STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245055	A. Building B. Wing	08/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lakehouse Healthcare & Rehabilitation Center	3737 Bryant Avenue South Minneapolis, MN 55409

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to ensure all staff knocked on individual resident bedroom doors, introduced themselves, and waited for permission to enter room prior to entry for 9 of 9 residents (R69, R77, R106, R119, R146, R167, R178, R196, R252) reviewed for dignity.Findings include: R69's quarter Minimum Data Set (MDS) dated [DATE], identified R69 with intact cognition.R146's quarterly MDS dated [DATE], identified R146 with intact cognition.R252's quarterly MDS dated [DATE], identified R252 with impaired cognition.During observation on 8/11/25 at 1:15 p.m., staff entered R252's room after one knock and did not introduce self or wait for a response or permission to enter. Once the staff entered the room, she looked at surveyor and turned around and left the room without a word. R252 stated, they do that a lot. Don't wait to let me answer or tell me who they are and what they want. I don't like that at all. I think it is rude.During interview with R146 on 8/12/25 at 9:01 a.m., R146 stated, I want people to knock and say who they are before barging into my room. Some of the staff just walk in and I don't like it. I expect them to respect my privacy and ask permission to enter my room.During observation on 8/13/25 at 8:15 a.m., two staff members entered shared resident room of R106 and R178 without knocking and announcing who they were.During interview with licensed practical nurse (LPN)-A on 8/13/25 at 8:21 a.m., LPN-A stated expectation of staff to knock, introduce themselves, and wait for permission to enter the resident room, for privacy [sic] dignity it is their home, and you do not just enter.During interview with registered nurse (RN)-A on 8/13/25 at 8:35 a.m., RN-A stated expectation of staff to knock and wait for response before entering a resident room. If I don't knock before entering it is rude because of dignity and privacy. I would not be happy if someone just walked into my house without knocking or introducing themselves. This is their home, and we need to remember to treat it as such.During observation and interview with nursing assistant (NA)-A on 8/13/25 at 9:01 a.m., NA-A entered R196 room after knocking but did not announce self or wait for response before entering the room. NA-A stated, I should have waited for [R196] to respond before I entered the room.During observation and interview with licensed practical nurse (LPN)-B on 8/13/25 at 9:29 a.m., LPN-B knocked on door of shared room for R167 and R119 but did not wait for a response before entering the room. At 9:36 a.m., LPN-B exited the room and stated, I did not wait for a response before entering. It [sic] important to wait for response due to privacy.During interview with director of nursing (DON) on 8/13/25 at 1:55 p.m., DON stated expectation of staff to knock on the resident door and wait for a response and permission to enter the resident room. They [staff] should be waiting for an invite or at least knock wait and then introduce self before walking in.During interview with NA-C on 8/14/25 at 8:23 a.m., NA-C stated expectation of all staff to introduce themselves after knocking on resident's door and wait for them to give permission to enter their room.During interview with NA-D on 8/14/25 at 8:37 a.m., NA-D stated expectation of all staff to introduce themselves and tell them [resident] what I am there for.During observation and interview on 8/14/25 at 8:46 a.m., NA-E entered shared room for R69 and R77 without knocking or introducing self and waiting for permission to enter. NA-E stated, I did not do that. It is important. During interview with R69 at 8:51 a.m., R69 stated staff do not always knock and introduce themselves waiting for me to give permission to enter. I had an incident with an aide that walked in on me with my pants down while I was taking care of my catheter. I asked her to not do that anymore. I am adjusting to my loss of independence since my admission here. I don't like anyone coming into my room while I am naked. It is a respect thing.During observation and interview on 8/14/25 at 9:07 a.m., NA-F entered resident room without knocking and waiting for permission to enter. NA-F stated, I did not introduce myself. We are to knock and wait for answer before entering room. For privacy.Facility policy titled Resident Rights, dated July 2025, state, The resident has a right to personal privacy and confidentiality of his or her personal and medical records. A. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care.

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. During observation and interview, the facility failed to implement interventions to ensure residents' personal care information was kept secured and out of public view when stored on 3 of 7 facility units with mobile medication/treatment carts. This had the potential to affect 9 residents on the 2nd floor, 8 residents on the 5th floor, and 11 residents on the 7th floor whose personal information was listed on unattended care sheets. Findings include:During observation and interview starting on 8/13/25 at 8:21 a.m., licensed practical nurse (LPN)-A left an unattended resident care sheet including thirteen resident names, room numbers, information on how they take their medications, bath information, and diagnoses and information on pressure ulcer status, assistance required for transfers and applying ordered adaptive equipment and infection control precautions. The form titled 7G ODD Nurse Census Sheet was left unattended on medication cart while two residents in wheelchairs were pushed past the cart by other staff members. LPN-A returned to cart and stated, [I] left the paper unattended on the med cart. I should flip it over so info [cannot be seen].During interview with registered nurse (RN)-A on 8/13/25 at 8:35 a.m., RN-A stated expectation of staff to protect [resident] information. Because of HIPAA.During interview with LPN-B on 8/13/25 at 9:36 a.m., LPN-B stated expectation of staff, to cover care sheets for privacy. HIPAA.During observation and interview on 8/13/25 at 1:04 p.m., a medication cart was unattended with a resident care sheet titled EVEN SIDE TCU that included nine resident names, including room numbers, diagnoses, personal care preferences, bath and shower days. The Director of Environmental Services (D)-ES and surveyor walked by the unattended care sheet and stopped at the medication cart. D-ES pointed to it and said, [that] should not be available because it is a HIPAA violation and patient privacy. Registered nurse (RN)-C walked past the cart and stated, It should not be left unattended. RN-D approached and stated she left the unattended care sheet prior to leaving the medication cart and entering a resident room. RN-D stated, I left it accidentally and [it] should not be left out here (pointing to the hallway where another staff member and resident were walking past). RN-D stated, [I] should know better.During interview with director of nursing (DON) on 8/13/25 at 1:55 p.m., DON stated expectation of staff to secure care sheets with resident information upside down and not seen. DON stated rationale was Patient privacy.During interview with NA-C on 8/14/25 at 8:23 a.m., NA-C stated, we [nursing assistants] are told to use the computer instead of paper. Concern for patient information [being] displayed. HIPAA.During interview with NA-D on 8/14/25 at 8:37 a.m., NA-D stated care sheets should be private and HIPPA private information not to be visible and not anyone else's business.During observation and interview on 8/14/25 starting at 8:58 a.m., an unattended medication cart was observed with a resident care sheet on top titled 5G ODD Nurse Census Sheet that included eight resident names including room numbers, how they take their medications, bath and shower day details, infection control precautions, and behavior monitoring precautions. Two staff members walked past the cart along with one resident in a wheelchair. RN-E approached unattended medication cart and care sheet and stated, I should not have left it unattended. Important for patient [sic] information is confidential.Facility policy titled Resident Rights, dated July 2025 identified The resident has a right to personal privacy and confidentiality of his or her personal and medical records.

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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** Based on interview and document review, the facility failed to ensure the Minimum Data Set (MDS) was accurately coded with the potential for inaccurate federal reimbursement and resident care planning for 1 of 5 residents (R218) reviewed for MDS accuracy.Findings include:R218's quarterly MDS dated [DATE] indicated R218 had memory problems and required assistance with personal cares. The MDS indicated under section N0350-A: Insulin injections. R218 received 7 insulin injections during the look-back period (LBP). R218's orders were reviewed and did not indicate orders for insulin, before or after LBP. R218 was diabetic and received two oral agents to treat her diabetes. R218's April and May's medication administration record indicated, R218 did not received insulin during LBP. During interview on 8/13/25 at 2:35 p.m., MDS coordinator verified R218 did not received insulin during LBP. MDS coordinator indicated probably the mistake was done when one of R218's oral diabetic medications was coded as insulin. MDS coordinator indicated she would complete a correction right away, because incorrect coding could affect the federal reimbursement. Facility's administrator indicated, the facility didn't have a MDS policy but followed the RAI manual.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to ensure a level I Pre-admission Screening (PAS) and, if needed, a Level II Pre-admission Screening and Resident Review (PASARR) was completed to screen for mental health needs for 3 of 4 residents (R40, R9, R6) reviewed for PAS. Findings include: R40’s quarterly Minimum Data Set (MDS) dated [DATE], indicated R40 was admitted to the facility on [DATE] and had intact cognition. The MDS indicated R40 was diagnosed with schizophrenia, post-traumatic stress disorder, and a “psychotic disorder”. R40's PAS notice dated 1/21/25, indicated a copy of the PAS was included with this notice, but the PAS was not final until the lead agency sent a final determination to the nursing home. R40's entire medical record was reviewed and lacked evidence that a final determination had been received. During an interview with the director of admissions (DOA) on 8/13/25 at 9:26 a.m., the final PAS was requested, and the DOA confirmed she would review R40’s medical record and provide the final PAS if able. On 8/14/25 at 10:46 a.m., the DOA stated she oversaw ensuring they had a PAS number for every resident and would sometimes reach out to the entity in charge of completing the final PAS for each resident but was unsure if she had prior to the start of the survey for R40. The DOA confirmed she had not been able to find the final PAS in R40's medical record, so she had contacted the lead agency yesterday. The DOA stated she did not keep documentation of any attempts to obtain the final PAS, so she would be unable to provide any. The DOA stated the director of social services (DOSS) assisted with ensuring the final PAS was received, and he may be able to give further information. During an interview on 8/14/25 at 10:49 a.m., the DOSS stated that admissions oversaw ensuring the final PAS was received, and his department did not assist with this. During an interview on 8/14/25 at 12:19 p.m., the administrator stated the director of admissions oversaw ensuring the final PAS was received before admission. R9's quarterly Minimum Data Set (MDS) dated [DATE], indicated R(9) was admitted to the facility on [DATE] and was cognitively intact. R9's Clinical Diagnosis Record dated 8/14/25 indicated, R9 was diagnosed major depressive disorder with severe psychotic symptoms, post-traumatic stress disorder and generalized anxiety disorder. R9's PAS notice dated 11/7/24, indicated a copy of the PAS was included with this notice, but the PAS was not final until the lead agency sent a final determination to the nursing home. R9's entire medical record was reviewed and lacked evidence that a final determination had been received. During interview with the director of admissions (DOA)) on 8/14/25 at 11:54 a.m., DOA stated she was responsible to make sure new residents had a pre-screening done before they were admitted to the facility. DOA stated the social worker was responsible to follow up with Senior Linkage to obtain the final determination. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 8/14/25 at 12:04 p.m., the social worker director (SWD) verified, R9's medical record did not have the final determination documentation. The SWD stated the admission team followed up to obtain the final determination. R6's admission Minimal Data Set (MDS), dated [DATE], identified R6 admitted to the care center on 6/25/25 and had multiple medical conditions including anxiety, major depressive disorder, bipolar, post-traumatic stress disorder, schizophrenia and traumatic brain injury. Review of R6’s electronic medical record (EMR) lacked any evidence a level I Pre-admission Screening (PAS) and, if needed, a Level II Pre-admission Screening and Resident Review (PASARR) was completed on R6 prior to admission to the care center. During an interview on 8/13/25 at 12:15 p.m., the director of admission (DOA) stated the care facility required that the hospital submit a PAS prior to the resident admitting to the care facility. The DOA stated the admission department would be responsible for uploading the PAS, and if needed the PASARR and social services would be responsible for reviewing the documents for any needed additional services. The DOA confirmed a PAS was not completed for R6, stating there was a new admission coordinator being trained in who “missed it” [the PAS]. The facility's Pre-admission Screening policy dated 10/22, indicated the facility would ensure a level I screening would be conducted for all applicants before admission.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to develop a comprehensive care plan to ensure correct application of a lower extremity brace for 1 of 3 residents (R178) reviewed for the use of a lower extremity brace. Findings include: R178's quarterly Minimum Data Set (MDS) dated [DATE], indicated R178 had severely impaired cognition, a functional limitation in the range of motion of both lower extremities, and required staff assistance with all activities of daily living. R178's diagnosis report dated 5/21/25, indicated R178 had a diagnosis of right-sided weakness following a stroke.R178's Medical Record Attestation Statement Delayed Certification Statement dated 7/2/25, indicated the provider instructed staff to continue to apply the right AFO brace as R178 tolerated. The statement included no further instructions for brace use. R178's care plan dated 7/3/25, order report dated 8/8/25, and tasks dated 8/13/25, were reviewed and did not include R178's use of a right lower extremity brace. R178's Therapy to Nursing Communication dated 8/13 (with no year included), indicated R178 should wear a right ankle foot orthosis (AFO) brace for greater than four hours a day when up in the wheelchair, and skin should be checked when taking the brace off and putting it back on. During an interview and observation on 8/13/25 at 9:50 a.m., R178 was observed sitting in his wheelchair in his room with an AFO brace on his right lower extremity. Nursing assistant (NA)-I stated R178 required a total assist from nursing staff, and he had helped R178 get ready this morning. NA-I stated R178 had a brace for his right foot that he wore every day, only when R178 was out of bed. NA-I confirmed he had received education on how to apply the brace but was unable to find where the instructions were that confirmed when the brace was to be applied. During an interview on 8/13/25 at 10:31 a.m., the director of therapy (DOT), a physical therapy assistant, stated R178 was being seen by physical therapy earlier this year but was discharged at the end of May. The DOT confirmed R178 was not being seen right now by therapy. The DOT stated therapy had helped to procure the AFO brace for R178 but would need to look into what the discharge instructions were for the use of the AFO. At 12:42 p.m., the DOT stated she had reviewed R178's medical record and was unable to find the initial order for the use of the right AFO brace. The DOT stated she had found the attestation statement dated 7/2/25 saying staff were to continue using the brace but could not find the original order. The DOT stated she was supposed to ensure that when therapy had new orders for brace use, this was added to the resident's care plan, but after reviewing the medical record, this had not occurred. During an interview on 8/13/25 at 11:44 a.m., licensed practical nurse (LPN)-A confirmed that she had received education from therapy staff on when R178 was to use his AFO brace. LPN-A stated R178 was to have his right AFO brace applied when he was out of bed. LPN-A confirmed she had reviewed R178's medical record and could not find that the instructions for the use of the right AFO brace had been added to R178's plan of care. During an interview on 8/14/25 at 1:39 p.m. with the director of nursing (DON) and the DOT, the DOT confirmed the therapy to nursing communication form referenced above was from 8/13/25 and stated staff should be applying the brace when R178 was up in the wheelchair and removing it when he is back in bed. The facility's Comprehensive Care Planning policy dated 10/22, indicated the resident's comprehensive care plan would describe the offered services the resident needed to attain or maintain their highest practicable wellbeing.

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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** Based on observation, interview and record review, the facility failed to update the plan of care 1 of 1 resident (R154) observed for position and mobility. In addition, the facility failed to revise and update a comprehensive care plan for 1 of 1 resident (R222) who had a history of resident-to-resident incidents. Findings include: R154’s quarterly MDS dated [DATE], identified mild cognitive impairment, used a wheelchair, and had impairments on one side to upper and lower extremities. The MDS lacked identification of an adaptive device such as a brace or ankle-foot orthosis (AFO). R154’s orders from admission through 8/15/25 were reviewed and lacked orders for the use of an adaptive device such as a brace or AFO. R154’s occupational therapy and physical therapy evaluations and treatment plans dated 5/6/23, lacked documentation pertaining to an AFO. R154’s provider visit dated 5/8/23, indicated an initial assessment and plan of care related to a history of stroke, and identified R154’s left side was flaccid and an AFO was in place. R154’s provider visit dated 6/5/23, identified R154 used a left boot for foot drop and required a Hoyer lift for transfers. The documentation lacked recommendations to continue to wear a brace on the LLE. R154’s progress notes dated 10/16/23, indicated ibuprofen was administered for pain in the right lower leg and a brace was removed due to pinching. R154’s care plan initiated on 7/25/24, identified a self-care deficit related to hemiplegia, impaired balance and limited mobility. A goal was set for R154 to maintain a current level of function and identified interventions to use a left leg brace for positioning. The plan also identified intervention for dressing with an assist of one staff to apply a left leg brace every morning and take off at night for positioning and protection. A provider visit dated 7/21/25, listed R154 had a diagnosis of left foot drop from 11/11/24 through present and lacked information related to AFO. R154’s progress notes dated 5/5/23 through 8/13/25, were reviewed and lacked documentation related to a left leg brace/AFO. During an interview on 8/12/25 at 9:41 a.m., registered nurse (RN)-F stated R154 wore the left leg brace for positioning. During an interview on 8/12/25 at 1:49 p.m., R154 stated the brace didn’t fit anymore, and they were not wearing it today. (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 on 8/12/25 at 2:00 p.m., licensed practical nurse (LPN)-E stated R154 was supposed to wear a brace on the left leg, but only when up in the wheelchair. LPN-E stated R154 told staff the brace was bothersome and sometimes they refused to wear it, but R154 had the right to refuse the brace because it was uncomfortable to wear and because it was R154's choice. LPN-E stated therapy assessed the brace a couple of times, and the brace was appropriate for use. During an observation on 8/13/25 at 7:43 a.m., R154 was in bed, and two braces were in the corner of the room on top of a box. R154 stated the brace didn’t fit them anymore, it caused pain, and it hadn’t been worn all week. During an interview on 8/13/25 at 8:12 a.m., nursing assistant (NA)- G stated R154’s Kardex (NA care plan) had not been reviewed but they were aware there was a leg brace on the floor. Sometimes R154 wore it, but most days R154 refused to put it on, and the nurse was notified. During an interview on 8/13/25 at 11:58 a.m., occupational therapist (OT)-J stated R154 had been working with OT since 10/24/25, and was currently working with OT for support and mobility for the motorized wheelchair. OT-J was not aware of a left leg brace. During an interview on 8/13/25 at 12:54 p.m., director of therapy (DOT)-G stated R154’s brace was for foot drop and because R154 was no longer ambulating it was no longer appropriate. DOT-G stated it was likely R154 came to the facility with the brace and stated that type of brace could only be worn a short time, or it could cause skin issues, and it should have been assessed. During an interview on 8/13/25 at 3:27 p.m., family member (FM)-T stated the brace was brought from a previous facility. R154’s progress note entered by the nurse manager dated 8/13/25, identified R154’s admission orders lacked documentation for the diagnosis, purpose, or function of an AFO. Furthermore, the note identified therapy assessed R154 and found the AFO was not clinically or functionally purposeful and therefore, no order was received from a provider. The AFO was determined to be in place per patient preference only and a family member confirmed R154 had the AFO for years and wore the AFO while ambulating prior to admission, however, had been unable to ambulate since admission to the current facility. The provider was updated related to the use and function of the AFO and determined no clinical indication for use, stating no need for AFO. During an interview on 8/14/25 at 12:01 pm., licensed practical nurse (LPN)-E stated R154’s hadn’t worn a brace/AFO for a while and that the order must have been discontinued. LPN-E confirmed there was no active order for a brace/AFO and when she called for a new order the nurse practitioner (NP) told LPN-E the brace was no longer appropriate because R154 wasn’t ambulating and that the brace should be removed from the care plan. R154’s family member was contacted and confirmed R154 brought the brace from a previous facility and wore it only when ambulating. LPN-E confirmed putting the brace on the care plan and that the care plan was incorrect. During an interview on 8/14/25 at 2:57 p.m., director of therapy (DOT) stated the brace for R154 was assessed in May of 2023 for about a month to ensure it wasn’t causing any skin issues. Because R154 was not standing or ambulating the brace wasn’t recommended for use by therapy, it was R154’s preference to wear it. The brace was then assessed for fit and skin issues in May of 2024 as R154 indicated it was causing pain. (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 on 8/14/25 at 3:21 p.m., physical therapist (PT)-K stated a brace or AFO would need a provider order and therapy would assess the fit. Because R154 required a Hoyer lift and not ambulating the brace would not be appropriate. PT-K stated it was most likely that R154 received the AFO from a previous facility when ambulating. PT-K reviewed R154’s therapy records and confirmed records reviewed from May 2023 lacked documentation regarding any assessment of a brace or AFO upon admission but could confirm the AFO was assessed a year later in May of 2024. During an interview on 8/14/25 at 4:36 p.m., the director of nursing (DON) stated R154's brace was brought from a previous facility, and it was R154’s preference to wear the brace/ AFO. DON verified no provider orders were ever written for the use of the brace/AFO because there were no indications for its use since R154 no longer ambulated. The DON stated R154 chose to be in bed most days and preferred not to wear stockings, so the brace/AFO would be more of a risk than benefit because of the rigidity of the brace and the risk of skin breakdown. The DON stated care plans were created with input from the floor nurse and recommendations made by therapy. The recommendations were discussed with the resident and if the resident agreed the interventions were added to the care plan. The DON confirmed that the expectation was that if a care plan could not be followed or interventions were no longer working the nurse should be notified and the care plan updated. R222’s annual Minimum Data Set (MDS) dated [DATE], indicated moderate cognitive impairment and did not have behaviors. R222 had impairment to both lower extremities and required setup or clean-up assistance for eating, substantial/maximal assistance for transfers, and independent with wheelchair mobility. R222’s diagnoses included aphasia, non-Alzheimer’s dementia, and anxiety. R222’s care plan focus area behavior/mood dated 7/7/25, included interventions dated 1/23/25 which directed staff to prevent opportunities for physical aggression, which may include considering proximity to others at meals, during activities, in the hall, and when moving throughout the unit and dated 7/7/25 which directed R222 to sit at the same table and spot daily and other residents may sit across from R222 but not next to her. R222’s progress notes indicated: -1/16/25, resident had increased behaviors and was combative with another resident and was removed from the common area for her safety. -1/20/25, resident was moved to another floor, and resident and family agreed with the move. -Further progress notes did not mention any other resident-to-resident incidents. R222’s Associated Clinic of Psychology (ACP) Progress Note dated 1/17/25, indicated the facility informed ACP R222 struck another resident on the wrist. The progress note indicated R222 did not recall striking another resident, denied interpersonal stressors, fearfulness, and anger, and may benefit from behavioral monitoring. The progress note encouraged staff efforts to prevent opportunities for physical aggression, which may include considering proximity to others at meals, during activities, in the hall, and when moving throughout the unit. R222’s ACP Progress Note dated 7/15/25, indicated R222’s mood and behaviors appeared “largely stable today”. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During observation on 8/11/25 at 11:39 a.m., R222 attended an activity, and residents were on both sides of her within arms’ reach. During observation on 8/11/25 at 12:36 p.m., R222 sat at a square table with three other residents. Residents were within arms’ reach. During interview on 8/13/25 at 1:43 p.m., nursing assistant (NA)-K stated they looked at the electronic care plan to know information about a resident. During observation on 8/14/25 at 8:34 a.m., R222 sat at the end of a table with two other residents within arms’ reach for breakfast. During interview on 8/14/25 at 9 a.m., NA-H verified R222 sat within arms’ reach of other residents and stated R222 had no special interventions in the dining area. R222 stated there were certain people R222 did not like to sit near, such as those who shouted. NA-H stated they verbally communicated to other staff who R222 liked or did not like to sit next to, or other staff already knew about R222’s seating preferences. During interview on 8/14/25 at 10:43 a.m., licensed practical nurse (LPN)-G stated R222 did not have physical altercations with other residents and more often yelled at other residents when behavioral. LPN-G was not aware of the care planned interventions for R222 to not sit next to other residents and only across from other residents. LPN-G confirmed R222 sat next to other residents in the dining area. During interview on 8/14/25 at 5:00 p.m., the director of nursing (DON) stated it was important to honor R222’s seating choices, protect R222, and make sure staff implemented care planned interventions. The DON was not aware of R222’s resident-to-resident incident history and would look further into R222’s history and care planned interventions. The DON stated the interdisciplinary team (IDT) worked together to review and update resident care plans. During a follow-up interview on 8/15/25 at 8:09 a.m., the DON stated R222 no longer engaged in aggressive behaviors, was seen by ACP, and was going to discontinue the intervention(s). The facility’s Comprehensive Care Planning policy dated January 2024, directed staff to develop, review, and revise each resident’s comprehensive care plan based on the results of the comprehensive assessment. The policy directed staff to update the care plan when a problem, goal, or approach was no longer appropriate or resolved.

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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. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on observation, interview, and document review, the facility failed to ensure routine personal hygiene (i.e., nail care) was completed and provided to reduce the risk of complication (i.e., infection, skin scratches) for 1 of 1 residents (R87) reviewed for activities of daily living (ADLs) and who were dependent on staff for their care. Findings include: R87's annual Minimum Data Set (MDS) assessment, dated 6/14/25, identified R87 had moderately impaired cognition with physical behavioral symptoms (hitting, kicking, pushing, scratching, grabbing, abusing others sexually) occurring 1-3 days that do not put resident at significant risk for physical illness or injury and do not significantly interfere with resident's care or participation in activities or social interactions. MDS identified rejection of care was noted 1-3 days during look-back period and there were no changes in behavioral symptoms since last MDS assessment. MDS identified R87 was dependent on staff assistance for shower/bathing needs and required setup/cleanup assistance from staff for personal hygiene needs. R87's care plan, printed 8/14/25, identified R87 required assist of staff for bathing/showering, trim and clean nails on bath days and as needed, and report any changes to the nurse, and for personal hygiene was independent and offer assist of 1 staff as needed. Furthermore, the care plan indicated the resident was resistive to accepting showers from specific staff members with the following interventions: allow resident to make decisions about treatment regime; if resident resists with ADLs, reassure resident, leave and return 5-10 minutes later and try again; provide consistency in care to promote comfort with ADLs. R87's progress notes reviewed for 7/10/25 to 8/13/25 and indicated the following: -8/5/25: weekly skin evaluation completed and residents' skin intact. No other comments.-7/24/25: the resident refused skin evaluation. Education/encouragement provided to resident regarding skin evaluation, with a comment of resident refused shower. -7/17/25: weekly skin evaluation completed and residents' skin intact. No other comments.-7/10/24: weekly skin evaluation completed and residents' skin intact. No other comments.The progress notes lacked any evidence of offering R87 nail care or refusals of nail care. During interview and observation on 8/11/25 at 1:52 p.m., R87 was observed to have long fingernails that were about a quarter inch long with dark colored debris underneath them. R87 stated, no one has done anything with them for a while.they should do that. R87 stated staff trim his fingernails for him. During an observation on 8/13/25 at 10:14 a.m., R87 was observed ambulating with a walker in the hallway. R87's fingernails were observed to long with dark colored debris underneath them. During an interview on 8/13/25 at 10:29 a.m., licensed practical nurse (LPN)-I stated they were familiar with R87. LPN-I stated nail care was to be done on shower days, and the nursing assistants provided the nail care unless a resident was diabetic, then a nurse trimmed the resident nails. LPN-I stated there was no place in the electronic medical record where it was documented that nail care was completed including on the skin assessment. LPN-I reviewed documentation for nursing assistants and verified that nail care was not documented. LPN-I stated again, I don't document anywhere when I do nail care. During an interview on 8/13/25 at 11:57 a.m., nursing assistant (NA)-M stated they were familiar with R87. NA-M stated R87 needed assist of 1 staff with cares and showers. NA-M stated nail care was done during showers typically but could be done anytime. NA-M stated R87 would refuse assistance at times. NA-M went and met with R87 to observe fingernails. NA-M stated R87 are kind of long, need to be cut, and have dark stuff under his nails. NA-M stated she would have thought they would have been trimmed during his shower last Thursday. R87 told NA-M that NA-M could cut his nails after lunch as lunch was just about to arrive. During an interview on 8/14/25 at 1:22 p.m., quality assurance registered nurse (QA) stated the expectation would be that a resident would be offered to have their nails trimmed during their weekly shower/bath at a minimum. QA stated if they noticed their nails needed to be trimmed in between that time they would reapproach them. QA stated, we don't document this as it is a standard of practice and it's routine. During an interview on 8/14/25 at 3:00 p.m., director of nursing (DON) stated the expectation regarding a resident's nails would be to follow the residents' preferences such as if they preferred to have longer fingernails, that would be ok but staff would support the resident to help keep the nails clean. DON stated she was unaware of a place where nail care was being documented in the electronic medical record but stated if a resident was continually refusing nail care, that would be documented in the EMR. A facility policy titled Activities of Daily Living (ADLs), dated August 2024, indicated a resident who is unable to carry out activities of dial living will receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review, the facility failed to ensure a therapeutic recreation assessment was addressed in the electronic medical record (EMR) and care planned to ensure a resident was offered appropriate activities for engagement while at the care facility for 1 of 2 residents (R76) reviewed for activities. Findings include:R76 's admission Minimal Data Set (MDS), dated [DATE], indicated R76 was admitted to the care center on 7/22/25 and was cognitively intact. R76's Activity Interview for Daily and Activity Preferences, dated 7/24/25, included a question How important is it to you to listen to music you like? which indicated R76 answered Very ImportantR76's Therapeutic Rec/Life enrichment Assessment, dated 7/24/25, which had boxes to fill in resident information such as past work experience/professions, religious preferences and current or past interest and hobbies, was left blank with will enter info 7/26/25 typed in to the first blank box of the assessment. A completed paper form of the same assessment was received during survey on 8/14/25 with a date of 7/24/25.R76's care plan, dated 8/13/24, lacked an activity section used to inform staff of R76's activity preferences and goals.R76's electronic medical record lacked evidence of life enrichment activities being offered or provided to R76. During an interview on 8/11/25 at 4:18 p.m., R76 stated he would like a radio in his room to keep him entertained as he does not like group activities. R76 stated he informed a few different facility staff members he would like a radio however never heard back. R76 stated, you ask and things never happen.During observation on 8/12/25 at 3:01 p.m., R76 was sitting in his wheelchair in his room, no music or television on in his room, asleep in his wheelchair. During observation on 8/13/25 at 11:16 a.m., and again on 8/14/25 at 8:18 a.m., R76 was sitting in a quiet room, asleep in in his wheelchair without any television, music or other type of activity or stimulation. During an interview on 8/14/25 at 8:28 a.m., the Director of Therapeutic Recreation (D-TR) stated the initial therapeutic recreation assessment was divided between the three therapeutic recreation staff, stating the department was a bit short staff but they tried to ensure everyone was assessed and care planned for appropriate activities. The D-TR stated the department had plenty of leisure activities for residents, including radios, which should be discussed with the resident during the initial assessment. During a follow up interview on 8/14/25 at 9:28 a.m., the D-TR confirmed R76's initial therapeutic recreation assessment in the EMR was blank and the care plan lacked an activities section. The D-TR stated she spoke with R76 that morning, brought him a radio and apologized for the delay. The D-TR also stated she completed his therapeutic recreation assessment. A facility policy titled Activities, dated 10-2024, indicated the admission assessment for therapeutic recreation should be completed within 14 days of admittance to the care facility. The policy further identified the activities department was an integral part of interdisciplinary care planning.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to implement interventions to ensure hearing aids were routinely applied or offered daily for 1 of 1 resident (R20) reviewed who had severe hearing loss. Findings include: R20's quarterly Minimum Data Set (MDS) dated [DATE], identified R20 with intact cognition, did not reject cares, required hearing aids, and diagnoses of paralysis due to a stroke affecting his non dominant side, hepatitis, seizures, anxiety, and depression.R20's care plan (CP) dated 5/1/25, identified HEARING LOSS: Resident has bilateral hearing loss with Goal of Staff to assist res with placement of hearing aids in bilateral ear.During observation and interview with R20 on 8/11/25 at 1:38 p.m., R20 was lying in bed without hearing aids. R20 asked State Surveyor several times to speak louder. R20 stated he did not know where his hearing aids were. R20 stated, I need to have my hearing aids to hear. No one told me where they are.During interview with nursing assistant (NA)-B on 8/12/25 at 2:06 p.m., NA-B stated expectation of nursing assistants to look at resident care sheet to inform them of what assistance was needed, bath or shower days, oral status, bowel and bladder status, rehabilitation needs and miscellaneous information for each resident in addition to receiving verbal report from outgoing shift. NA-B stated I put hearing aids in if the care plan tells me to. [R20] used to have them. NA-B walked to R20's room and looked around, It is not here. I did not put them in this morning and stated she did not inform the nurse of missing hearing aids. NA-B stated she could not remember when the last time she saw R20's hearing aids. Could have been a few weeks or last month. I don't know.During interview with registered nurse (RN)-I on 8/12/25 at 2:18 p.m., RN-I looked in R20's electronic medical record (EMR) and said, I see it in the care plan. It does say he has hearing aids. RN-I walked to R20's room and looked around and said, not in there. RN-I said she did not check with R20 at start of shift to see if he had his hearing aids. I should have. He went whole day without them. I don't have them in the medication cart either. I do not know where they are. I did not receive report or information that they were missing or put somewhere.During interview with licensed practical nurse (LPN)-C on 8/12/25 at 2:33 p.m., LPN-C stated as her role of nurse manager she had possession of R20's hearing aids. LPN-C stated, I have them in my office. I have had them a couple weeks. LPN-C looked in R20's EMR and verified there was no communication with R20 or staff to inform them of location of R20's hearing aids. LPN-C stated, I forgot to put in note. It should be in the care plan where the hearing aids are. I should update the care plan, so staff know.During interview with Director of Nursing (DON) on 8/13/25 at 2:24 p.m., DON verified R20's EMR failed to identify LPN-C having secured his hearing aids and providing report to staff or to R20 verbally or in a progress note of this action.Facility policy on quality of care was requested but not received.

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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. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to ensure residents had received ordered meals to increase calorie intake and weight per provider orders for 1 of 5 resident (R214) reviewed for nutrition and weight loss.Findings include:R214's comprehensive Minimum Data Set (MDS) assessment dated [DATE], identified R214 had intact cognition with no hallucinations, delusions, behaviors or rejection of care present. R214 was dependent on staff for activities of daily living (ADL's) and needed assistance from staff for set up/clean-up for eating. Pertinent medical diagnoses included traumatic brain dysfunction, quadriplegia (a medical condition described as paralysis of all four limbs), diabetes melilites (DM), osteoporosis, cerebrovascular accident (CVA--a sudden interruption of blood supply to the brain that caused brain cells to be deprived of oxygen and nutrients which led to brain damage, loss of function or death), seizure disorder, and malnutrition. R214 had one, stage three and one stage four pressure ulcer as well as one moisture associated skin damage (MASD) wound. R214's assessment documented their height as 66 inches and 128 pounds.R214's provider orders dated 10/14/24, identified a consistent carbohydrate diet, regular texture with thin consistency.R214's weight summary report identified on 7/1/25, R214's weight was 131.1 pounds and on 8/1/25, they weighed 123.1 pounds, a difference of 6.10% weight loss which indicated severe weight loss according to the Centers for Medicaid/Medicare Services (CMS).R214's care plan last reviewed on 5/17/25, identified a self-care deficit and they required total assist of one staff with eating. Additionally, nutrition was identified as a focus with interventions including explain and reinforce the importance of maintaining the diet ordered, encourage compliance, explain the consequences of refusals as it related to obesity/malnutrition risk factors. Food and beverage preferences were small warm milk for breakfast with cornflakes, no lactose in milk/cheese/sour cream/yogurt/pudding. Staff were directed to monitor and record/report to provider any signs of malnutrition, muscle wasting or emaciation. The guidelines for staff were significant weight loss: three pounds in one week, greater than five percent in one month, greater than seven and on half percent in three months, greater than ten percent in six months. Staff to provide supplements as ordered: Argiment (a nutritional supplement) twice daily, ProSource 30 cubic centimeters (cc) three times per day, a sandwich at bedtime and drink of choice, and ensure this was given twice daily. Staff were to provide snacks as needed and as requested, provide and serve diet as ordered, monitor intake, and record every meal. Registered dietician to evaluate and make diet changes recommendations as needed.R214's Nutrition Screen and assessment dated [DATE], identified high risk nutritional status related to multiple pressure ulcers, bilateral wounds, and sacral wounds. R214's diet order was consistent carbohydrate diet, regular textures, thin liquids, lactose intolerant. R214 was mostly independent with set up and assist as needed. R214 liked warm milk with his cornflakes in the morning. R214 spoke Spanish and the kitchen was contacted about menus in Spanish. Nutritional supplements were identified as Argiment twice a day, Prosource 30 cc three times a day, peanut butter and jelly every day. A box labeled unintentional weight loss in past three months was marked YES and documented weight on 5/1/25 was 127.9 pounds and on 4/1/25 weight was 129.8 pounds. R214's goal weight was 145 pounds and had a body mass index (BMI) of 20.6.R214's Nutrition Screen and assessment dated [DATE], identified high risk nutritional status for skin healing. R214's diet order was consistent carbohydrate diet, regular textures, thick liquids. R214 liked warm milk with their cornflakes in the morning. Resident was independent with eating. A box labeled unintentional weight loss was marked NO and indicated weight on 8/1/25, R214 was 123.1 pounds and had a BMI of 19.9. Goal weight was set at maintain weight. A note in the comment section read Gradual weight loss. During an observation and interview on 8/13/25 at 10:13 a.m., R214 had no breakfast tray in the room and dining aid (DA)- B stated breakfast was finished today at 9:15 a.m., all meals were served and pointed to the dining cart pushed back against the wall.R214's Nutrition Amount Eaten/Drank dated 7/31/25 through 8/14/25, indicated the resident refused breakfast on 8/12/25 and refused all three meals on 8/13/25.During an observation and interview on 8/13/25 at 1:30 p.m., R214 was in the dining room seated in a wheelchair. Nursing assistant (NA)-G brought over a tortilla and beans. R214 stated breakfast was never delivered. He stated the aid came in for repositioning at 8:00 a.m., and the meal was requested but never received. R214 identified NA-G as their assigned aid.During an interview on 8/13/25 at 1:31 p.m., NA-G stated R214 didn't generally eat breakfast and was unsure who was supposed to pass the tray, but then stated it was busy, and two rooms did not get trays. NA-G stated the other aid was supposed

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review the facility failed to follow care planned interventions to prevent re-traumatization for 1 of 1 resident (R6) reviewed for trauma informed care who was diagnosed with post-traumatic stress disorder and had identified triggers.Findings include: R6's admission Minimal Data Set (MDS), dated [DATE], identified R6 admitted to the care center on 6/25/25 and had multiple medical conditions including anxiety, major depressive disorder, bipolar, post-traumatic stress disorder (PTSD), schizophrenia and traumatic brain injury. R6's brief interview for mental status (BIMS) assessment, dated 7/1/25, indicated R6 was cognitively intact. R6's trauma history assessment, dated 7/1/25, identified R6 had a history of sexual abuse by males at a young age and could not be in the same room as another male with the door closed. R6's care plan, dated 7/1/25, indicated R6 reported childhood sexual abuse at the hands of two older males, making him distrust the majority of males he has worked with since this event. An intervention, dated 7/1/25, indicated R6 preferred to avoid male caregivers due to past abuse. During an interview on 8/11/25 at 1:37 p.m., R6 stated he had been having some anger issues due to feeling like he was not getting the physical care he needed and not feeling like facility care staff were taking his PTSD seriously. R6 stated there were still males entering his room alone. R6's Associated Clinic of Psychology (ACP) note, dated 8/6/25, indicated R6 was very angry with anger issues. The ACP provider stated R6 could not tolerate male staff in his room and preferred female caregivers and physical and occupational staff. The note indicated honoring female staff was important for staff safety. During observation on 8/11/25 at 1:10 p.m. , an unnamed male entered R6's room with his lunch tray and closed the door after he entered to discuss R6's lunch choices with him. During an interview on 8/13/25 at 7:54 a.m., nursing aide (NA)-O (a male aide) stated he often helped R6 when he need[ed] it. NA-O stated R6 was fairly independent with his activities of daily living but at times would need assistance in the bathroom and would call for help. During an interview on 8/13/25 at 9:17 a.m., NA-P stated she had been working at the care facility for about one year and was only aware of one resident on the unit (not R6) who had a preference for female caregivers. During an interview on 8/13/25 at 7:58 a.m., NA-Q stated she worked in a different unit but would come over to assist another resident (not R6) who preferred female only caregivers. NA-Q stated there were no other residents on the unit who only wanted female caregivers. During an interview on 8/13/25 at 10:42 a.m., registered nurse (RN)-J, referencing the care sheets (used by staff which contained resident specific information such as diagnoses, bath days and any special treatment such as wound care, oxygen use or preference for specific caregivers), and stated there was only one resident on second floor (not R6) that had a preference for female only caregivers. The sheets lacked any information regarding R6 preferring female only caregivers. During an interview on 8/13/25 at 11:00 a.m., R6 stated I don't feel safe at times further elaborating that male staff continued to come into his room despite him voicing his past trauma and distrust of men. During an interview on 8/14/25 at 10:51 a.m., nurse manager and RN-K confirmed the careplan and kardex (aide care plan) identified R6 as preferring female only staff, stating it would be expected that staff were aware and following R6's preferences.During an interview on 8/14/25 at 11:25 a.m., R6's ACP provider stated R6 often made threatening statements, and his preference for not wanting med in his room was associated with his history of abuse. The ACP provider stated, for his [R6] well-being and staff safety, males should stay out [of his room]. A facility policy on behavioral management and trauma informed care was requested but not received.

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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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to ensure medication errors were prevented for 2 of 2 residents (R138, R30) observed during medication administration. This resulted in a medication error rate of 7.14% (percent) with two errors out of 28 opportunities. Findings include:R138R138's admission Minimum Data Set (MDS) dated [DATE], indicated intact cognition and diagnoses of anemia, atrial fibrillation, heart failure, hypertension, hyponatremia, hyperlipidemia, non-Alzheimer's dementia, and malnutrition. The MDS indicated R138 had a feeding tube.R138's provider order dated 5/6/25, indicated R138 required potassium chloride (used to treat and prevent low potassium levels in the body) ER (extended-release) 10 mEq (milliequivalents) via PEG-tube (percutaneous endoscopic gastrostomy tube; a tube passed into the stomach through the abdominal wall) one time a day with instructions to dissolve in water.During observation and interview on 8/13/25 at 8:14 a.m., licensed practical nurse (LPN)-H prepared R138's medications. All tablets were crushed, including potassium extended release, and each medication was placed in separate medication cups. LPN-H added water to each medication cup and flushed R138's PEG-tube before medication administration, between each medication, and after medication administration. LPN-H verified they crushed all tablets given to R138 and knew what medications could or could not be crushed based on nursing school and a nursing drug book.During interview on 8/14/25 at 10:39 a.m., (LPN)-G stated extended-release potassium should be dissolved in water if by the book.R30R30's significant change in status MDS dated [DATE], indicated R30 had intact cognition and diagnoses of benign prostatic hyperplasia and kidney disease.R30's provider order dated 4/10/25, indicated R30 required two capsules of tamsulosin hydrochloride (helps to improve urination and reduce discomfort for men with enlarged prostate.) 0.4 mg (milligrams) by mouth one time a day and specified to give after a meal.During medication administration on 8/13/25 between 9:13 a.m. and 9:28 a.m., registered nurse (RN)-B prepared R30's medication which included tamsulosin. RN-B entered R30's room and R30 was still eating breakfast. R30 took all medications and continued his meal.During interview on 8/13/25 at 11:59 a.m., RN-B stated provider orders indicated what medications were given before, during, or after meals. RN-B reviewed R30's orders and stated R30 stated he wanted all his medications at the same time during previous interaction. RN-B stated they would update the provider, and staff would update the care plan.During interview immediately after above interview, LPN-C expected staff to honor resident choices for medications and update the provider.During interview on 8/14/25 at 5:00 p.m., the director of nursing (DON) expected staff to dissolve instead of crush potassium chloride extended release. The DON expected staff to follow the doctor's orders and update a provider if a resident preferred to take medication in a way different than ordered.During interview on 8/15/25 at 7:16 a.m. , the consultant pharmacist (CP) stated crushing potassium extended release was advised against or discouraged due to compromising the extended-release function of the medication. CP stated abrupt release of potassium could cause irritation of the GI (gastrointestinal) tract. The CP stated tamsulosin given during a meal instead of 30 minutes after a meal decreased the medication effectiveness by potentially decreasing the absorption rate and peak level of the medication. Tamsulosin given after a meal decreased side effects, such as low blood pressure and dizziness.The facility's Medication Administration policy dated May 2025, directed staff to verify resident name, medication name, form, route, and time. The policy directed staff to administer medications per provider orders and administer medication as ordered in accordance with manufacturer specifications.

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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 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. (continued on next page)

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on interview and document review, the facility failed to ensure identified dental concerns (i.e., need for dentures) were acted upon and, if needed, referred to the appropriate resource in a timely manner for 1 of 2 residents (R87) reviewed who voiced dental concerns.R87's annual Minimum Data Set (MDS) assessment, dated 6/14/25, identified R87 had moderately impaired cognition. Further, the MDS identified a section labeled, L0200, along with spaces to record no natural teeth or tooth fragments(s) (edentulous). This was answered, None of the above were present. Further, R87's Clinical Census report, printed 8/14/25, identified R87's current payor source listed as, Medicaid MN.During an interview on 8/11/25 at 1:52 p.m., R87 stated, I don't have any dentures, and I want to wear dentures. R87 explained the facility was supposed to make arrangements for getting her dentures but that was a long time ago. Furthermore, R87 stated he was limited on what he can eat due to not having teeth/dentures.R87's care plan, printed 8/14/25, identified R87 was independent with oral care, had no natural teeth and only two root-tips present #20, 21. Furthermore, it indicated R87 had expressed interest in getting dentures with the following interventions: coordinate arrangements for dental care, transportation as needed; follow up with dental for denture creation, placement, and fitting as needed (date initiated on 7/30/25) and diet as ordered. Further, identified R87 Likes: Jello with his dinner, has a stash of it and buys food at the vending/gift shop per CNA (certified nursing assistant). Likes Mountain Dew, Sweet Tea, Jello, mashed potatoes, little protein and Food/beverage preferences: Likes: pancakes, frosted flakes, frozen meals, potatoes, tilapia, ranch dressing, chocolate pudding, jello with a regular diet with regular texture and thin liquids.R87's progress notes, dated 2/10/25 to 8/13/25, reviewed and identified the following: -3/13/25: Therapy note: R87 was seen extensively for swallowing skills. He is able to safely consume level 5/0, minced and moist and thin liquids. This is due to his lack of teeth and his preference for softer foods. He has many food preferences and likes to discuss these at length. He is sometimes nonsensical with his preferences and contradicts himself. He reports that he is only able to consume mashed potatoes. Recommend a dental consult for dentures. The progress notes lacked any additional information of R87 dental appointments for dentures. Furthermore, lacked any evidence of R87 not wanting to proceed with dentures. R87's Chart Progress Note, dated 3/14/25, indicated R87 was seen for dental exam and completed a step in the denture making process which R87 tolerated well. R87's Chart Progress Notes, dated 3/27/25, indicated R87 was seen for denture fabricating process. R87 had some difficulty tolerating this step in the process and it was recommended if R87 wanted to proceed with dentures a referral would be made, at any time, to a specialist. R87's Oral/Dental Assessment Form, dated 5/2/25, indicated R87 had no natural teeth or tooth fragments(s). Furthermore, assessment notes indicated Pt (patient) would like dentures. The notes to nursing staff for follow up/care conferences indicated, Pt would like denture, so please help me schedule. R87's Care Conference Summary, dated 6/18/25, identified R87's most recent dental appointment was 5/2/25. Furthermore, indicated resident stated that he would like dentures but has been unable to tolerate plate used for denture fabrication d/t (due to) discomfort on two separate occasions. Dentist noted that if he cannot tolerate this process, he would likely be unable to tolerate dentures. Appointment will be made if resident wants to attempt denture process again.R87's physician's provider note, dated 7/28/25, indicated requests dentures-order for dentistry referral.During an interview on 8/13/25 at 2:25 p.m., licensed practical nurse (LPN)-I stated they were familiar with R87. LPN-I verified R87 did not have any teeth or dentures. LPN-I stated R87 was currently being seen by in-house dental services and in the process of having dentures being made as he had expressed numerous times the desire to have dentures. LPN-I stated R87 has expressed the desire to eat regular food and has not been able to due to not having dentures. LPN-I stated the dentist came every Friday and hopefully R87's dentures would be ready soon but was unsure of where they were in the process. LPN-I stated R87 talked about dentures frequently and the desire to have them.On 8/14/25 at 10:36 a.m., nursing assistant (NA)-N stated R87 did not have dentures, however NA-N stated they didn't typically work with R87.On 8/14/25 at 10:40 a.m., family member (FM)-A stated R87 had been talking about wanting dentures for some time. FM-A stated they visit R87 frequently and have heard R87 tell staff he would like dentures. FM-A stated he was aware that the dentist was in the process of making dentures for R87 but had not been updated in the last 3 months or so about the process. FM-A stated they were to be notified with any changes with R87 or concerns.During an interview on 8/14/25 at 11:32 a.m., director of health information management (HIM) stated she was responsible for following up with in-house dental services. HIM reviewed R87's electronic medical record (EMR) and stated

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure therapeutic diets are prescribed by the attending physician and may be delegated to a registered or licensed dietitian, to the extent allowed by State law. (continued on next page)

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and document review the facility failed to ensure 2 of 2 resident (R9, R105) received ordered therapeutic diet to maintain or improve their nutritional status.Findings include: R9R9's quarterly Minimum Data Set (MDS) assessment dated [DATE], indicated R9 had intact cognition with no hallucinations, delusions, behaviors or rejection of care present. R9 was dependent on staff for activities of daily living (ADL's) to include set up assistance for eating. R9's MDS assessment documented height as 76 inches and 171 pounds and was triggered for weight loss. Pertinent medical diagnoses include traumatic brain injury, coronary artery disease (CAD), malnutrition, anxiety, post-traumatic stress disorder (PTSD), and hyponatremia. R9 had one stage four pressure ulcer present upon admission.R9's provider orders indicated on 11/12/24, a therapeutic diet of regular texture, thin consistency, for double portions all meals, cut into bite sized pieces was ordered.R9's Medical Diagnosis list included moderate protein-calorie malnutrition dated 1/27/25.R9's care plan last revised on 7/9/25, identified an actual impairment for skin integrity of the coccyx and applied interventions for good nutrition and hydration to promote healthier skin. The plan also included a focus for ADL and mobility and identified interventions for eating as staff would assist with set up to maximize independence with eating.A report titled Nutrition-Amount Eaten/Drank dated 7/16/25 through 8/14/25, identified amounts eaten. The column identified as 0-25% was marked one time, a column identified as 26-50% was marked three times, a column identified as 51-75% was marked twenty-one times, a column identified as 76-100% was marked sixty-two times. R9 was marked not available one time and no refusals were documented out of the eighty-eight possible meals served.R9's Weight Summary report dated 8/1/25, indicated 172.8 pounds. Six months prior on 1/22/25, R9's weight was recorded as 198.1 pounds which was a 12.77% weight loss over six months which was identified as severe weight loss according to the Centers for Medicaid/Medicare Services (CMS).R9's current dining ticket dated 8/13/25, indicated pudding cup-1 each, double entree meal-1, beef vegetable soup-8 ounces (oz), Greek yogurt-1, mashed potatoes/gravy-1, beef pot roast with roasted vegetables-1 cups, mini baker potatoes-4 oz, country trio vegetables-4oz, bread, margarine-1 each, ice cream or sherbert-#8 scoop, milk- 8 fluid oz.R9's March through August 2025, Treatment Assessment Record (TAR) identified double portions at all meals, order mashed potatoes and gravy with lunch and dinner. Order vegetable beef soup with lunch, tomato soup with dinner every shift with a start date of 11/12/24. Staff documented R9 received double portions for all meals except two during this timeframe. The TAR also identified ice cream as needed for nutrition with a start date of 11/12/24, the TAR lacked any documentation that R9 received the ice cream as needed.R9's progress notes dated 1/27/25, identified an order for double portions at all meals. Order mashed potatoes and gravy with lunch and dinner. Order vegetable beef soup with lunch, tomato soup with dinner every shift. R9's progress note dated 6/20/25, identified a nutritional risk note related to wounds. Diet order: regular with regular thin liquids and double portions. No meals refused for the past 14 days.During an interview on 8/11/25, R9 expressed concerns that the therapeutic diet was not followed. During observation and interview on 8/13/25 at 1:38 p.m., R9 stated breakfast was good, but it wasn't a double portion, and lunch has been sitting for twenty minutes. R9 stated the dining ticket was usually highlighted so the servers did not forget the double portions. The plate was observed to have one piece of bread, four golden potatoes, approximately two tablespoons of vegetables, and approximately 1/4 cup of roast beef. One Greek yogurt and one ice cream cup was on the side of the tray along with one margarine, but no soup was present. Registered nurse (RN)-A verified the dining ticket stated double portions and confirmed R9 did not receive double portions. No servers were available to verify portion size.During an interview on 8/14/25 at 9:48 a.m., District Regional Manager (DRM)-F stated residents received therapeutic diets and it was possible that a resident did not receive soup based on the consistency, but if it was ordered and no thickened restrictions were present then soup should have been given on the meal tray. R9's lunch tray delivered on 8/13/25 was reviewed with the DRM-F and DRM-F stated it didn't sound like R9 received double portions if there was only one piece of bread and four round potatoes.During an interview on 8/14/25 9:45 a.m., the administrator stated if the facility heard a resident wanted a meal staff would get them food. Anyone could call down to the kitchen and get a meal at any time. The staff work closely with the kitchen, a dining ticket could be reprinted, and a new meal could be delivered. The administrator was unsure what would happen if a resident was unable to call the kitchen or advocate for themselves and stated the expectation was that all residents received their ordered meals and that the dining

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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** Based on observation, interview, and document review, the facility failed to ensure personal protective equipment (PPE) was used for 2 of 7 residents (R3, R12) when providing care for residents in enhanced barrier precautions (EBP). Findings include: The CDC article titled Implementation of Personal Protective Equipment (PPE) Use in Nursing Homes to Prevent Spread of Multidrug-resistant Organisms (MDROs), dated 4/2/24, indicated that MDRO transmission in skilled nursing facilities was common and contributed to substantial resident morbidity. EBP is an infection control intervention to reduce transmission of MDROs by using gowns and gloves during high contact resident care activities. The article indicated high-contact activities include providing hygiene, changing briefs, dressing, urinary catheter care, transferring, etc. The article indicated that EBP should be implemented (when contact precautions did not apply) for residents with indwelling medical devices (urinary catheter) or chronic wounds, regardless of MDRO colonization status. R3's significant change Minimum Data Set (MDS) dated [DATE], indicated R3 was diagnosed with diabetes. The MDS indicated R3 had two unstageable pressure ulcers and required assistance with all activities of daily living. During an interview on 8/13/25 at 2:27 p.m., the nurse manager, registered nurse (RN)-G, confirmed that R3 had multiple pressure ulcers that were unstageable but open and required dressing changes. During an interview and observation on 8/14/25 at 10:20 a.m., an EBP sign was observed on R40’s door. Nursing assistant (NA)-C and NA-J were observed to wheel R40 into her room and then close her door. Neither aide was observed to don a gown. RN-G was observed to walk by the room, knock, and then open R40’s door. NA-C and NA-J were observed with gloves and no gowns on, assisting R40 to transfer to bed. RN-G then left the room and closed R40’s door. NA-C and NA-J were observed to exit R40’s room, and R40 was observed in bed. NA-C stated they had just assisted R40 to bed and had checked R40’s brief for incontinence. NA-C and NA-J confirmed they had not worn a gown as they only needed to be worn during morning cares. During interview on 8/14/25 at 11:08 a.m., the facility’s infection preventionist/registered nurse (RN)-H stated the staff needed to wear a gown and gloves whenever they touch a resident on transmission-based precautions (TBP) or EBP. The RN-H added “you absolutely need to use a gown with any contact care that requires to touch the residents like changing a brief, transferring, repositioning, or taking vital signs. ” R12’s quarterly Minimum Data Set (MDS) dated [DATE], identified severe cognitive impairment and diagnoses of coronary artery disease, heart failure, hypertension, obstructive uropathy, urinary tract infections in the last 30 days, and non-Alzheimer’s dementia. R12 required substantial/maximal assistance with toileting hygiene, upper and lower body dressing, and supervision or touching assistance for chair/bed-to-chair transfers and toilet transfers. R12 had an indwelling catheter. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R12’s care plan focus area dated 7/23/25, identified R12 had a foley catheter and an intervention dated 7/23/25 which indicated enhanced barrier precautions were in place, signage on door, and PPE cart outside room. During observation on 8/13/25 at 1:07 p.m., a sign indicating Enhanced Barrier Precautions was on the outside of R12's door and identified providers and staff must wear gloves and gown for High-Contact Resident Care Activities including dressing, transferring, providing hygiene, and device care with urinary catheters. A cart of PPE was outside R12’s room. Nursing assistant (NA)-H entered R12's room, completed hand hygiene and applied gloves. NA-H emptied R12’s urinary leg bag, provided perineal hygiene, and changed R12’s pants which were soiled. NA-H doffed gloves and completed hand hygiene. During interview on 8/13/25 at 1:32 p.m., NA-H stated they used a gown for residents on isolation and could decide if they wore a gown or not to empty a urinary catheter. During interview on 8/14/25 at 10:39 a.m., licensed practical nurse (LPN)-G agreed R12 was on enhanced barrier precautions and had a catheter. LPN-G expected staff to follow the sign on R12’s door to keep infection from spreading. During interview on 8/14/25 at 5 p.m., the director of nursing (DON) expected staff to wear gloves and gown to empty a urinary catheter for resident protection. The facility’s Enhanced Barrier Precautions policy dated March 2024, indicated enhanced barrier precautions referred to the use of gown and gloves during high-contact resident care activities for residents with increased risk of MDRO (multi-drug-resistant bacteria) acquisition, such as residents with an indwelling medical device (urinary catheter). The policy identified high-contact resident care activities as dressing, transferring, providing hygiene, changing briefs, and device care such as urinary catheters.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During observation, interview and record review the facility failed to ensure facility was kept sanitary and maintained in good repair on all six resident units which had the potential to affect all 225 residents, staff, and visitors of the facility.Findings include: Walls:During observation on 8/12/25 at 8:56 a.m., on the sixth floor, wall outside R184's room had gouges and underlying wallboard exposed. Partial repair was done but not painted to match the wall. The wall across from aviary was tan in color with nine sections or areas of wall covering four feet by two feet with repairs but no matching paint.During observation on 8/12/25 at 9:26 a.m., in second floor dining room, two residents were seated at a dining room table. The wall of the dining room had gouges and scrapes observed with repairs done but no paint to match the wall cover.During observation and interview with the administrator and director of environmental services (D)-ES on 8/13/25 at 8:31 a.m., on the seventh floor, the D-ES and surveyor observed knee wall in dining room with gouges and visible wallboard repaired but did not have any matching paint. D-ES and administrator state we are identifying areas that need repair and replacements. D-ES stated he had not received any maintenance requests from staff to repair and match paint for the dining room.During observation on 8/13/25 at 9:20 a.m., in third floor dining room, all of the walls had wallboard that had been repaired but no paint to match the walls. Several residents were eating breakfast in the area.During observation and interview with licensed practical nurse (LPN)-B on 8/13/25 at 9:36 a.m., LPN-B stated gouges should be looked at. I would like it to be repaired or replaced in my home and It does not look good if there are so many holes and dings in the wall. LPN-B stated process for repairing equipment was for staff to utilize a walkie talkie to the maintenance department or submit request through the computer system. LPN-B stated they had not submitted anything to maintenance for repairs to any resident walls, doors, or carpets.Floors:During observation on 8/12/25 at 9:05 a.m., on fifth floor a long black vinyl piece was resting against the baseboard of the alcove right off the elevator and across from the dining room. The vinyl piece was not attached to anything. A section of carpeting in the dining room was missing the transition piece from laminate flooring of the dining room to the carpeted areas outside the dining room. One resident sitting in wheelchair next to the gap in flooring stated he was concerned for ambulatory residents and staff for risk of tripping.During observation on 8/13/25 at 8:53 a.m., three dark stains were seen on R97's carpet inside door. The black stains on the tan carpet ranged from two to three inches in circumference and was visible from the hallway.During interview with D-ES on 8/13/25 at 12:10 p.m., D-ES stated the missing transition piece on fifth floor dining room was replaced, It is a safety issue. Do not want anyone to trip.During observation and interview on 8/13/25 at1:08 p.m., R191's carpet in their room had large dark stain visible to the hallway. D-ES stated, it should definitely be cleaned. It is stained and had not received a maintenance request to clean the carpet.Ceiling:During observation and interview with nursing assistant (NA)-B on 8/12/25 at 2:06 p.m., in R20's unoccupied bedroom, NA-B looked at the dark stains on his 4 white ceiling tiles and stated, I would not like it in my home. It is not good to see those stains on the ceiling and the unpainted section there (pointing to the unfinished wall repair two feet by three feet in size next to R20's head of bed). NA-B stated process for repairing equipment is for staff to utilize walkie talkie to the maintenance department or submit request through the computer system. NA-B stated they had not submitted anything to maintenance for repairs to R20's wall or ceiling tiles.During observation and interview with licensed practical nurse (LPN)-C on 8/12/25 at 2:42 p.m., LPN-C looked at R20's wall and ceiling tiles and stated, Oh stains and the wall needs to be redone. If it was my house, I would not like to see that. LPN-C stated process for repairing equipment is for staff to utilize walkie talkie to the maintenance department or submit request through the computer system. LPN-C stated they had not submitted anything to maintenance for repairs to R20's wall or ceiling tiles.During observation and interview with R20 on 8/12/25 at 3:06 p.m., R20 stated, I don't like the wall. Its right next to my head when I lay in bed. The paint does not match and it looks unfinished. It is not attractive. No one has mentioned it to me. It was here when I [admitted to facility]. R20 then pointed to ceiling of his room and four white ceiling tiles that were darkly stained. I think it looks crappy.Doors:During observation and interview with nursing assistant (NA)-A on 8/13/25 at 9:01 a.m., NA-A and surveyor observed a missing piece of laminate wood about eight inches long by three inches from R196's bathroom door about 4 feet up from the floor near the hinges. The edges were ragged and sharp. NA-A stated Not in good repair to me. I don't like that. It looks bad and It is dangerous and could hook on someone's clothes and could snag. NA-A stated process for repairing equipment is for staff to utilize walkie talkie to the maintenance department or submit request through the computer system. NA-A

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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. (continued on next page)

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Lakehouse Healthcare & Rehabilitation Center	3737 Bryant Avenue South Minneapolis, MN 55409

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** During observation, interview and record review, the facility failed to ensure an effective pest control program was in place to eliminate fruit flies and black flies for 5 residents (R6, R69, R76, R88, and R223) who verbalized concern about flies. This had the potential to affect all 225 residents of the facility.Findings include:R6's admissions Minimum Data Set (MDS) dated [DATE], identified R6 with no physical or verbal behaviors and did not reject cares, no impairment of upper extremity range of motion, impairment of lower extremity range of motion, utilized a wheelchair for mobility, and required assistance with toileting, and dressing.R69's quarterly MDS dated [DATE], identified R69 with intact cognition, no physical or verbal behaviors and did not reject cares, no impairment of upper or lower extremity range of motion, utilized a walker for mobility, and required set up or clean-up assistance with eating, oral hygiene, toileting hygiene, dressing, and personal hygiene.R76's admissions MDS dated [DATE], identified R76 with intact cognition, no physical or verbal behaviors and did not reject cares, no impairment of upper and lower extremity range of motion, utilized a walker for mobility, and required assistance with dressing, and toileting.R88's quarterly MDS, dated [DATE]/25, identified R88's short-term and long-term memory to be intact, no impairment of upper extremity range of motion, impairment of lower extremity range of motion, utilized wheelchair for mobility, and required assistance with toileting, and dressing.R223's significant change in status assessment MDS dated [DATE], identified R223 with intact cognition, no physical or verbal behaviors and did not reject cares, impairment of one side of upper and lower extremity for range of motion, utilized a wheelchair for mobility, and required assistance with toileting and dressing.Review of facility's monthly pest control visit notes, the facility was treated for Cluster Flies, Drain Flies, Flies, Fruit Flies, House Flies on the following dates:2/11/25, 3/14/25 which identified fruit flies throughout the kitchen and garbage collection areas, 4/4/25, 5/14/25, 6/12/25, and 7/11/25 (which identified fruit flies).During observation and interview with R6 on 8/11/25 at 1:06 p.m., R6 pointed to several fruit flies and regular black flies buzzing around her room and said her room is visibly dirty. R6 stated she was upset about it and I am at the point of begging to rid her room of them.During observation and interview with R88 on 8/11/25 at 3:44 p.m., R88 was lying in bed with a fly swatter in her right hand. A fly was buzzing around her, and she was swatting at it. This is bothering me. My friend had to bring in the fly trap (pointing to window with sticky fly strip hanging down from window blind). They need to do something about pests in here. R88 stated she stayed in bed, rarely got out of the bed, and was stuck with the flies. During observation and interview with R76 on 8/11/25 at 4:24 p.m., R76 had multiple flies in room flying around his food tray and legs. R76 was swatting flies away. R76 stated, They come and they go.During observation and interview with director of environmental services (D)-ES on 8/13/25 at 1:16 p.m., D-ES and surveyor walked into R88's room, with permission, and observed two large black flies buzzing around and the fly strip that was attached to the blinds. I know we did not get a work request for the flies in her room. I will have to look at it.During interview with D-ES on 8/13/25 at 1:11 p.m., D-ES reviewed facility's maintenance request logbook for 2/2025 to 8/2025, and stated there were no requests for additional pest control visits to address flies. D-ES also reviewed and verified the pest control visit notes stated facility did not reach out to ask for additional services to address the flies. D-ES stated the services were clearly not effective.During interview with director of nursing on 8/13/25 at 2:10 p.m., DON stated It is really hard to manage [flies].During interview with licensed practical nurse (LPN)-D on 8/14/25 at 8:15 a.m., LPN-D stated she had seen some flies yesterday in a resident's room but was unable to say which room. LPN-D stated expectation of staff to notify nurse manager or maintenance through walkie talkie or submit a request through the computer for issues relating to flies or pests. LPN-D stated she failed to notify anyone of the flies.During interview with nursing assistant (NA)-C on 8/14/25 at 8:23 a.m., NA-C stated, there have been complaints from residents about flies and expectation of staff to notify nurse manager or maintenance through walkie talkie or submit a request through the computer for issues relating to flies or pests. NA-C stated she failed to notify anyone of the flies.During interview with NA-D on 8/14/25 at 8:37 a.m., NA-D stated the appearance of flies, Usually [sic] happens a lot during summertime and they [flies] move around the place. NA-D stated expectation of staff to notify maintenance through walkie talkie or submit a request through the computer for issues relating to flies or pests. NA-D stated she failed to notify anyone of the flies.During interview with NA-F on 8/14/25 at 9:07 a.m., NA-F stated flies appeared in the dining room and sometimes the residents will say they bother them. In the hallway there will be some. NA-F stated he had seen them recently but did