientation. The Facility Assessment indicated staff competencies included person-centered care, activities of daily living, disaster planning and procedures, infection control, vitals, caring for people with dementia, mental and psychosocial disorders, trauma, substance use disorder, and non-pharmacological management of responsive behaviors. The facility's Orientation Program for Newly Hired Employees, Transfers, Volunteers policy dated 3/4/25, indicated the orientation program included a tour of the facility, instructions to be followed in an emergency, introduction to resident care procedures and administrative structure. The policy indicated orientation records included the date reviewed, participant's initials, subject matter reviewed, and other information deemed necessary or appropriate.

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F 0730 Level of Harm - Potential for minimal harm Residents Affected - Many	Observe each nurse aide's job performance and give regular training. 48299 Based on interview and document review, the facility failed to complete annual performance reviews for 2 of 5 nursing assistants (NA-A, NA-B) whose employee files were reviewed. This had the potential to affect all 47 residents who resided at the facility. Findings include: Review of NA-A and NA-B employee files contained counseling forms with verbal and written warnings. Both files lacked documentation of an annual performance review in the last year. NA-A was hired on 5/26/21, and NA-B was hired on 12/6/23. During interview on 4/24/25 at 3:03 p.m., the human resources manager (HR) stated were not sure of the process for performance reviews. HR further stated recently started role and planned to implement a process to ensure performance reviews were completed during employees' work anniversary month. During interview on 4/24/25 at 3:14 p.m., the director of nursing (DON) stated they referenced the performance review policy to know how often performance reviews were required. The DON stated they (NA-A and NA-b) held their role for approximately two years, and performance reviews were not completed in the past year. The DON stated performance reviews were important, so staff knew how well or not they performed their job duties and gave staff an opportunity to voice their concerns about education. Facility Job Descriptions and Performance Evaluations policy dated 9/2020, indicated performance evaluations measured the standards against job performance. The policy indicated the director of human resources and/or respective department director reviewed with each employee a copy of the employee's job description prior to or upon employment, or upon assignment of duties, to determine if the essential functions of the job can be performed, or if modification of the job position needs to be made. The policy lacked time frame for further performance reviews.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 40614 Based on observation and interview, the facility failed to maintain safe storage of medications when over the counter stock medications were left unlocked and unattended in an office. Findings include: On observation and interview on 4/21/25 at 3:31 p.m., through an open door, observed bottles/containers of over the counter (OTC) medications spread out on a table in an office located at the end of 1 [NAME] wing, a resident hallway. At the end of the hallway by the office was a vending machine for soda pop and snacks for staff and residents. There was no exit or entry located in this area. Medications included vitamins, acetaminophen, probiotics, lidocaine patches and ibuprofen. Some medications were still in boxes, and some were unpackaged and on the table. Medical Records Director (MRD)-O was present in the room and stated she was also central supply and ordered supplies including OTC medications. MRD-O stated she was in the process of unpacking the medications to refill the medication closet on the nursing unit. MRD-O stated she locked the door when she left her office. On observation 4/21/25 at 6:30 p.m., the MRD office door was open and MRD-O was not in the office. At 6:34 p.m., MRD-O returned to her office and said she left it open as she just had to run to the second floor and wasn't gone long. On observation and interview on 4/22/25 at 12:37 p.m., MRD office door was closed, but not locked. At 2:23 p.m., MRD-O office door remained closed but unlocked. At 3:23 p.m., MRD office door was closed but remained unlocked. At 3:26 p.m., MRD-O returned to her office and opened the door without a key. MRD-O stated she was on a unit that was close by, so she did not lock the door. During an observation and interview on 4/22/25 at 3:24 p.m., during a tour with the administrator, the MRD office door was open. The OTC medications were still on the table and unattended. The administrator confirmed this was a potential safety issue and the medication should not be left unattended. On observation and interview 4/24/25 at 11:02 a.m., a tour of the 2nd floor medication room (only medication room in the building) was completed with licensed practical nurse (LPN)-C. Multiple boxes of tube feeding solutions were present on the counter and multiple other non-medication supplies were stored on the shelves and counters. LPN-C stated they don't have a lot of room to store anything else in the medication room. On interview 4/24/25 at 12:03 p.m., the director of nursing (DON) stated medications should not be stored in a room that is not locked including over the counter stock medications. The DON stated she would expect MRD-O to lock the door when leaving with medications present even if she is gone for a short time. A policy on medication storage was requested and none received.

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46885 Based on interview and document review the facility failed to employ either a full-time registered dietician (RD) or a qualified dietary manager (DM) to carry out the functions of the food and nutrition service, which had the potential to affect 44 of 44 residents who received food from the kitchen. Findings include: During interview on 4/21/25 at 2:39 p.m., the dietary manager (DM) stated she had a food safety certification and an MDH certification, but did not have her qualifications on hand. During interview on 4/22/25 at 12:16 p.m., DM stated, the administrator told DM to bring her certifications in on Thursday, 4/24/25. DM stated the registered dietician (RD)-I worked every day. During interview on 4/23/25 at 7:53 a.m., RD-I stated he was the dietician for the facility, was contracted, and had been with the facility for 5 or 6 years and worked on Mondays. When asked about RD-I's FTE status, RD-I stated he had to look at his hours report and stated he worked 10 to 12 hours per week and again stated he usually only came in on Mondays. During interview on 4/23/25 at 2:38 p.m., DM came into the kitchen and stated the internet was poor and the HR director instructed her to email her qualifications and he would provide the qualifications to the surveyor. DM could not show or verify her certifications and qualifications and stated she tried to pull the certification up on her phone but the internet was bad. During interview on 4/23/25 at 2:18 p.m., human resources (HR)-C stated his role consisted of interviewing new staff, conducting background checks, and verifying licenses. HR-C stated personnel files were kept in his office and he tries to digitize them. HR-C further stated he had worked at the facility about a month and stated there were problems with employee files being incomplete and stated DM's personnel file was incomplete and stated DM had certifications and licenses but HR-C did not have them and expected DM's file be in the HR department. HR-C further stated did not know what DM's certifications were, and stated DM was a director or manager for a previous facility. HR-C verified there was nothing in smart links and verified DM did not have an employee file. During interview on 4/23/25 at 3:57 p.m., DM stated she had a food safety certificate, but did not have a certified dietary manager certificate. DM stated she was not a certified food service manager, but stated it is part of her course. DM stated she had a food safety certification from another nursing facility she worked at for [AGE] years. DM further stated she did not have an associate's degree or higher, was a manager at a facility for [AGE] years and stated she consulted with the dietician every day. DM did not provide any evidence of her certifications and qualifications. (continued on next page)

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During interview on 4/23/25 at 4:03 p.m., the administrator stated a CDM was a certified dietary manager and added they had a certified dietician that superceded the CDM and verified their dietician was not full time. The administrator stated she knew the DM was a CDM and stated their dietician was a consultant. DM's personnel file was requested and the administrator stated HR-C noticed a lot of employees were without personnel files. A policy was requested for the dietician and dietary manager qualifications and verification of the dietician's qualifications or certifications. An unsigned and dated job description, Certified Dietary Director, indicated the purpose of the position was to plan, organize, develop and direct the operations of the food and nutrition services department in accordance with current federal, state and local standards. the job description further identified requirements for the position included: preferred, as a minimum, a bachelor's degree in nutrition, dietary management or related field from an accredited college or university, must be a certified dietary manager or comparable certification in the state. The facility provided the dietary manager's (DM) resume on 4/24/25, at 11:04 a.m., that indicated DM was a kitchen manager from February 2019, to October 2023, at a senior living, and identified the following responsibilities: cooked, ordered food, cleaned the kitchen, and completed staff training and prep. Under a heading, Certifications and Licenses, indicated DM had ServSafe from June 2012 to present, was a Certified Dietary Manager from February 2018 to February 2028, had Food Handler Certification from September 2019 to present. Evidence of DM's qualifications including certifications was requested, on 4/24/25 at 12:59 p.m., however no additional information was provided.

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48065 Based on observation, interview, and document review, the facility failed to ensure identified preferences for menu selection were honored for 1 of 1 resident (R16) reviewed for choices. Findings include: R16's 5-day Minimum Data Set (MDS assessment dated [DATE], indicated R16 had intact cognition with no behaviors and diagnoses included end stage renal disease, dependence on renal dialysis, diabetes, paroxysmal atrial fibrillation, and essential hypertension. R16 was independent with eating, required substantial assistance from staff for toileting, lower body dressing and transfers, and required moderate assistance for bed mobility. R16's Order Summary Report printed 4/23/25, indicated an order for renal diet, regular texture and thin liquids. Progress note dated 3/18/25, authored by registered dietician (RD) indicated resident states that he has no questions or concerns regarding nutrition with the exception that he would like larger portion sizes . Dietician provided education regarding weights and encouraged him to continue with regular portions, but resident was adamant that he wanted larger portions, Dietician notified manager of a preference for larger portions. Progress note dated 4/17/25, authored by RD indicated RD spoke with dialysis RD who spoke with this resident [R16] regarding his diet and nutritional concerns. Resident and dialysis RD discussed switching to a regular diet, and both agreed this is acceptable. Dialysis RD states all labs look good with the exception of phosphorus, but that is d/t [due to] resident running out of Tums per his statement. Resident is able to return back to a renal diet at his request. DON and NP notified of resident diet order change to a regular diet. During an interview on 4/21/25 at 3:44 p.m., R16 stated he got white rice twice a day and he had requested multiple times to stop giving him rice with every meal. R16 stated I don't eat the rice. R16 added he was not supposed to have bananas or milk which he received three times day. R16 stated he had never talked to the facility's RD. During observation and interview on 4/22/25 at 12:53 p.m., R16 was eating lunch, and his tray had a piece of ham, white rice, steam vegetables, a piece of cake, and apple juice. R16's meal card indicated renal diet, assorted juices (cran, apple or grape juice), regular protein-smaller portions, no potato, steamed rice, seasonal vegetables, strawberries and decaf coffee with creamer. R16 stated he was supposed to get strawberries but instead they gave a piece of cake rich in sugar. R16 added last night they gave me white rice, and milk. (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 4/22/25 at 1:44 p.m., licensed practical nurse (LPN)-C stated for two days R16 received mashed potatoes and today he got rice. LPN-C stated for weeks R16 had complained about receiving rice white, he never eats the rice. LPN-C stated R16 told her for months he had complained and talked to the dietary staff about the rice and his diet. LPN-C stated during a RD's visit to the facility, she informed RD about R16's request to visit with him. LPN-C stated later that day, R16 told her RD never talked to him. LPN-C suggested to R16 to talk to the dialysis dietician to discuss his concerns. During interview on 4/23/25 at 1:01 p.m., RD stated the dietary manager stated the last dietary manager had a paper version of residents' food likes and dislikes, but he wasn't sure what the current dietary manager used. RD stated he met the resident in February 2025, and he didn't recall talking to R16 about his dislike for rice. RD stated on 4/17/25, the dialysis dietician contacted him and agreed to change R16's diet to a regular diet. During interview on 4/23/25 at 2:20 p.m., dietary manager (DM) stated she looked at all the trays returned to the kitchen and if residents didn't eat their meals, she talked to the residents to find out if they were not hungry, maybe they were sick, or didn't like the food. DM stated the resident's likes and dislikes were added to the residents' meal cards. DM stated she didn't recall talking to R16 or hearing bout his dislike of rice. R16's meal card dated 4/22/25, still indicated Renal diet and white rice. DM stated today she received an order, and she updated R16's meal card indicating a regular diet, double portions and no rice. During interview on 4/24/25 at 2:59 p.m., director of nursing (DON) stated we need to offer choices. DON stated she talked to the floor staff and dietary department to offer him (R16) choices. Not following R16's choices is a dignity and respect issue. We need to change his diet, document risk and benefits and educate the resident about his food choices. Facility Resident Food Preferences policy dated 12/9/21, indicated individual food preferences will be assessed upon admission and communicated to the interdisciplinary team. The policy also indicated, if the resident refuses or is unhappy with his diet, the staff will create a care plan that the resident is satisfied with.

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F 0807 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides drinks consistent with resident needs and preferences and sufficient to maintain resident hydration. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42073 Based on observation, interview, and document review the facility failed to provide water, consistent with the resident needs and preferences, and sufficient to maintain hydration for 1 of 1 resident (R31) reviewed for hydration. In addition, 2 of 2 resident (R18 and R33) voiced concern of not receiving clean water mugs. Findings include: R31's face sheet received on 4/24/25, included diagnoses of left below the knee amputation, diabetes, and protein calorie malnutrition. R31's quarterly Minimum Data Set (MDS) assessment dated [DATE], indicated R31 was cognitively intact, had clear speech, could understand and be understood. R31 was independent in her ability to transfer from bed to wheelchair and to self-propel her wheelchair. R31's physician order dated 1/7/25, indicated consistent carbohydrate diet regular texture, thin liquids consistency. R31's care plan dated 4/26/23, indicated the facility would encourage good nutrition and hydration in order to promote healthier skin. R31's care plan with revised date of 1/7/25, indicated R31's preferences would be considered when providing care. During an interview and observation on 4/22/25 at 8:47 a.m., no water mug or cup was visible in R31's room. R31 stated staff did not provide fresh water, that she had to get it herself. R31 stated she knew she should drink water throughout the day. Further, R31 stated they no longer had access to ice for their water, stating the facility just removed the ice machines. During an observation on 4/23/25 at 12:45 p.m., there was no water mug/cup visible in R31's room. Observations and interviews in the same hallway included: --R18: quarterly MDS assessment dated [DATE], indicated intact cognition, clear speech, could understand and be understood. Was independent with mobility via wheelchair. R18 stated he replenished his water mug with water from his bathroom sink; no one brought him fresh water. In addition, R18 stated he never received a clean water mug; he reused the same one. --R33: quarterly MDS assessment dated [DATE], indicated intact cognition, clear speech, could understand and be understood. R33 was independent with ambulation. R33 stated no one brought him fresh water - he refilled his cup himself. In addition, R33 stated he never received a clean water mug; he reused the same one. During observations on 4/21/25 through 4/23/25, while on second floor, did not observe staff pass water to resident rooms. (continued on next page)

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F 0807 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/23/25 at 1:11 p.m., dietary manager (DM)-J stated kitchen staff had nothing to do with water pass for residents, other than supplying the mugs. DM-J was not aware of a process to ensure residents received received a clean water mug and fresh water daily. During an interview on 4/23/25 at 1:14 p.m., licensed practical nurse (LPN)-C stated she had never seen nursing assistants (NA's) formally pass water to residents; had only seen staff refill a residents cup if requested. LPN-C stated there used to pitchers of ice water near the nurses station for nurses to use to fill water for residents, but it was removed this week - she did not know why. LPN-C stated she did not know how residents were supposed to get fresh water now. During an interview on 4/23/25 at 3:10 p.m., (NA)-A stated most of the residents on this floor (2nd floor) were independent and could get their own water; that staff did not go around with a cart and provide fresh water. NA-A stated there used to be a pitcher of water for residents to access but now that was gone. NA-A stated she did not know how residents were supposed to get fresh water now. During an interview on 4/24/25 at 10:46 a.m., assistant director of nursing (ADON), who's office was on the second floor, stated NA's were supposed to pass water on the day and evening shifts, was aware it was not happening consistently, but did not know why. During an interview on 4/24/25 at 12:50 p.m., the director of nursing stated she expected staff to pass water daily and provide residents with a clean mug daily. Facility Bedside Water Containers policy dated 4/23/25, indicated the facility would provide residents with fresh drinking water at their bedside daily. The night shift would be responsible for collecting used water containers and replacing clean water containers, filled with fresh water and ice on a daily basis.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 46885 Based on observation, interview, and document review, the facility failed to ensure kitchen food items were labeled and dated, scoops were not stored in the dry bins, opened foods were properly wrapped or stored, outside food containers were cleaned. In addition the facility failed to ensure resident meals brought from outside were labeled and dated in the 1 of 1 kitchenettes. This had the potential to affect all residents who consumed food from the kitchen. Findings include: See also F925 related to pest control. During the tour of the kitchen on 4/21/25 from 2:01 p.m., to 2:15 p.m., with the dietary manager (DM), observed the following: The kitchen refrigerator: A sponge cake that was opened, unlabeled and undated and the DM asked to have it labeled. A container of dried milk dated 1/11, DM verified was dated 1/11 and stated dried milk was good for a week and it wasn't kept because it could grow yeast inside the bag. The kitchen freezer: 1 box containing gluten free pasta shells was stored on the floor and packages of vegetables were located on top of the box and DM stated the box should not be stored on the floor. At 2:12 p.m., DM picked up the box and placed it on the shelf. 3 packages of waffles with 10 in each package were undated and without a label. 1 of the bags was opened. 1 opened bag of egg omelets that was undated and unlabeled. 1 more package of waffles was stored on another shelf and the DM stated they were bad and instructed staff to throw them out the previous week and stated they would go in the garbage. 1 bag of opened chicken sitting in a box. The DM stated the chicken bag should have been closed. 1 bag of chicken strips that were unlabeled and undated. Dry Storage: One 3.79 liter jug of molasses opened 10/9/23, had a brown substance on the outside of the jug. DM stated it was molasses and staff just didn't wipe it down and stated it should have been discarded. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	One 138 ounce jar of salsa that the DM stated contained dried salsa on the outside of the jar. DM verified the lid was not secured tightly. Five 16 ounce opened bags of Tostitos tortilla chips not tied closed. The DM stated the chips should be wrapped in plastic and took the bags off the shelf. A dry bin marked, Sugar contained two scoops in the bin. DM stated scoops should not be stored in the sugar. Additionally, the top of the lids of the sugar and flour contained flour and sugar on each and DM instructed kitchen staff to wipe down the lids and stated it was important to wipe down because of germs and food debris. During interview and observation on 4/21/25 at 2:37 p.m., the coffee machine contained debris on the under side of the machine. The DM stated it looked like coffee debris and stated it was dried up coffee and stated there was some white chunks she could not identify what it was and stated it looked like buildup from not being cleaned every day. During interview and observation on 4/21/25 at 2:44 p.m., the DM looked in the kitchenette refrigerator on the first floor that contained a salad in a Wendy's bag that was unlabeled and undated and the DM removed the item from the refrigerator. During interview on 4/22/25 at 12:16 p.m., the DM stated she would be concerned with opened food items because they have pests in the kitchen and food was supposed to be closed right away. During interview on 4/22/25 at 2:14 p.m., the administrator stated it was a known fact that improperly stored food would attract something. Additionally, the administrator stated when food is delivered, it is placed on the floor in the cooler and the team puts the food away. Facility Foods Brought by Family/Visitors, dated 12/20/21, indicated food brought by family/visitors that is left with the resident to consume later will be labeled and stored in a manner that it is clearly distinguishable from facility prepared food. Perishable foods must be stored in re-sealable containers with tightly fitting lids in a refrigerator. Containers will be labeled with the resident's name, the item and the use by date. Facility Food Storage, dated 7/13/23, indicated food would be stored in an area that is clean, dry and free from contaminants. Plastic containers with tight-fitting covers must be used for storing cereals, cereal products, flour, sugar, dried vegetables, and broken lots of bulk foods. All containers must be legible and accurately labeled and dated. Scoops are not to be stored in food or ice containers, but are kept covered in a protected area near the containers. Leftover food will be stored in covered containers or wrapped carefully and securely. Each item will be clearly labeled and dated before being refrigerated. Leftover food is used within 7 days or discarded as per the 2013 Federal Food Code. All foods should be covered, labeled and dated. All foods will be checked to assure that foods including leftovers will be consumed by their safe use by dates, or frozen where applicable, or discarded. All foods will be stored off the floor.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48065 Based on observation, interview and document review, the facility failed to ensure enhanced barrier precautions (EBP) were followed for 1 of 1 resident (R22) reviewed for EBP. In addition, facility failed to ensure proper use of gloves while providing personal cares for 1 of 1 resident (22) observed for personal cares. Findings include: EBP R22's quarterly Minimum Data Set (MDS) assessment dated [DATE], indicated R22 was severely cognitively impaired, had no behaviors and did not refuse personal cares. R22's MDS indicated diagnoses of cerebral infarction, quadriplegia, essential hypertension, and seizure disorders. R22's Clinical Profile printed 4/23/25, indicated R22 was on enhanced barrier precautions (EBP). R22's Clinical Orders report printed 4/23/25, indicated orders for care of gastrostomy tube and wound care orders for his buttocks and left great toe. R22's care plan printed 4/23/25, indicated R22 had a risk for infection related to gastrostomy tube placement and directed staff to initiate appropriate isolation precautions. During observation on 4/21/25 at 4:10 p.m., an EBP sign was taped to R22's room door directing staff to wash their hand before entering the room, and to wear gloves and gown to provide personal cares. Also, a bin was located next to the door, containing personal protection equipment (PPE). During observation on 4/22/25 at 12:38 p.m., nursing assistants (NA)-E and NA-F were giving a sponge bath and providing pericare for R22 without using gowns. During interview on 4/22/25 at 12:45 p.m., NA-E stated she had worked at facility for 8 years and today she was oriented NA-F to the facility. NA-E stated she knew R22 was on EBP, but she forgot to put on a gown because the nurse was rushing her to complete cares for other residents. NA-E stated R22 was on precautions because he had an infection on his foot and had a tube feeding. NA-E stated the staff needed to wear gowns to prevent contamination. Glove Change During observation on 4/23/25 at 9:18 a.m., NA-H and NA-G put on PPE prior entering R22's room. NA-H provided most of the personal cares and NA-G primarily assisted with turning and repositioning R22. NA-G changed her gloves after each discrete area of the body as listed was washed; R22's face, upper body, genital area, buttocks and before dressing for a total of 5 glove changes. NA-H changed his gloves once while personal cares were given to R22. NA-H and NA-G did not wash their hands after removing each pair of dirty gloves and before putting on new gloves. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 4/23/25 at 9:48 a.m., NA-H stated he needed to wash his hands before putting on clean gloves and added I forgot. During interview on 4/23/25 at 9:51 a.m., NA-G stated, I forgot I needed to wash my hands after removing my dirty gloves and put on clean gloves. NA-G she needed to wash her hands for infection control issues. During interview on 4/23/25 at 2 p.m., licensed practical nurse (LPN)-C stated nursing assistants needed to wear proper PPE before providing cares for any resident on EBP. LPN-C stated we (nursing staff) need to wash their hands after removing dirty gloves and before putting on clean gloves to prevent infections. There are signs of the door, directing staff to wear PPE. Failure to follow precautions represented a risk to transmit infections. During interview on 4/23/25 at 3:02 p.m., director of nursing (DON) stated there were signs on the doors and carts by the resident's doors directing staff to wear PPE to prevent spread of infections. DON stated she expected nursing staff to follow infection control measures. Facility Enhanced Barrier Precautions policy dated 10/8/22, indicated EBP were utilized to prevent the spread of multi drug-resistant organisms (MDRO) to residents. The Policy also indicated EBP were indicated for residents with wounds and/or indwelling medical device regardless of MDRO colonization. Facility Using Gloves Personal Protective Equipment policy dated 4/24/25, indicated the objectives to use gloves were to prevent spread of infections, prevent wounds from contamination, to protect hands from potentially infectious material . The policy directed staff to wash their hands after removing gloves.

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	245028	A. Building B. Wing	04/24/2025

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42073 Based on observation, interview and document review, the facility failed to ensure resident call lights were functioning for 1 of 1 resident (R31) reviewed for call lights. Findings include: R31's facesheet received on 4/24/25, included diagnosis of left below the knee amputation. R31's quarterly Minimum Data Set (MDS) assessment dated [DATE], indicated R31 was cognitively intact, had clear speech, could understand and be understood. R31 was frequently incontinent of bowel and bladder, used briefs for toileting and was dependent upon staff for toileting hygiene. R31's care plan with revised date of 3/27/25, indicated R31 was incontinent of bladder and bowel related to immobility and would remain free from skin breakdown due to incontinence and brief use. Care plan dated 10/29/24, indicated R31 was a total assist/one-person physical assist. During an interview on 4/21/25 at 4:53 p.m., R33 who resided in the same hallway as R31, stated that on 4/20/25, at about 7:00 p.m., R31 was hollering for help because she needed to be changed, and her call light did not work. R33 stated after 30 minutes, he walked to the dining room to inform staff. R33 stated that was not the first time R31 had hollered out for help. During an interview and observation on 4/22/25 at 8:34 a.m., R31 stated her call light did not work. Both R31 and surveyor attempted to activate the call light by pressing the red button on the end of the white call cord. The small red light on the call station located on the wall at the head of the bed did not illuminate to indicate the call light had been activated, nor did her room number appear on the electronic scrolling sign in the hallway. R31 could not recall when she first noticed her call light not working, but had been given a tap bell to use. A metal tap bell was observed on her overbed table. R31 stated staff did not always hear the bell and stated she had to call out for help sometimes. During an interview and observation on 4/22/25 at 3:24 p.m., together with the administrator, entered R31's room and attempted to activate the call light by pressing the red button on the end of the white call card. The small red light did not illuminate on the call station located on the wall at the head of the bed, nor did R31's room number appear on the electronic scrolling sign in the hallway. Using her cell phone, the administrator immediately informed maintenance. The administrator did not know why this had not been addressed sooner and expected call lights to be functioning at all times. Facility Call System, Resident policy dated 3/6/25, indicated each resident was provided a means to call staff directly for assistance; the call system would remain functional at all times. The call system would be routinely maintained and tested by the maintenance department. Calls for assistance would be answered as soon as possible, but no later than 5 minutes. Urgent requests for assistance would be addressed immediately.

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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** 46885 Based on interview, observation, and document review, the facility failed to implement interventions to maintain an effective pest control program to eliminate mice in the facility. This had the potential to affect 47 of 47 residents who resided at the facility. Findings include: See also F812 related to food storage. A Paffy's pest control inspection report dated 4/22/25 at 2:45 p.m., indicated the facility staff reported seeing mice activity with droppings in the kitchen, but no rodents were found. Additionally, the facility provided the following inspection reports: 1/9/25, a comment indicated nothing was entered on the pest log. 1/23/25, a comment indicated nothing had been entered on the pest log, however the kitchen had seen activity and exterior bait stations had varying degrees of activity. 2/7/25, a comment indicated the logbook was checked and nothing was added to the logbook, minor activity was found in the kitchen. 2/20/25, a comment indicated nothing was added to the logbook and minor activity was found in the kitchen. 3/6/25, a comment indicated nothing new was entered to the logbook, however kitchen staff reported seeing a mouse run into a wall void and light activity was found upon an exterior inspection. 3/20/25, a comment indicated nothing was entered to the logbook and no activity was found in the facility. 4/3/25, a comment indicated in unit 210 activity was not found other than old green mouse droppings. The kitchen was inspected, and kitchen staff reported seeing a mouse run under the steam table 2 days prior and RTU was moved near the back door since they opened that door a lot. 4/17/25, a comment indicated no issues were reported and moderate activity was identified on an exterior inspection on the east side and light activity was identified on a bait station across from staff's office. A report log provided by the facility, Pest Sighting Report Facility Deficiency Report indicated mice sightings in various locations in the facility on 3/12/24, 3/21/24, 4/19/24, 4/24/24, 5/3/24, 5/9/24, 5/15/24, 6/3/24, 6/11/24, 6/13/24, 6/17/24, 6/16/24, 6/20/24, 6/22/24, 6/23/24, 6/24/25, 7/23/24, 7/29/24, 8/5/24, 8/11/24, 8/13/24, 8/14/24, 8/19/24, 8/20/24, 9/3/24, 9/9/24, 9/10/24, 9/17/24, 9/22/24, 9/23/24, 9/25/24, 10/24/24, and on 10/30/24. No other mouse sightings were logged after 10/30/24. (continued on next page)

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During interview and observation 4/21/25 between 2:16 p.m., and 2:31 p.m., a Plunkett's pest trap was in the kitchen on the floor. At 2:17 p.m., on the way to the dumpster located through the door that went to the outside from the kitchen, the dietary manager (DM) was going to prop the door open and stated they propped the door open to bring the trash outside and leave the door open to come back inside. The dumpster was uncovered, and the DM stated they kept the dumpster covers opened because the nurses also disposed of trash. The dumpster contained bags in the bottom of the bin and briefs were visible in the bags. At 2:21 p.m., a Plunkett's pest trap was in the dry storage room and next to the trap were several black particles. The DM stated, it looks like mouse turds and further stated it would be mopped that evening. The DM further stated there were three traps in the dry storage area. DM stated she had been at the facility 5 months and had not seen mice in the kitchen. At 2:25 p.m., a 3.79-liter jug of molasses was located on the shelf in the kitchen and the DM verified there was molasses around the outside of the container and stated staff didn't wipe it down. At 2:26 p.m., a 138-ounce jar of salsa was in the dry storage that the DM verified had dried salsa on the outside of the jar and the lid had not been securely closed. At 2:28 p.m., five 16-ounce opened and unsecured bags of Tostitos tortilla chips were in the dry storage and DM stated the bags should have been wrapped in plastic and took the bags off the shelf. At 2:31 p.m., the sugar and flour storage bins contained sugar and flour on top of the lids and was verified by the DM who instructed staff to wipe down the lids. At 2:37 p.m., the underside of the coffee machine contained brown flaky material the DM stated was dried coffee along with some white chunks the DM could not identify and stated it was a build up from not being cleaned. During observation on 4/22/25 at 7:52 a.m., the last table on the first floor towards the East hall had a whitish chalky material on the table. During observation on 4/22/25 between 7:53 a.m. and 7:56 a.m., the table on the first floor by the window and closest to the [NAME] Hall and the table across from the table by the window had crumbs on the table and on the floor next to the table. During observation on 4/22/25 at 7:59 a.m., the food cart was going towards the west hall on the first floor. During interview and observation on 4/22/25 at 8:00 a.m., housekeeping (H)-A stated tables were wiped down in the a.m., and in the afternoon before housekeeping left at 2:30 p.m. H-A stated the nursing assistants were supposed to wipe down the tables at night and stated housekeeping did not vacuum at night because housekeeping didn't work at night and observed the tables and floor and stated the crumbs were cookies on the tables and floor and wiped down the tables. During interview on 4/22/25 at 8:04 a.m., nursing assistant (NA)-I stated no residents eat in the dining area on the first floor for breakfast and stated they were just passing meal trays at this time and no residents had eaten in the dining area. During observation on 4/22/25 at 8:23 a.m., meal trays were being passed out on the East hallway. During observation on 4/22/25 at 8:52 a.m., staff took a meal out of room [ROOM NUMBER]E and did not wipe down the table. A plastic lid with a white cream substance was located on the floor in room [ROOM NUMBER]E with the cream substance also on the floor. (continued on next page)

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During interview and observation on 4/22/25 at 12:16 p.m., the DM stated pest control was coming today. The area around the Plunkett's trap in the dry storage area contained little black particles and stated they swept and mopped the floor last night and stated they had a pest problem and verified the particles were mouse droppings and stated food items needed to be closed and secured. The DM further stated the aides were responsible for wiping down the dining room tables and stated propping the door open can be a problem for pests and further stated the cook will open the door if it was smoky in the kitchen or hot. The dumpster outside was uncovered with several garbage bags and the DM verified it was opened and stated she thought it should be closed but stated that was maintenance's responsibility and verified the dumpster contained food items and several garbage bags. During interview on 4/22/25 at 12:59 p.m., maintenance (M)-A stated for mouse prevention they utilized mouse traps, but the mice didn't seem to want food and traveled through the registers. He further stated it would be important for food to be in containers. Mice were more prevalent in the fall and spring and the doors should not be propped open. M-A further stated the dumpster should be closed and were approximately 25 feet from the kitchen door. M-A and M-B denied seeing mice. During interview on 4/22/25 at 1:47 p.m., licensed practical nurse (LPN)-C stated she found a dead baby mouse in a room two weeks ago and was busy and forgot to log it in the pest control book. During interview and observation on 4/22/25 at 2:06 p.m., Paffy's pest control staff (PPC)-N stated there were droppings in the kitchen, but no rodents in the traps. PPC-N stated they used mouse poison and metal traps or bait stations. PPC-N stated the mice eat the poison and they had several traps in the property and about a year prior there had been ground movement which created a huge influx of mice, and the administrator called this week due to droppings. PPC-N stated food, and warmth could attract mice and added propping doors open was the worse thing in the world and kitchens loved to leave the doors open which invited critters and stated mice lived in a 10-foot radius if they had warmth, food, and water. The door to the outside on the second floor where residents went to smoke contained a gap on the bottom and the door opened automatically to a small room with another door that went to the outside of the building. Both doors opened and closed automatically, the door to the outside did not have a gap. During interview on 4/22/25 at 2:14 p.m., the administrator stated the kitchen got hot and has directed staff to shut the door and further stated the dumpster had been uncovered since she had been at the facility and added 99% of their staff were short making it difficult to shut. The administrator stated housekeepers left at 2:30 p.m., and added that was probably why food was on the tables and floors in the a.m. and the aides were supposed to clean the tables after dinner. The administrator stated Paffy's used to come twice a week and then went down to once a week and a few months ago went down to every other week because there was no activity and no complaints from staff or residents and stated the mice that are here were only coming out at night and added it was a known fact that anywhere food was not stored properly would attract something and stated the kitchen door should always be shut and if the door was propped open should be fast. The administrator further stated if residents kept food in the room they talked to residents and asked families to bring in sealable containers to keep goodies to avoid mice from going into rooms and stated anyone going into the rooms could monitor this. If no family, the facility would purchase them for the resident. The administrator stated she was not aware of mice sightings and stated Paffy's started coming to the facility every other week in January. (continued on next page)

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During further interview on 4/22/25 on 2:15 p.m., the administrator stated if there was of an uptick in sightings of mice, the pest control agency was contacted immediately to come to the facility. A logbook was established for staff and residents to report sighting and were instructed to report each time a mouse was sighted to ensure appropriate follow up. (The last entry in this logbook was 10/30/24. The administrator was informed of a dead mouse sighting by a nurse two weeks ago and stated, That's the first I'm hearing this. During an interview and observation on 4/22/25 at 3:24 p.m., together with the administrator, toured the facility for upkeep/maintenance. In R31's room, observed multiple candies and snacks on R31's overbed table and a loaf of bread on the dresser. These items were not in covered containers. Observed many items on the floor around the perimeter of the room and in the closet. Across the hall in R27's room, concern was expressed for the amount of clutter on the floor and bed which could potentially attract and conceal mice. The administrator stated she was well aware of R27's room and stated staff went through the mounds of clothing and items on the floor to ensure there were no mice. During an observation on 4/23/25 at 8:44 a.m. and again at 3:00 p.m., R31's snacks and bread were still not in covered containers. During an interview on 4/23/25 at 10:05 a.m., at resident council meeting, R16 stated LPN-C had been doing morning medication rounds in his room and said, Oh my gosh, there is dead mouse on the floor. R16 said that was about two weeks ago. During observation and interview on 4/23/25 at 2:37 p.m., the door to the outside from the kitchen was propped open with a plastic pink wet floor sign. At 2:40 p.m., the door remained propped open approximately seven inches. At 2:43 p.m., the door remained propped open. At 2:46 p.m., the door was still opened. At 2:48 p.m., the door remained open. At 2:49 p.m., a staff person opened the door and stepped over the pink wet floor caution sign and went out the door which was still propped open. The DM verified the door was propped open and stated they needed water and were going back and forth so she monitored the door to make sure nobody came in. At 2:50 p.m., the door remained propped open. 42073 During an interview on 4/24/25 at 1:44 p.m., the director of nursing (DON) was informed of the dead mouse finding and stated the facility had not had a mouse sighting in over 90 days or longer but would put a plan in place. Facility Pest Control policy dated 9/6/23, indicated on-going measures are taken to prevent, contain and eradicate common household pests such as roaches, ants, mosquitoes, flies, mice and rats. General measures to decrease pests include elimination of cracks and crevices, proper lighting and ventilation, use of screen on windows and doors, and the use of self-closing doors. All food stored in the dietary area is kept in a designated area in securely covered containers, is off the floor and away from walls. All food items kept in resident rooms are stored in covered containers, with the exception of uncut fruits such as bananas and oranges, a contract with a pest control company will be elected to assure regular inspection and application of chemical pesticides. Staff will report all sightings of pest to the maintenance and or environmental services director for pest control intervention.