STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245067	A. Building B. Wing	05/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Emeralds at Faribault LLC	500 Southeast First Street Faribault, MN 55021

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 - 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** 44656 Based on observation, interview and document review, the facility failed to ensure dignity was maintained for 2 of 2 residents (R54, R74) who utilized urinary catheters. Findings include: R54 R54's annual Minimum Data Set (MDS) dated [DATE] identified R54 with intact cognition, impairment of both lower extremities, dependent on staff for toileting hygiene and lower body dressing and had an indwelling catheter (tube for urine collection from bladder to a bag outside of the body). During observation on 4/28/25 at 1:42 p.m., R74 was lying in bed with an uncovered large urine drainage bag attached to side of bed visible to the hallway. During observation on 4/28/25 at 2:39 p.m., R74 was lying in bed with an uncovered large urine drainage bag attached to side of bed visible to the hallway. Two staff walked past the room. At 5:13 p.m., a staff member pushed a meal cart past R74's room. At 5:15 p.m., one staff member was observed inside the room speaking to R74 and left the room. During observation and interview with R74 on 4/28/25 at 6:35 p.m., R74 was lying in bed with an uncovered large urine drainage bag attached to side of the bed visible to the hallway. R74 stated, staff have never asked me if I wanted a cover on my urine bag. And I imagine other people would not feel comfortable looking at my urine in this bag. I guess I would not like to see anyone else's urine in their bag if I think about it. During observation and interview on 4/29/25 at 8:39 a.m., registered nurse (RN)-B was obtaining medications from the medication cart which was located across the hall from R54. RN-B observed the uncovered partially filled large urine drainage bag from hall and stated, catheter bag should be covered for dignity and decency. R74 R74's admissions MDS dated [DATE] identified R74 with intact cognition, required substantial to maximal assist with toileting hygiene and lower body dressing, and had an indwelling catheter. (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 observation on 4/29/25 at 8:03 a.m., R74 wheeled self around hallway seated in wheelchair with large urine drainage bag attached to underside of wheelchair. R74 wheeled self to nursing station where four residents were eating a meal at tables adjacent to the nursing station. The urine bag was visible and uncovered. During observation and interview on 4/29/25 at 8:31 a.m., licensed practical nurse (LPN)-A observed R74 wheel past her as she was obtaining medications from medication cart and stated, that [urine bag] should be covered for dignity. During interview with R74 on 4/30/25 at 10:04 a.m., R74 stated, It [catheter drainage bag] was never covered until yesterday when they [staff] came in and put one[sic] cover on it. I don't want to see another person's pee[urine]. I should be more respectful. During interview with director of nursing (DON) on 4/30/25 at 10:48 a.m., DON stated, Foley [catheter] need to be covered and stated the uncovered catheter bags were a concern for infection control and dignity. Facility policy for dignity was requested and not received. 51567

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F 0583 Level of Harm - Potential for minimal harm Residents Affected - Some	Keep residents' personal and medical records private and confidential. 44656 During observation and interview, the facility failed to ensure resident records that contained private, medical, and personal information were not accessible to unauthorized personnel. This had the potential to affect 20 residents on the first floor of facility, and all 13 residents on the second floor whose personal information was listed on exposed care sheets. Findings include: During observation and interview starting on 4/29/25 at 12:54 p.m., licensed practical nurse (LPN)-A was observed to leave medication cart and enter a resident room. A patient care sheet was left on top of the medication cart showing private patient information for 8 residents. At 12:58 p.m., three staff members walked past the cart. Upon returning to medication cart at 1:01 p.m., LPN-A stated the unattended care sheet belonged to another clinician and he should have moved it demonstrating turning the form over and placed it under the work laptop. LPN-A stated the uncovered unattended care sheet had private patient information and it was important to secure that information to only those who require it. During observation and interview starting on 4/29/25 at 3:44 p.m., an unattended care sheet with 12 residents' private health care information was observed on top of medication cart in the hallway of first floor. Three staff members walked past the cart. Then registered nurse (RN)-C exited resident room and walked to the medication cart. RN-C stated he had left the exposed care sheet on the medication cart. RN-C stated he should not have left it unattended due to privacy and HIPAA. During observation and interview starting on 4/30/25 at 7:41 a.m., trained medication aide (TMA)-A left medication cart unattended with an exposed patient care sheet containing information for all 13 residents of the second floor. The medication cart was located across from the dining room and residents were starting to appear for breakfast. One resident moved past the cart and another staff member walked past the cart. At 7:44 a.m., TMA-A returned to the medication cart and stated she had left the care sheet unattended and exposed. TMA-A stated, I should flip that over for privacy. During interview with director of nursing (DON) on 4/30/25 at 10:48 a.m., DON stated unattended and exposed patient care sheets were a HIPAA violation and impacted dignity and privacy. DON stated [it]should not be done to ensure resident information is not available for everyone to see. Undated facility policy titled HIPAA state, Simple tips to remain compliant: Don't not leave care sheets or other client identifying papers laying out.

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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 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** 44656 Based on observation, interview, and document review, the facility failed to ensure a sanitary and homelike environment for 1 of 1 residents (R40) whose tube feeding pole and equipment had dried, white substance on it. Findings include: R40's quarterly Minimum Data Set (MDS) dated [DATE], identified R40 with intact cognition and diagnoses of depression, anxiety, chronic respiratory failure resulting in oxygen dependence, and a history of head and neck cancer with all nutrition through a percutaneous endoscopic gastrostomy (PEG) tube (soft flexible feeding tube inserted through the abdominal wall into the stomach). During observation on 4/28/25 at 5:07 p.m., R40's tube feeding (TF) pole was coated with dried white substance on entire surface of the pole and all five legs of the base. The TF unit/machine had greasy smeared substance on the entire front programming screen. During interview with licensed practical nurse (LPN)-A on 4/29/25 at 1:03 p.m., LPN-A stated the nursing staff was responsible for wiping down and cleaning tube feeding equipment if there were spills or visible soil on the unit and pole. During observation on 4/29/25 at 1:06 p.m., R40's tube feeding (TF) pole was coated with dried white substance on the entire surface of the pole and all five legs of the base. The TF unit/machine had greasy smeared substance on the entire front programming screen. During observation and interview with registered nurse (RN)-B on 4/29/25 at 1:18 p.m., RN-B stated everyone is responsible for making sure patient care equipment was clean. If we see if it is dirty we should clean it so the gunk doesn't dry like concrete. During observation and interview with RN-B on 4/29/25 at 1:21 p.m., RN-B looked at R40's TF pole and machine and stated, that is horrible. RN-B stated the white substance appeared to be TF solution that was not wiped up after nurses prepared to administer the solution and following disconnecting the feedings from R40. During interview with R40's spouse on 4/29/25 at 1:22 p.m., R24 stated the pole was soiled in appearance and, It is not good to look at. No one wipes up their spills or messes. During interview with R40 on 4/29/25 at 2:07 p.m., R40 stated the TF pole and machine is always cruddy looking. R40 stated he had never seen any staff member clean or wipe up the TF solution or wipe down the feeding equipment before or after attaching the feeding to his PEG. During interview with director of nursing (DON) on 4/29/25 at 10:50 a.m., DON stated expectation of nursing staff to be cleaning and wiping the machine, pole, and the base of the pole if there is spillage or visible soil on them. DON stated it was a concern for infection control and dignity for the resident. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Facility policy requested for environmental cleaning of patient care equipment and not received.

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51567 Based on observation, interview, and document review, the facility failed to ensure grievances were sufficiently acted upon for 1 of 1 resident (R53) reviewed for grievances. Findings Include: R53's quarterly Minimum Data Set (MDS) dated [DATE], indicated R53 was cognitively intact. During an interview on 4/28/25 at 4:28 p.m., R53 stated approximately two months ago, during an evening shift a nursing assistant entered her room and attempted to change an incontinent brief. R53 was concerned because she didn't wear incontinent briefs, and the aid was unkind during the encounter. The following morning R53 reported the incident to staff. During a subsequent interview on 4/29/25 at 1:28 p.m., R53 stated she filed a grievance approximately two months ago and requested the nursing assistant not return to the unit. R53 confirmed that no one from the facility followed up with the results of the grievance. R53 stated the aid did work on the unit after staff was made aware of the incident and told residents he had been off for two weeks having a party. R53's progress notes failed to mention an incident which occurred on or around February 2025 through March 2025. Facility Report of Grievances/Complaints/Care Concerns 2024-2025 contained a list of grievances related to care concerns and lost items. The list lacked indication R53 filed a grievance. During an interview on 4/29/25 at 2:21 p.m., nursing assistant (NA)-D stated the completed grievance forms were kept on file in the social workers office. The process would be if a resident had a concern, staff would talk to the charge nurse. Grievance forms were completed by the residents, or a social worker could assist with the forms. During an interview on 4/29/25 at 2:46 p.m., registered nurse (RN)-D stated all grievances were given to social services and resolved using an electronic software, Med Trainer. RN-D stated R53's grievance was unfamiliar, but whomever was working should have filed a grievance immediately. During an interview on 4/30/25 at 9:13 a.m., social services (SS)-A stated when a resident filed a grievance, social services, the DON, and the Administrator would start collecting staff and resident statements. If the grievance fell under nursing, nursing aids, or resident cares the DON would follow-up. Grievances were manually entered into Med Trainer and once the hard copy was scanned into the program, the paper could be discarded. All statements, education, or resolutions were scanned into Med Trainer. SS-A was not 100% familiar with R53's grievance but remembered hearing about a concern with an employee. During an interview 4/30/25 at 9:15 a.m., Administrator in Training (AIT) called the DON who stated the previous social services director, SS-B, was involved in addressing the concern. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview 4/30/25 at 9:31 a.m., Activities Director(A)-A stated R53 asked why the facility didn't follow up with the grievance form. A-A then reported her concern to facility leadership. During an interview 4/30/25 at 9:48 a.m., (SS)-B stated no involvement in R53's grievance in February or March of 2025. During an interview 4/30/25 at 9:53 a.m., Administrator stated on or about 3/7/25, a nursing assistant entered R53's room without checking the Kardex, the aid started to do cares, R53 said to stop, and he left the room. The administrator indicated the issue was addressed with the aid, however was unable to locate the grievance form, or any written resolution provided to R53. Administrator confirmed someone was aware of the incident and it was investigated but there was no resolution or follow up by the facility provided to R53 at that time. Facility Policy titled Complaint and Grievance, revised 9/2023 stated, a grievance form should be completed when a complaint has been given to any employee of the facility. All completed grievance forms will be kept on record at the facility for a period of no less than three years.

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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. 49339 Based on interview, observation, and documentation review, the facility failed to ensure a comprehensive care plan was developed and maintained to ensure appropriate care was provided for 1 of 1 resident (R51) reviewed for smoking. Findings include: R51's admission Minimum Data Set (MDS) assessment, dated 2/19/25, indicated R51 had intact cognition with no hallucinations or delusions present and no behaviors. Section J: Health Conditions indicated R51 currently used tobacco. Section O: Special Treatments and Programs indicated R51 used oxygen. R51's Admission Record, printed 5/1/25, identified R51's admitted to the facility as 2/13/25. Furthermore, it identified the following relevant diagnoses: nicotine dependence, emphysema (chronic lung disease that progressively damages the tiny air sacs in the lungs), and congestive heart failure (condition where the heart doesn't pump blood as efficiently as it should). During an interview on 4/28/25 at 6:54 p.m., R51 stated she smoked cigarettes. R51 stated she had smoked for a long time. R51 stated the facility assessed me to make sure I am ok to smoke. R51 stated she had smoked since she has been at the facility and staff had been aware of her smoking. R51 stated she currently used oxygen at night only and did not wear it during the day. R51 stated she never wore her oxygen when she smoked. R51's care plan, reviewed on 4/28/25, lacked evidence of R51 being a current cigarette smoker. Furthermore, the care plan lacked the identification of safety interventions needed during the smoking assessments (i.e., ensuring resident removes oxygen while smoking). R51's Smoking Evaluations, dated 2/13/25, 2/17/25 and 4/14/25, identified R51 as a current smoker. During interview on 4/30/25 at 10:41 a.m., registered nurse (RN)-B verified they work with and were familiar with R51. RN-B stated R51 currently smoked and had smoked since admitting to the facility. RN-B reviewed R51 electronic medical record (EMR) and verified three smoking assessments had been completed. RN-B stated if a resident was identified as a smoker it should be on the care plan as everything should be on the care plan. RN-B verified R51 lacked identification that R51 was a smoker. RN-B verified they were adding it to the care plan during the interview, stating, it should be on there. During an interview on 5/1/25 at 8:48 a.m., registered nurse manager (RN)-D stated when a resident admitted to the facility, a smoking assessment was to be completed which included observing the resident smoke, and assessing for safety risks and concerns. RN-D stated if a resident was a smoker it needs to be added to the care plan. RN-D stated R51 currently smoked. RN-D reviewed R51's EMR and verified smoking assessments completed on 2/13/25, 2/17/25, and 4/14/25. RN-D reviewed R51's care plan and stated, I might be wrong, but it shows a date initiated 4/30/25, for smoking but I am not sure if I am looking at it right. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/1/25 at 9:29 a.m., director of nursing (DON) reviewed R51's EMR. DON verified R51 was a current smoker, had smoked since admission, and the care plan had not been updated until 4/30/25 (two days after survey entrance). DON stated it was important to have a comprehensive care plan as that is how you care for the resident. A facility policy titled Care Planning, dated 11/2024, indicated The care plan shall be used in developing the resident's daily care routines and will be utilized by staff personnel for the purposes of providing care or services to the resident.

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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** 51567 Based on observation, interview, and document review, the facility failed ensure the care plan was updated and revised to reflect current interventions for 1 of 1 resident (R62) reviewed for positioning and mobility. Findings include: R62's quarterly Minimum Data Set (MDS) dated [DATE], identified R62 as independent with mobility, had no upper extremity impairment (shoulder, elbow, wrist, hand), and used a walker. R62's Occupational Therapy Discharge Summary dated for services March 12, 2025, through April 9, 2025, indicated therapy was provided seven times for muscle weakness. R62's therapy involved improved strength for the left wrist, and R62 was given a brace on 4/9/25. Therapy directed R62 to wear the brace as tolerated. R62's care plan with a review date of 3/17/25, indicated a walking program of 200 feet one to three times per day with an assist of one during ambulation, bed movements, and transfers. The care plan lacked updates after R62 was discharged from therapy to walk independently with his walker and given a brace for his left wrist. R62's progress note dated 4/11/25, indicated R62 had a diagnoses of chronic kidney disease, type two diabetes, orthostatic hypotension, dehydration, and a failure to thrive (gain weight). R62's medications were noted as increasing a risk for falls and that R62 was an assist of one with transfers and mobility and with all activities of daily living. R62's progress note dated 4/17/25, indicated R62 was seen by the medical doctor and no new orders or changes to the current plan of care. R62 was also seen by the nurse practitioner on 4/16 no new orders or changes to the current plan of care. During observation and interview on 4/28/25 at 4:10 p.m., R62 was wearing a black brace on his left wrist. R62 stated the brace was for significant pain but was unable to explain the reason for its use or where it came from. (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 4/30/25 at10:54 a.m., director of therapy (DOT)-A stated that R62 had recently undergone therapy for hand weakness and joint pain in the thumb, with therapy sessions from March 12, 2025, through April 9, 2025. DOT-A also confirmed that R62 had participated in therapy on three separate occasions in 2024. Additionally, DOT-A confirmed that the brace on R62's left hand was used for joint pain and the brace was applied intermittently with R62 being independent with its use, and continued use was recommended. R62 discharged with independent use of a walker and self-cares. DOT-A stated R62 needed no supervision with the walker or the brace at the time of discharge and managed these items independently. Nursing managed any care plans or concerns related to their use. R62 was given a green card and walked the entire facility. DOT-A confirmed R62's care plan stated he was on a walking program of 200 feet one to three times a day with staff assist and acknowledged the care plan needed to be revised. Licensed practical nurse (LPN)-D, who shared a desk with therapy, joined the interview, reviewed R62's care plan, and acknowledged R62 was now independent with his walker and was no longer on the walking program. Additionally, LPN-D stated the wrist brace wasn't care planned because R62 was independent with its use and the walking proram was a standing order and did not need revision. During an interview on 4/30/25 at12:26 p.m., registered nurse (RN)-D stated all braces and splits should be care planned and positioning should be checked under skin to make sure it is intact. RN-D reviewed R62's care plan and confirmed the care plan did not mention the brace worn on the left wrist. RN-D stated it was important to put braces on the care plan to monitor for alteration of skin integrity and skin breakdown. A policy titled Care Planning revised on 11/2024 and stated the care plan shall be used in developing the resident's daily care routines and will be utilized by staff personnel for the purposes of providing care or services to the resident. The plan of care will be utilized to provide care to the resident. The care plan is to be modified and updated as the condition and care needs of the resident changes.

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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** 47495 Based on interview and document review the facility failed to reassess a resident with known constipation to determine what, if any, new interventions could be put in place to prevent constipation for one of one resident (R28) reviewed for constipation. Findings include: R28's quarterly Minimum Data Set (MDS), dated [DATE], indicated R28 was cognitively intact, was frequently incontinent of bowel without a bowel program, and required substantial to maximum assistance with toileting. R28's diagnoses, dated 3/7/25, indicated R28 had several medical diagnoses including Parkinson's Disease in which constipation is a common symptom. R28's bowel movements document in April indicated R28 often went three or more days in between bowel movements. R28's first documented bowel movement in April was 4/10/25, indicating 10 days without a bowel movement. R28 also did not have a bowel movement between 4/17/25 and 4/20/25 indicating three days between bowel movements, between 4/20/25 and 4/26/25 indicating 6 days between bowel movements, and between 4/20/25 and 4/29/25 only 1 small bowel movement was documented. R28's Orders indicated R28 had an order for Polyethylene Glycol Powder (Miralax) 17 grams by mouth two times a day for constipation, dated 1/22/25, and Senna- Docusate Sodium 8.6-50 milligrams (ml) two tablets two times a day for constipation, dated 12/3/24. R28's most recent Bowel Evaluation, dated 11/13/24, indicated R28 was continent of bowel but lacked any further assessment of R28's typical bowel movement patterns, what was normal or abnormal for her, and interventions attempted, or in place, to prevent constipation. R28's progress notes, dated 4/1/25 - 4/28/25, lacked any notes of R28's constipation or intervention used to promote bowel movements. On 4/29/25, it was documented R28 reported constipation to the nursing assistant (NA) and was offered milk of magnesia and an additional Senna in addition to her scheduled Miralax and Senna. It was also documented on 4/29/28, that R28 was also given prune juice by the nurse. During an interview on 4/28/25 at 5:15 p.m., R28 stated she had not had a complete bowel movement in over a week, stating she was often constipated due to her diagnosis of Parkinson's disease and was starting to have stomach pain due to her constipation. During an interview on 4/30/25 at 9:48 a.m., NA-E stated it was expected that the NAs document each shift if a resident had a bowel movement, stating the NAs did not do any of the tracking of bowel movements but that the nurses should be tracking when a resident had a bowel movement last to determine if they needed additional interventions to promote a bowel movement. NA-E stated R28 struggled with constipation but was unsure what the nurses did to help her manage her constipation. (continued on next page)

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	245067	A. Building B. Wing	05/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Emeralds at Faribault LLC	500 Southeast First Street Faribault, MN 55021

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/30/25 at 10:43 a.m., licensed practical nurse (LPN)-E stated it was expected that bowel movements were tracked, stating the NAs should let the nurses know if a resident had not had a bowel movement and that the clinical manager also tracked bowel movements. LPN-E stated most residents were already on Senna or Miralax but if it gets bad and a resident does not have a bowel movement in 3-4 days then a suppository should be given. LPN-E stated Milk of Magnesia was also available to give to residents as needed and any interventions used to promote a bowel movement should be documented in progress notes. LPN-E stated R28 seemed to struggle with constipation and reported that the Miralax was not effective for her so LPN-E would offer her milk of magnesia. During an interview on 4/30/25 at 12:42, nurse manager and registered nurse (RN)-D confirmed R28 struggled with constipation and stated the expectation was that on day three of no bowel movement the nurses should be offering prune juice or Milk of Magnesia, and if there is no bowel movement by bedtime that day the nurses should be offering to administer a suppository. RN-D stated R28 at times would toilet herself independently and the NAs should be asking R28 each shift if she had a bowel movement. During a follow up interview on 5/1/25 at 7:58 a.m., RN-D stated bowel assessments were completed on admission, annually, with a significant change in condition and as needed. RN-D confirmed R28 should be reassessed to determine what changes could be made to her bowel regiment to prevent frequent episodes of constipation and that she had reached out to the provider yesterday. A policy on constipation management was requested and not received.

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51567 Based on observation, interview and document review, the facility failed to follow-up and implement treatment for improved hearing for 1 of 1 resident (R62) who had complaints of hearing loss which were not addressed. Findings include: R62's admission Minimum Data Set (MDS) dated [DATE], identified R62 as highly impaired with the absence of useful hearing, did not wear hearing aids, and had a diagnosis of unspecified sensorineural hearing loss. R62's care plan initiated 9/23/24, indicated the use of a pocket talker to aid in communication, but failed to mention the use of R62's hearing aids. R62's most recent care plan with a review date of 3/24/25 indicated sensorineural hearing loss bilaterally. The care plan indicated the use of a pocket talker to aid in communication as needed and to speak clearly and distinctly to the resident, but failed to mention R62's hearing aids. R62's physician's note dated 12/12/24, indicated R62 wore hearing aids. R62's quarterly Minimum Data Set (MDS) dated [DATE], identified R62 had no cognitive impairment. Further, R62 had moderate difficulty with hearing and did not wear hearing aids. R62's treatment administration records (TAR) were reviewed from December 2024 through April 2025. The TAR failed to list any type of hearing device for R62 during this timeframe, and included orders started 4/29/25 to place and remove hearing aids. R62's quarterly MHM Hearing and Vision Form V3 dated 2/27/25, selected moderate difficulty for ability to hear and indicated R62 did not use hearing aids. During observation and interview on 4/28/25 at 5:52 p.m., R62 indicated he could not hear, had difficulty communicating his needs, and wanted to know if the facility was going to help with hearing aids. R62 was observed with no hearing aids. During an interview on 4/29/25 3:25 p.m., nursing assistant (NA)-B stated NAs carried care sheets to determine what residents had adaptive equipment but failed to have a care sheet readily available. NA-B located a care sheet from an office down the hall dated 4/18/25, and confirmed no hearing aids were listed for any of the residents on the unit which included R62. NA-B stated residents should tell staff if they wear hearing aids, but the care sheets should be updated with that information in case the resident couldn't inform the aid. NA-B confirmed the treatment administration record in the computer identified residents who needed hearing aids placed in the morning and removed at night. NA-B confirmed R62's care sheet and care plan did not indicate hearing aids, but R62 had a new order dated 4/29/25 to remove hearing aids. Nursing assistant (NA)-C also confirmed the care sheets were not accurate for the residents on the unit since there were two other residents who both also wore hearing aids. (continued on next page)

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/30/25 at 8:40 a.m. nursing assistant (NA)-D stated R62 had hearing aids for years but hasn't worn them frequently until this morning. NA-D stated the activities director (A)-A found batteries and A-A mentioned having R62 wear his hearing aides today, 4/30/25, but NA-D could not confirm. During an interview on 4/30/25 at 8:48 a.m., A-A reported that during a conversation with R62 on 4/29/25, R62 mentioned having difficulty hearing and was offered a pocket talker. R62 also noted that he had hearing aids in the closet but hadn't worn them in a while. R62 then removed two hearing aids from a tote, and A-A assisted with inserting new batteries. During interview on 4/30/25 at 12:17 p.m., registered nurse (RN)-D confirmed completing the quarterly MHM Hearing and Vision Form V3 dated 2/27/25. RN-D talked with R62 and confirmed moderate difficult hearing and stated R62 denied having hearing aids in his ears nor were any on the bedside table. RN-D asked the on-duty nursing assistant who indicated R62 did not wear hearing aids, although RN-D could not recall who the aid was working during the assessment. RN-D stated. RN-D confirmed R62 did have difficulty hearing during the assessment and did not have a consent on file for a referral for hearing aids. RN-D noted a refusal in the R62's electronic medical record that he did not want a referral for hearing aids, dated 9-20-24. Medication and Treatment Policy, revised 2/24 stated orders for medications and treatments will be transcribed accurately and in a timely fashion. The policy failed to directly mention hearing aids or adaptive devices.

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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** 33925 Based on observation, interview and document review, the facility failed to comprehensively reassess and, if needed, determine or develop proactive interventions to help address pressure injury risk and development after a new pressure injury was identified (i.e., change of condition) for 1 of 2 residents (R13) reviewed whom had active pressure injuries. Findings include: The Centers for Medicare (CMS) State Operations Manual (SOM) Appendix PP, dated 2/2023, identified definitions for pressure ulcer care and treatment. This included guidance provided on the several stages of injury definition which included, Stage 3 Pressure Ulcer: Full-thickness skin loss . subcutaneous fat may be visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present. Slough and/or eschar may be visible . depth of tissue damage varies by anatomical location . Undermining and tunneling may occur . R13's quarterly Minimum Data Set (MDS), dated [DATE], identified R13 had intact cognition along with multiple medical conditions including heart failure, high blood pressure, and multiple sclerosis (MS). The MDS outlined R13 consumed multiple high-risk medications including opioids, diuretics and antiplatelets. Further, the MDS identified R13 was at-risk for pressure injury development and had one current stage IV pressure injury which had not been present upon admission. On 4/28/25 at 3:05 p.m., R13 was observed lying in bed while in her room. R13 had an air-alternating pressure mattress (APM) on her bed and was interviewed. R13 stated she had a sore on my butt which staff did a dressing change on multiple times a day. R13 stated she felt the wound was slowly healing but would likely never resolve. R13 stated she obtained the wound from sitting in her wheelchair for extended periods and reiterated it would likely never heal adding, No matter what I do, it will never go away. R13 denied concerns with the wound and requested to end the interview due to feeling unwell. R13's [NAME] Northwestern Hospital Wound Clinic Progress Note, dated 4/10/25, identified R13 was seen in the office for a wound check. R13's past medical history of her wounds was outlined within the note. This identified R13 presented in August 2024, for initial evaluation of the sacrum wound which had been present for . a few weeks and that it began without a clear cause. A section labeled, Treatment Course, identified each visit and subsequent information of the wound and it's progress. On 1/27/25, the note recorded R13 was seen by a plastic surgeon and an MRI was ordered. R13 was recorded as being on protein supplement daily and having wound cares done . one or two times daily. On 4/10/25, the note recorded R13 was identified to have a new wound to the right IT [ischial tuberosity] today. R13 was listed as continuing to get up in her wheelchair for approximately four hour increments every other day, still smoking, and still using protein supplement. The note recorded R13's new wound as, Pressure Injury Stage [blank space] Stage 3, and listed it as having some slough present and being 3.4 X 1.5 X 0.1 (cm) in size. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R13's care plan, printed 4/30/25, identified R13's actual or potential medical and/or care-related problems and corresponding interventions to address them. The care plan identified R13 had an alteration in skin integrity and required extensive assistance with bed mobility adding, Resident runs the show . The care plan listed multiple interventions to address R13's skin risk and concerns including limiting her time seated in the powered wheelchair, monitoring skin integrity with cares, and using an air mattress. The last time the interventions were revised prior to the onsite survey was recorded as, 09/27/2024, with multiple interventions being added and/or revised on 4/29/25 and 4/30/25 (after survey started). R13's MHM (Monarch Healthcare Management) Skin Evaluation and Skin Risk Factors V-2, loaded 10/20/24, was identified with dictation present, In Progress. However, the entire evaluation was left blank and not completed. There were no additional Skin Evaluation and Skin Risk Factors V-2 evaluations loaded or completed in the record. On 4/29/25 at 12:36 p.m., nursing assistant (NA)-A was interviewed, and verified they had cared for R13 prior adding, [I've] worked with her many times. NA-A explained they often helped the nurses complete R13's wound care and stated R13 rarely got up from her bed due to her own choice. NA-A stated R13 would also, at times, refuse meals and seemed not not really want you in there much. NA-A stated R13 used an air mattress and nurses would mix medications into her mashed potatoes. NA-A stated they were unsure how long R13 had the sacral pressure wound but added, Since I started [working there]. NA-A described R13 as being somewhat dismissive and independent with her cares adding, She knows what she wants. R13's dietary progress note, dated 4/24/25, identified a nutrition follow-up was completed due to R13's weight and wound adding, Discussed resident at IDT [interdisciplinary team] wound meeting. R13's weight was outlined as stable and added, Will discuss with nurse manager about increasing protein powder to 2 scoops per serving to better meet protein needs which would provide ~24 gm [grams] protein. However, the note lacked evidence of what, if any, other factors the IDT had reviewed which could contribute to pressure ulcer risk or skin breakdown (i.e., mobility, medication use, continence) to determine what, if any, interventions were needed to reduce the risk of skin breakdown and promote healing since R13 developed a new pressure injury on 4/10/25. When interviewed on 4/29/25 at 1:37 p.m., registered nurse (RN)-A stated they had worked with R13 multiple times prior. RN-A explained R13 did not like to get up from bed and would only get into her electric wheelchair like every 3rd day which was usually just so she could smoke outside. RN-A verified R13 had an active wound on her sacrum and expressed it was larger sized than an orange (fruit) adding oh, it's bigger. RN-A stated the wound was slow to heal due to R13 being resistive with interventions and getting out of bed adding R13 had super, super fragile skin. RN-A stated they were aware of R13 having a second wound now, however, RN-A stated they felt it was a little tiny one and due to bandage-tape being pulled off the skin. RN-A stated they felt the wounds were both getting better just slowly adding aloud, It's really slow to heal. RN-A stated the nurse manager would like know more about the wounds as they tracked it and measure it. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/30/25 at 9:36 a.m., licensed practical nurse manager (LPN)-C was interviewed, and verified they had a chance to review R13's medical record. LPN-C verified R13 had two active pressure injuries which both developed in-house, and explained R13 beats to her own drum with cares and interventions. LPN-C stated the wound was checked for measurements and status every week, and R13 was also being seen by an outside wound clinic for it at times. LPN-C stated R13 had been educated on the risks of not allowing repositioning and being so specific with what interventions she would allow. LPN-C explained the right IT pressure injury was new and recorded as a stage three pressure area from the wound clinic. LPN-C verified the first recorded evidence of the wound was on 4/10/25 from the wound clinic note, and explained when a new wound developed the staff wanted to obtain treatment orders, update the provider, and then the plan of care needed to be updated. LPN-C stated R13's wound treatments were tweaked due to the new wound. LPN-C stated the facility' skin evaluation evaluation (i.e., MHM Skin Evaluation and Skin Risk Factors V-2) was just an extra tool to help review someone adding the comprehensive part of the review could be more within the IDT discussion which happened every morning. LPN-C then provided a Microsoft Word document which had IDT notes listed on it. The untitled page, undated, identified R13's name along with, New Wound Right IT. The page outlined, IDT discussed and reviewed Care Plan and orders for any changes to interventions. Resident continues 'to run the show' and does not allow [hospital] wound clinic repositioning direction. Uses pillows. New Orders for wound healing, dietician involved, provider updated, Resident involved. However, the provided document lacked evidence what, if any, other interventions were considered, offered, refused despite R13 having multiple wounds and being resistive to recommendations. Further, R13's medical record was reviewed and lacked documented evidence R13 had been comprehensively reassessed for pressure wound risk or what, if any, interventions were considered, adopted or agreeable despite R13 developing another wound with some interventions, such as monitoring and an air mattress, already in place prior to the right IT wound developing. At this time, the director of nursing (DON) joined the interview via telephone. DON explained a new wound should be assessed and photographed, then the provider and family should be updated. DON stated the IDT would then discuss the wound and review the care plan. DON stated they felt everything was in place for R13 and reiterated R13 likes to do her own thing with cares she will allow. DON stated the skin evaluation form was just a tool and expressed they didn't feel completing one was necessarily required for a new wound development adding, We don't have a policy for that. LPN-C verified R13's medical record lacked evidence of a comprehensive reassessment being done in the evaluations or progress notes. DON acknowledged the actual medical record possibly lacked evidence of the IDT' discussion on R13's new pressure injury adding aloud, I see what you're saying. DON stated having the documentation in the medical record was important to promote continuity of care. A facility-provided Skin Assessment & Wound Management policy, dated 2/2025, identified a pressure ulcer risk assessment (Braden Scale) would be completed per an established schedule and, Skin Evaluation and Skin Risk Factors Form is completed before initial MDS, annually, and upon significant change. A section labeled, New Skin Problem, outlined a series of steps to be completed for developed pressure injuries which included notifying the provider, completing education with the resident, and initiating the Skin and Wound Evaluation (i.e., weekly monitoring). However, the policy section lacked direction or guidance on how a comprehensive reassessment process would look or be documented within the medical record.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. 49339 Based on observation, interview and record review, the facility failed to provide services to maintain and/or prevent loss of range of motion and contracture care for 1 of 1 residents (R51) reviewed for limited range of motion. Findings include: R51's admission Minimum Data Set (MDS) assessment, dated 2/19/25, indicated R51 had intact cognition with no hallucinations, delusions, behaviors or rejection of care. In addition, R51 had no impairment in function limitation in range of motion, utilized a wheelchair for mobility, dependent on staff for lower body dressing and dependent on staff for transfers. R51's Admission Record, printed 5/1/25, indicated the following relevant diagnoses: chronic pain, abnormalities of gait and mobility, dorsalgia (back pain), muscle weakness, disease of spinal cord, restless sleep syndrome and cervicalgia (neck pain). During an interview on 4/28/25 at 6:51 p.m., R51 stated she was not getting physical therapy (PT). R51 stated she had been getting occupational therapy (OT) but hadn't received any OT in probably at least two weeks. R51 expressed frustration stating, this is the whole reason I am here, and I am not getting therapy. R51 stated one of the therapy staff had told her that the nursing staff could work with my legs in bed but they aren't doing that. R51 stated she can no longer straighten her left leg which she could do prior to coming to the facility and indicated she currently used a Hoyer lift (a medical device used to transfer individuals, who cannot bear weight, with limited mobility from one place to another, such as a bed to a wheelchair). A Nursing Order-External Facility note, dated 3/4/25, indicated Patient is cleared to toe touch during transfer while wearing a Darco shoe. A Nursing Order-External Facility note, dated 4/15/25, indicated It is also recommended that the patient participate in physical therapy daily at the facility, while maintaining non-weight bearing status to the left heel, but can do to-touch transfers on the left foot. Darco shoes were provided during a previous appointment for this reason. A Nursing Order-External Facility note, dated 4/22/25, indicated It is also recommended that the patient participate in physical therapy daily at the facility, while maintaining non-weight bearing status to the left heel, but can do to-touch transfers on the left foot. Darco shoes were provided during a previous appointment for this reason. R51's care plan, printed 5/1/25, lacked evidence of a restorative nursing program. Furthermore, lacked evidence of PT recommendations or recent assessments. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/30/25 at 10:39 a.m., registered nurse (RN)-B stated that nursing and therapy work together to coordinate care for residents. RN-B stated therapy would update nursing when there were changes to how residents ambulated, transferred or were new to the program. RN-B reviewed R51's electronic medical record (EMR) and verified R51 was discharged from OT on 4/16/25. RN-B verified R51 was not receiving any restorative nursing services after reviewing R51's EMR and three-ring binder that contains information on exercises for residents participating in the restorative nursing program. RN-B verified R51 was not receiving PT services, and stated R51 relied heavily on caregiver assistance. During an interview on 4/30/25 at 11:04 a.m., registered nurse manager (RN)-D reviewed R51's EMR. RN-D stated they reviewed communication with outside providers and had reviewed Nursing Order-External Facility Notes listed above. RN-D stated she had talked to therapy about changing R51 to toe touch. RN-D stated she could not remember when she had talked to therapy, did not have documentation regarding the conversation, and stated she thought it was when she had reviewed the first note during stand up (interdisciplinary team meeting). RN-D verified R51 should have been assessed by therapy. During an interview on 4/30/25 at 11:11 a.m., director of therapy (DOT)-A stated all residents had standing orders for therapy evaluations. DOT-A stated nursing communicated to therapy when a resident needed to be assessed or reassessed. DOT-A verified R51 was currently not getting any therapy (PT/OT) services. DOT-A stated R51 had PT services from 2/16/25 to 3/13/25, and OT services from 2/16/25 to 4/16/25. DOT-A stated R51 had not been reassessed for PT services since being discharged , and stated he had been given a copy of one of the Nursing Order-External Facility notes, did not remember exactly when it was, but did verify it was after R51 had discharged from PT services. DOT-A reviewed R51's EMR and verified there was no restorative nursing program. DOT-A stated R51 had not been able to move her legs on her own since admission, and we tried to get her to move her legs, but she always asked for help. DOT-A verified R51 transferred with a Hoyer lift since admission. DOT-A verified that a PT assessment should have been completed for R51. DOT-A stated R51 might not be able to bear weight, but it would be important to prevent any contractures. During a follow up interview on 5/01/25 at 8:56 a.m., RN-D verified R51 did not receive and had not received any restorative nursing services. During an interview on 5/01/25 at 9:34 a.m., director of nursing (DON) stated he had reviewed R51's EMR. DON stated R51 should have been reassessed by therapy. DON stated it was important to work with therapy and have a restorative nursing program to see how we can improve your life and prevent things that shouldn't happen and live a better life. DON stated R51 was going to be reassessed by therapy today, and he had followed up with R51 that morning. DON had assessed R51 that morning (5/1/25) and stated R51 did not have any contractures in lower or upper extremities, decrease in extension of legs and therapy would complete a full reassessment this day. A facility policy titled Medication and Treatment Orders, dated 2/24, indicated Orders for medications and treatment will be transcribed accurately and in a timely fashion.

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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** 47495 Based on observation, interview and document review the facility failed to ensure a resident with a catheter had medical justification for continued use and failed to attempt a trial removal, if recommended, for one of one resident (R35) reviewed for indwelling catheter. Findings include: R35's quarterly Minimum Data Set (MDS), dated [DATE], indicated R35 had moderate cognitive impairment, required supervision with toileting and moderate assistance with bathing and had an indwelling catheter in place. R35's admission MDS, dated [DATE], indicated R35 was admitted with an indwelling catheter in place. R35's Diagnoses, dated 5/16/22, indicated R35 had several medical diagnoses related to potential need for an indwelling catheter including other obstructive and reflex uropathy which can hinder the normal flow or urine, unspecified retention of urine, renal hypoplasia (a congenital condition in which one or both kidneys are underdeveloped), benign prostatic hyperplasia with and without lower urinary tract symptoms (a non-cancerous enlargement of the prostate gland), and infection and inflammatory reaction due to indwelling urethral catheter. However, the electronic medical record (EMR) failed to demonstrate duration of the retention, attempts (if any) to manage without a catheter, and medical justification for why the catheter was necessary on an ongoing basis (i.e neurogenic bladder). The EMR further lacked any evidence of post void residual (PVRs) to determine the extend of R35's urine retention. A urology note for R35, dated 7/28/22, stated anticipate SP (suprapubic catheter - a urinary catheter that is surgically inserted through the abdominal wall directly into the bladder) on 8/17/22. The EMR lacked any evidence of follow up on this order or potential for a SP catheter to be placed. During an interview on 4/3025 at 9:41 a.m., R35 stated he believed he had his catheter since coming to Minnesota years ago to prevent urine leaking on the plane. R35 stated it has had an indwelling catheter since then because he has only had 2-3 urinary tract infections with the indwelling catheter in place. During an interview on 4/30/25 at 12:42 p.m., nurse manager and registered nurse (RN)-D stated she emailed R35's provider that day about an appropriate catheter diagnosis, stating I don't believe we have [one]. RN-D further stated the facility had not attempted to remove R35's catheter since his admission to the care facility to assess the extent of his urine retention or if it could be managed without an indwelling catheter. During a follow up interview on 4/30/25 at 2:33 p.m., RN-D stated R35 had an appointment with urology on 5/1/25, and she would follow up on the goal for his catheter, including a proper diagnosis, order for a removal attempt, or a supra pubic placement, stating it was not clear what the goal for his indwelling catheter currently was. (continued on next page)

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	245067	A. Building B. Wing	05/01/2025

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A facility policy titled Indwelling Catheter Care Procedure was provided, however it only spoke to proper care of a residents catheter while in place i.e. peri care with a catheter, emptying catheter bags and ensuring they are draining properly.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47495 Based on interview, observation and document review the facility failed to comprehensively reassess a resident for pain who was hospitalized for concerns with her pain medication and had pain medication changes, and who still reported frequent pain for one of one resident (R1) reviewed for pain. Findings include: R1's quarterly Minimum Data Set (MDS), dated [DATE], indicated R1 was cognitively intact and independent with most activities of daily living (ADLs). The MDS further indicated during the look back period R1 received scheduled pain medication, no PRN (as needed) pain medications, and was in pain almost constantly which effected R1's sleep and day to day activities. R1's Orders indicated R1 had several medications for pain including: Buprenorphine HCl Sublingual Tablet Sublingual, give 2 milligrams (mg) sublingually one time a day for chronic pain syndrome, dated 4/11/25; Oxycodone HCl Oral Tablet 5 mg, give 1 tablet by mouth every 6 hours as needed for Chronic pain/Nonacute pain and give 2 tablets by mouth every day with wound care, dated 4/2/25; Pregabalin Oral Capsule 150 mg, give 150 mg by mouth three times a day for pain, dated 3/12/25; and Acetaminophen Oral Tablet, give 1000 mg by mouth as needed for pain three times a day, dated 2/19/25. The orders also contained an order to monitor for pain daily, dated 5/30/24, and to document any non-pharmacological pain interventions every shift, dated 10/15/24: 0: No intervention needed 1: Ice 2: Heated blankets 3: Massage 4: Repositioning 5: Music 6: Essential Oils 7: Food/Drink 8: Relaxation Breathing. R1's most current comprehensive pain assessment, dated 2/21/25, indicated R1 reports constant pain to BLEs [bilateral lower extremities] and reported 10/10 pain. R1's medication administration record (MAR) for April 2025 indicated R1 received as need Tylenol 10 times and as needed Oxycodone 15 times in the month of April. A hospital note for R1, dated 4/10/25, indicated R1 was hospitalized for concerns regarding over sedation due to changes to her pain medication buprenorphine. The note indicated more changes were made to her pain medication in the hospital including stopping buprenorphine film and patch and adding buprenorphine 2 mg sublingual tablet. The note also indicates changes were made to Pregabalin (a medication used to treat nerve and muscle pain). R1 electronic medical record (EMR) lacked evidence that R1 was comprehensively reassessed since having changes to her pain medications to see what, if any additional medications or pain interventions could be added to promote pain control despite R1 still frequently reporting uncontrolled pain. During observation and interview on 4/28/25 at 2:24 p.m., R1 was sitting in her room in her wheelchair, with tears in her eyes stating she had almost constant pain in her knees and shoulders. During an interview on 4/30/25 at 9:48 a.m., R1 stated her left leg was in excruciating pain. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/30/25 at 9:48 a.m., nursing assistant (NA)-E stated R1 would complain of pain at times, and she would let the nurses know, though she did not work with R1 often. During an interview on 4/30/25 at 10:43 a.m., licensed practical nurse (LPN)-E stated R1 had been having issues with her legs and often had pain. LPN-E stated they would assess R1's pain level and need for non-pharmacological pain interventions prior to administering PRN pain medications but that she was not responsible for comprehensive pain assessments. During an interview on 4/30/25 at 12:42 nurse manager and registered nurse (RN)-D stated comprehensive pain assessments would be expected to be completed quarterly and with a change in condition, stating a hospitalization would be considered a change in condition and she would have expected a comprehensive pain reassessment to be completed with R1 after her hospitalization with pain medication changes. RN-D confirmed R1 had not been comprehensively assessed for pain since 2/21/25. A facility policy on pain was requested and not received.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 51567 Based on observation, interview, and document review, the facility failed to ensure the three-compartment dish sink was of proper sanitization parts per million (ppm) which had the potential to affect all 76 residents who received meals from the main kitchen. Furthermore, the facility failed ensure employees wore beard restraints to prevent hair from contacting food. Findings Include: A report titled Diet/consistency Rollup printed on 4/30/25, categorized each diet and had total meals served out of the main kitchen as 76. During the initial kitchen walk through conducted on 4/28/25 at 1:22 p.m., an area over the three-compartment sink had logs for documentation of water sanitization for April 2025, completed for April 1-24th. Above the sink were two large bottles held by a wire rack with two tubes that ran down into the three compartment sink, both were empty. The bottle on the left was labeled quaternary sanitizer and the one on the right was labeled pot/pan detergent and sanitizer. A large bottle of Dawn dishwashing detergent sat on the far right of the three-compartment sink. A cook was wearing a navy-blue baseball cap and had a beard that extended from the chin approximately 1. During an interview on 4/28/25 at 2:11 p.m., culinary services director (DOC)-A confirmed hair nets were available for employees and donned one himself. DOC-A stated employees needed to either wear a hat or a hairnet. DOC-A then stated if a beard was too big they need to wear a cover or shave it, and after a couple of days beards should be shaved or covered or else it could fall into the resident's food. DOC-A could not recall a facility policy on beards in the kitchen, but said employees would be written up if they didn't wear a beard restraint. DOC-A confirmed beard restraints were not available for employees at the kitchen entrance or in the office on 4/28/25. During an observation on 4/29/25 at 11:43 a.m., The pots/pan detergent and sanitizer bottle above the three compartment sink had approximately 1 inch of a blue bubbly solution. On the right hand of the three-compartment sink was a large bottle of Dawn dish detergent. During an observation and interview on 4/29/25 at 12:07 p.m., cook (C)-A removed a puree mixer lid and blade from the drying rack located on the left of the three-compartment sink. C-A stated the puree mixer was hand washed with Dawn and often Dawn detergent was added to the pots/pans bottle above the sink. Dawn and water were then mixed and the sink was filled to wash pots, pans, and kitchen utensils. During an interview on 4/29/25 at 2:08 p.m., dietary aid (DA)-A stated the three-compartment sink area was used for pots and pans. The pots and pans were scrubbed with Dawn and then used to cook. All resident dishware was put through dishwasher. During an observation on 4/30/25 at 12:41 p.m., Dawn dish detergent was used to wash a clear/gray plastic top to the puree mixer. The top was rinsed off and set on the side of the sink to dry. These items were rinsed less than 30 seconds. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 4/30/25 at 12:43 p.m. C-A stated no thermometer was available to check the water coming out of the sink and confirmed a puree blender top were hand washed with Dawn and other kitchen utensils. During an observation on 5/1/25 at 9:44 a.m., a three-compartment sink had a large bottle of Dawn dish soap. During an interview on 5/1/25 at 10:31 a.m., DOC-B stated the facility policy allowed for manually washing dishes in the three-compartment sink, but all dishes needed to be sent through the dishwasher to be sanitized. DOC-B stated he was not aware the cooks were manually washing and reusing the items without sending the items through the dishwasher and replied, oh no, they can't do that to which the nearby DOC-A responded, yes we talked about that. DOC-B also confirmed beards should be no longer than a 1/2 for all Monarch facilities and that C-A should wear a beard cover. Facility Policy titled Sanitization, revised October 2008, #9 Manual washing and sanitizing will employ a three-step process for washing, rinsing and sanitizing. C: Sanitize with hot water or chemical sanitizing solution. Chemical sanitizing solution may consist of: Chlorine, Iodine, Quaternary ammonium. Facility Policy titled Cleaning and Disinfection, revised September 2012, Mixer bowls, beaters, grinders, pots, pans, roasters, electric knife, blades, food thermometers, etc. 1. Wash in 3 compartment sink or dishwasher: a. 1st compartment-soap and water (110-120 degrees Fahrenheit). B. 2nd compartment-clear water for rinsing (120 degrees Fahrenheit). c. 3rd compartment-Detergent/disinfectant (170 degrees Fahrenheit for 2 minutes). 2. Allow to remain wet for 10 minutes to air dry. Facility Policy titled Food Preparation and Service, revised April 2019, Food and nutrition services staff wear hair restraints (hair net, hat, beard restraint, etc.) so that hair does not contact food

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. 33925 Based on observation, interview, and document review, the facility failed to ensure soiled personal laundry and linens were bagged (i.e., contained) at the point-of-use and transported in a manner to reduce the risk of cross-contamination and potential infectious spread in 1 of 1 main washrooms and 2 of 2 units (70's, 90's) reviewed. This had potential to affect all 75 residents within the care center. Findings include: On 4/29/25 at 7:57 a.m., the campus' main laundry washroom was toured with housekeeper (HSK)-A present. HSK-A explained they were the primary person who completed laundry for the care center, and they then provided a tour of the laundry process and the machines used. The soiled linen receiving area and washroom were located on one side of the hallway and folding area (clean) on the opposite. However, in the hallway between these areas were a series of mobile, off-white colored hard plastic bins including one labeled, Soiled Linen Only, in black paint. The bin was covered with a light-blue colored cloth covering which was lifted exposing it's contents which was soiled white linens and personal clothing, much of which was not bagged but rather loose in the bin causing articles to touch. HSK-A verified the items were not bagged and expressed they should have been prior to transport. HSK-A stated the bin was likely brought down last evening by the nursing assistant (NA) staff. HSK-A stated they had, at times, noticed soiled laundry items to be coming down to the main washroom not bagged adding aloud on occasion, yes. HSK-A stated they had talked about the issue with the care center administrator in the past, however, added, But not as frequently as maybe I should have, to be honest. HSK-A then verified they had not collected any soiled linen from the units today yet. A tour of the '70's Unit' was then completed. The soiled utility room was opened with HSK-A present which, inside, had three mobile, off-white containers similar to the one observed by the washroom. HSK-A stated two were used for trash and one was used for soiled linens and personal clothing. The laundry container had a balled-up light-blue cloth cover inside the corner of the container and, again, nearly all of the soiled laundry inside was not bagged. HSK-A stated they items should be bagged at the point-of-use and not transported loosely like it appeared had happened adding aloud, [They should be] bagging in, bagging out. HSK-A stated most of the personal laundry and linens were laundered by the care center adding, Pretty much [yes]. HSK-A stated the soiled linen should be bagged to help prevent cross contamination between the garments. Following, a tour of the '90's Unit' was then completed. The soiled utility room was opened with HSK-A present which, inside, had multiple mobile, off-white containers similar to the one observed by the washroom and '70's unit.' The container for soiled linens and laundry was uncovered and, inside, nearly all of the garments and linens were not bagged. Further, sitting on top of the soiled laundry was two yellow-colored bags which had markings on them to indicate potential bio-hazard (i.e., isolation room, active infection). HSK-A verified the items were not covered or bagged and stated aloud, That will be addressed today. HSK-A stated they did complete audits of laundry care which included walking around with the administrator and observing general cleanliness. HSK-A stated they would provide these for review. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	A series of three Monthly Facility Tour Form(s), dated 12/27/24 to 3/28/25, were provided. These outlined various areas of the care center and provided spacing to record a score (0 to 10) of cleanliness of the corresponding area. A section was listed, Laundry/Linen, which outlined three specific areas to review including linen closets, personals, and laundry room. The spacing provided to write-out any comments was left blank and no concerns were written. However, the provided audits all lacked evidence the soiled utility rooms (where soiled linens were kept until transport to the washroom) were included in the review or audit process. On 4/30/25 at 10:01 a.m., the interim director of nursing (DON) was interviewed, and they verified they were the campus' infection preventionist (IP). DON explained they have educated staff through staff meetings and such about the need to bag soiled items where collected, and he verified soiled laundry and linens should be bagged prior to transport. This was important to do as staff could spread infections from one place to another. DON added, We will continue to do staff education and follow-up with the staff. A facility-provided Infection Prevention and Control Program policy, dated 11/2024, identified the facility would establish and maintain an infection prevention and control program (IPCP) designed to provide a safe, sanitary and comfortable environment. The policy outlined several steps taken with this program including infection surveillance, antibiotic stewardship and data analysis; however, the policy lacked information on soiled linen handling or transportation. A separate, facility-provided Skill 6. Gown, Glove, and Bag Linen protocol, undated, identified a checklist for staff to implement with gown removal and soiled item collection in an isolation room. This identified, 5. Remove the soiled linen. Keep the linen contained during removal and place in the appropriate bag/receptacle. A facility' policy on soiled laundry handling and transportation was not provided.