

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

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245067	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/22/2026
NAME OF PROVIDER OR SUPPLIER The Emeralds at Fairbault LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. Based on interview and document review, the facility failed to ensure ongoing surveillance for infections, ongoing review of surveillance data, and documentation of follow-up activity and response. This practice had the potential to affect all 82 residents residing in the facility. Findings include: Review of the facility infection control binder provided 7/20/26, did not include line listing, mapping, or surveillance data for tracking and monitoring infections in the facility. During interview on 7/22/26 at 10:30 a.m., assistant director of nursing (ADON) stated she was new, had just started a few weeks ago, and was also hired to be the infection preventionist. ADON stated she had searched the prior infection preventionist's office, binders, and files and was unable to locate any infection control tracking, data, surveillance, or mapping documents. ADON stated she had to start from scratch and would need to implement a new program and start fresh. During interview on 7/22/26 at 1:32 p.m., interim director of nursing (IDON) stated the prior infection preventionist had left and they had just replaced her with ADON. IDON stated she was unable to find any evidence of surveillance or tracking of infections and ADON had been working on getting things up and running but things were not fully in place yet for infection prevention. Facility Infection Prevention and Control Program policy dated 11/2024, indicated the following: The Infection Control Program is comprehensive in that it addresses detection, prevention and control of infections among residents and personnel. The major elements of the program are: Coordination/Oversight, Policies and Procedures, Surveillance, Data analysis, Antibiotic Stewardship, Outbreak Management, Prevention of Infection, Employee Health.		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245067	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/22/2026
NAME OF PROVIDER OR SUPPLIER The Emeralds at Fairbault LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Implement a program that monitors antibiotic use. Based on interview and document review, the facility failed to implement a process for antibiotic review to determine appropriate indications, dosage, duration, trends of antibiotic use and resistance. This had the potential to affect all 82 residents residing in the facility. Findings include: Review of the facility infection control binder provided on 7/20/26, indicated no antibiotic tracking for correct indications, dosage, duration, resistance, and no 72-hour time-outs (a check that the resident is on the right antibiotic) to review cultures and verify correct antibiotics or resistance to prescribed antibiotics. During interview on 7/22/26 at 10:30 a.m., assistant director of nursing (ADON) stated she was new to the facility, had been hired to be the infection preventionist, and had just started working on an antibiotic stewardship program. ADON further stated she was unable to find any documents from the prior infection preventionist to show that antibiotic usage was being tracked and monitored. ADON stated she had started working backwards tracking antibiotics and had made it back a few months. ADON stated she did not think anything had been done with antibiotic stewardship or infection prevention for the year prior. During interview on 7/22/26 at 1:32 p.m., interim director of nursing (IDON) stated the prior employee in charge of antibiotic stewardship had left the facility. IDON was unable to find any evidence of tracking of antibiotic usage for correct dosage, duration, resistance, or that 72-hour time-outs were being completed to ensure proper antibiotic use. IDON stated she was aware this was a problem at the facility and ADON was working on antibiotic stewardship. IDON stated this was an area that needed improvement and that antibiotic usage should be monitored to ensure residents are getting the correct treatment and prevent worsening of symptoms. Facility Infection Prevention and Control Program policy dated 11/2024, indicated the following: Antibiotic Stewardship: Culture reports, sensitivity data, and antibiotic usage reviews are included in surveillance activities. Medical criteria and standardized definitions of infections are used to help recognize and manage infections. Antibiotic usage is evaluated and practitioners are provided feedback on reviews.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245067	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/22/2026
NAME OF PROVIDER OR SUPPLIER The Emeralds at Fairbault LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to ensure each resident or the resident's representative received education on pneumococcal immunization and failed to offer resident's the opportunity to receive or decline pneumococcal immunizations for 3 of 5 residents (R2, R35, R69) reviewed for immunizations. Findings include: R2's quarterly Minimum Data Set (MDS) assessment dated [DATE], indicated intact cognition, and diagnoses of cancer, high blood pressure, renal (kidney) failure, and diabetes mellitus. R35's quarterly MDS assessment dated [DATE], indicated intact cognition, and diagnoses of high blood pressure, malnutrition, renal (kidney) insufficiency, and chronic lung disease. R69's admission MDS dated [DATE], indicated intact cognition, and diagnoses of heart failure, fracture, and malnutrition. Review of R2's electronic health record (EHR) in Point Click Care (PCC) column titled Immunizations on 7/22/26 at 8:35 a.m., indicated no immunizations on file with the facility. Review of R2's facility form titled Resident Vaccine Administration Consent form dated 4/21/26, indicated no vaccines marked to be administered, and no vaccines marked as declined. No dates were listed for prior vaccines. No education provided. The form was signed by R2 but was not filled out by facility staff. Review of R35's EHR in PCC on 7/22/26 at 8:35 a.m., indicated past history of pneumococcal immunization (PCV 20) on 11/24/23. There was no facility form titled Resident Vaccine Administration Consent form on file for R35 to indicate she was educated on vaccines or given the opportunity to accept or decline any needed vaccines. Review of R69's EHR in PCC on 7/22/26 at 8:35 a.m., indicated she had no immunizations on file with the facility. Review of R69's facility form titled Resident Vaccine Administration Consent dated 6/25/26, indicated no vaccines marked to be administered, and no vaccines marked as declined. No dates were listed for prior vaccines. No education provided. Review of facility immunization records in the facility electronic health record (EHR) on 7/22/26 at 8:35 a.m., indicated no documentation that pneumococcal immunization education had been offered and further indicated pneumococcal vaccines were not offered to R2, R35, and R69. During interview on 7/22/26 at 10:30 a.m., assistant director of nursing (ADON) stated she was new to the facility and had just started a few weeks ago. ADON stated she recognized a concern with vaccines not being offered to residents when she was reviewing records. She verified that forms included in the admission documents were not filled out, and immunizations were not documented in the facilities electronic health record (EHR). ADON stated she would need to educate nurses about educating and offering vaccines to residents. ADON stated she had a plan to work with the pharmacy to get all residents who wanted vaccines up to date on their vaccines. Facility Infection Prevention and Control Program policy dated 11/2024, indicated the following: Prevention of Infection: Immunizing residents and staff to try to prevent illness.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245067	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/22/2026
NAME OF PROVIDER OR SUPPLIER The Emeralds at Fairbault LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to ensure each resident or the resident's representative received education on Covid-19 immunizations and boosters and failed to offer Covid-19 immunizations for 3 of 5 residents (R2, R35, R69) reviewed for immunizations. Findings include: R2's quarterly Minimum Data Set (MDS) assessment dated [DATE], indicated intact cognition, and diagnoses of cancer, high blood pressure, renal (kidney) failure, and diabetes mellitus. R35's quarterly MDS assessment dated [DATE], indicated intact cognition, and diagnoses of high blood pressure, malnutrition, renal (kidney) insufficiency, and chronic lung disease. R69's admission MDS dated [DATE], indicated intact cognition, and diagnoses of heart failure, fracture, and malnutrition. Review of R2's electronic health record (EHR) in Point Click Care (PCC) column titled Immunizations on 7/22/26 at 8:35 a.m., indicated no immunizations on file with the facility. Review of R2's facility form titled Resident Vaccine Administration Consent form dated 4/21/26, indicated no vaccines marked to be administered, and no vaccines marked as declined. No dates were listed for prior vaccines. No education provided. The form was signed by R2 but was not filled out by facility staff. Review of R35's EHR in PCC on 7/22/26 at 8:35 a.m., indicated no documentation of a Covid vaccine. There was no facility form titled Resident Vaccine Administration Consent form on file for R35 to indicate she was educated on vaccines or given the opportunity to accept or decline any needed vaccines. Review of R69's EHR in PCC on 7/22/26 at 8:35 a.m., indicated she had no immunizations on file with the facility. Review of R69's facility form titled Resident Vaccine Administration Consent dated 6/25/26, indicated no vaccines marked to be administered, and no vaccines marked as declined. No dates were listed for prior vaccines. No education provided. Review of facility immunization records in the facility EHR on 7/22/26 at 8:35 a.m., indicated no documentation that Covid immunization education had been offered and further indicated Covid vaccines were not offered to R2, R35, and R69. During interview on 7/22/26 at 10:30 a.m., assistant director of nursing (ADON) stated she was new to the facility and had just started a few weeks ago. ADON stated she recognized a concern with vaccines not being offered to residents when she was reviewing records. She verified that forms included in the admission documents were not filled out, and immunizations were not documented in the facilities electronic health record (EHR). ADON stated she would need to educate nurses about educating and offering vaccines to residents. ADON stated she had a plan to work with the pharmacy to get all residents who wanted vaccines up to date on their vaccines. Facility Infection Prevention and Control Program policy dated 11/2024, indicated the following: Prevention of Infection: Immunizing residents and staff to try to prevent illness.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245067	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/22/2026
NAME OF PROVIDER OR SUPPLIER The Emeralds at Fairbault LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to ensure bathing safety for 1 of 1 resident (R38) reviewed for activities of daily living (ADLs), when a safety seatbelt had not been applied during the bathing process. In addition, based on interview and document review, the facility failed to ensure safe electric wheelchair use for 1 of 1 resident (R73) reviewed for accidents, when a resident fell from her wheelchair on a community outing. Findings include: R38's diagnoses report dated 7/22/26, included diagnosis of non-traumatic intracerebral hemorrhage (bleeding in the brain not caused by injury and a type of hemorrhagic stroke). R38's quarterly Minimum Data Set (MDS) assessment dated [DATE], indicated moderately impaired cognition, clear speech, could understand and be understood. R38 was dependent upon staff for most activities of daily living and did not walk. R38's care plan dated 6/1/24, indicated a self-care deficit related to intracranial injury and impaired mobility; used a Hoyer (mechanical lift device) with assist of two for transfers, and required assistance with bathing. During an interview on 7/20/26 at 3:03 p.m., R38 stated there had been an incident about three weeks prior where he had been given a tub bath and staff did not apply a safety seatbelt and he slid down off the chair into the water. R38 stated he hollered and staff came to help. R38 did not know the nursing assistant (NA) who had put him in the tub; had not seen her prior to or since the incident. During an interview on 7/21/26 at 1:47 p.m., registered nurse (RN)-A who was also a nurse manager, stated she had been aware R38 had slipped down in the tub when an unknown agency NA had given him a bath. It had been the NA's first shift at the facility, and since she did not have an assignment, it had been determined she would be the bath aid on the long-term care unit. RN-A stated staff had not informed the NA where the safety seatbelt was for the tub, so she used a gait belt. RN-A had not informed the DON following the incident because R38 didn't think it was a big deal. RN-A could not recall the date of the incident or who was involved. During an interview and observation on 7/21/26 at 2:49 p.m. in the tub room, observed an [NAME] brand bathing system which included a chair that when a resident was seated on it, would be rolled into the tub, a door shut and then water added. NA-C demonstrated how a safety seatbelt would be applied to a resident and the tub chair. Observed multiple safety seatbelts hanging on the wall which were long white rubber straps with holes. NA-C stated the seatbelt went around the residents' belly, then attached to pegs on the back of the chair, stating the strap should be snug, but comfortable. NA-C stated a gait belt wouldn't do anything for a resident in the tub; they would just slide out of the chair. NA-C stated gait belts were only used for ambulating residents and that a safety seatbelt should always be used when bathing a resident. (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245067	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/22/2026
NAME OF PROVIDER OR SUPPLIER The Emeralds at Fairbault LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 7/21/26 at 3:54 p.m., the interim director of nursing (IDON) stated she had not been made aware of the incident until informed by RN-A today. The IDON stated it should have been investigated and staff re-educated if necessary. The IDON stated she locked out/tagged out the tub (e.g., taken out of service) until the vendor could do a safety check. Manufacturer instructions for the [NAME] bathing system were requested and received; dated November 2017. During an interview on 7/22/26 at 10:24 a.m., both nursing assistants NA-A and NA-B stated they had been working the day of the incident and recalled the events. Both stated it had to have occurred the second or third week in June when a particular NA was on vacation and it had to have been on a Friday as that was R38's bath day. They were aware it was an agency NA and her first day at the facility. NA-A stated NA-D had radioed over her walkie talkie that she needed help in the tub room ASAP (as soon as possible). Both NA-A and NA-B rushed to help. NA-B stated R38 had a gait belt under his arms, not the safety seatbelt, and that R38 had not been under the water, but rather slid down off the chair with water up to chest. Both NA-A and NA-B stated R38 had not been at risk of drowning. They both reported the incident to RN-A and to licensed practical nurse (LPN)-A. During an interview on 7/22/26 at 10:32 a.m., based upon interviews from NA-A and NA-B, met with scheduling coordinator (SC)-B and was able to determine the date of the incident was 6/19/26, and was able to identify the agency NA by name. SC-B stated that had been NA-D's first and only shift at the facility. During a telephone interview on 7/22/26 at 10:41 a.m., LPN-A stated she had been working the day of the incident and recalled the events. LPN-A stated when she entered the tub room to help, she assisted R38 up onto the tub chair and had observed a gait belt around him. LPN-A stated at no time was R38 at risk of drowning. LPN-A stated she didn't tell anyone or document a progress note because R38 had not sustained an injury. During an interview on 7/22/26 at 12:58 p.m., the IDON stated there had been no orientation or training provided to NA-D prior to the start of her first shift. The current orientation packet for agency staff, provided by the IDON, did not include information about bathing, the [NAME] tub, chair or safety seatbelt. During a telephone interview on 7/22/26 at 7:28 p.m., NA-D stated she worked for an agency and when she saw the open shift at the facility on 6/19/26, she picked it up. NA-D stated she had not worked at the facility prior to this. When NA-D arrived, she stated staff were unaware she was coming and did not know where to assign her. After 30 minutes of staff trying to reach the IDON without success, they determined NA-D would be the bath aid on the long-term care unit. NA-D stated she had not received orientation/training prior to starting the shift. NA-D had asked the NA assigned to R38 if there was anything she should know about R38 but was given only general information. NA-D stated she had not been provided access to the electronic medical record (EMR) in order to review R38's care, adding, They just threw me into the position, so had to go off what residents and staff told her. The NA who had been assigned to R38 helped NA-D transfer R38 to the tub chair but said nothing about a safety seatbelt for the chair so she applied a gait belt to R38. When the water filled about halfway, NA-D stated R38 started to slide down off the tub chair. NA-D stated she quickly started draining the tub then called for help. NA-D stated staff came in right away and lifted R38. (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245067	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/22/2026
NAME OF PROVIDER OR SUPPLIER The Emeralds at Fairbault LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	NA-D stated at no time had R38's head been close to the water. NA-D stated she was familiar with the brand of tub and had used it before and stated not all residents required the use of a safety seatbelt as they were strong enough to hold themselves up. NA-D stated typically staff would tell her if a resident needed a safety seatbelt or she would see it in their chart. NA-D stated no one at the facility had talked to her about the incident. During a telephone interview on 7/23/26, at 11:34 a.m., customer service (CS)-C at [NAME] Bath company stated instructions for use of the safety seatbelt were not included in the operating manual; those instructions came on a laminated document attached to the chair so that the chair/bathing system could not be used until the instructions were removed. CS-C provided the instructions titled Moving Resident to and from Bathing System, dated 10/17. Instructions included: before moving resident, fasten seatbelt (secure over white knobs on back of chair). Further, the instructions included a Warning indicating in part: only trained and authorized personnel conduct resident transfers with this system. Seatbelts are in good condition and secure snugly to the white knobs on the back of the chair. Facility policy on use of the tub, or a policy on safety measures when bathing residents was requested and not received. ELECTRIC WHEELCHAIR R73's quarterly MDS assessment dated [DATE], indicated intact cognition, use of wheelchair, setup assistance for eating, dependent for toileting hygiene, substantial assistance for personal hygiene, dependent for transfers, and diagnoses of debility due to cardiac (heart) and respiratory conditions, heart disease, heart failure, and diabetes mellitus. R73's care plan updated 5/23/26, indicated risk for injury related to decreased visibility, environmental hazards, and impaired judgment during evening outings. Risk for impaired physical mobility related to potential equipment malfunction or environmental barriers. Remain free from injury or falls during and after outings through the next review dated 8/26. Demonstrate understanding safety precautions for evening wheelchair use through next review date. During interview on 7/20/26 at 11:37 a.m., R73 stated she fell off her scooter a few days ago. R73 stated she was at bingo at a community establishment in her motorized wheelchair, missed the ramp, and fell down five stairs. R73 stated she had some scrapes and bruises and her daughters made her go to the emergency department to get checked out. R73 stated she was not admitted to the hospital and returned to the facility the same night. R73 further stated she was upset the facility had taken her motorized wheelchair away. Facility progress note dated 5/6/26, indicated R73 returned to facility at 11:00 p.m., accompanied by police officer due to darkness. Facility progress note dated 5/13/26, indicated R73 left the facility for bingo on her electric wheelchair at 4:45 p.m., writer was alerted by another staff member that emergency medical services and police were with resident because she got stuck on the sidewalk. Resident had minor skin tear on (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245067	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/22/2026
NAME OF PROVIDER OR SUPPLIER The Emeralds at Fairbault LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	her right hand. Facility progress note dated 6/3/26, indicated R73 left facility at 4:32 p.m., electric wheelchair got caught in a rock on the sidewalk twice and got stuck. Staff pulled wheelchair and assisted R73. Facility progress note dated 7/11/26, indicated R73 choked on chicken nugget outside of gas station. R73 drove electric wheelchair to gas station, hit wood pile, and received a skin tear to right hand. Emergency medical services were called to the scene to complete wound care. Facility progress note dated 7/13/26, indicated R73 will be reevaluated with her electric wheelchair due to safety concerns on community outings. Therapy will conduct a new Community Assessment and SLUMS (cognitive test). Facility progress note dated 7/15/26, indicated social services spoke with R73 regarding her desire to attend bingo in the community that evening. R73 wanted to attend due to a special event. Risks of high temperatures reviewed. Ensure to fully charge phone. Facility progress note dated 7/15/26, indicated nursing received a call from a community establishment stating R73 drove her electric scooter off the steps instead of the ramp and fell on the ground. Emergency medical services arrived and R73 refused to go with them. Facility staff walked with her back to the facility. R73's daughters encouraged her to go the the emergency department and she agreed. R73 had bruises and abrasions and returned to the facility that night. Facility interdisciplinary team (IDT) note dated 7/16/26, indicated root cause analysis completed with cause determined to be decreased coordination with electric wheelchair. Immediate intervention included electric wheelchair removed from R73's possession, daughters in agreement. During interview on 7/21/26 at 1:34 p.m., assistant director of nursing (ADON) stated she was aware R73 was unsafe in her wheelchair but it was a tough situation. ADON further stated if it was her choice she would have taken the electric wheelchair away a long time ago. ADON stated the wheelchair should have been removed on 7/13/26, when it was determined a new community assessment was needed. ADON further stated R73's daughters had stated they thought R73 was a danger to herself and others in her wheelchair and supported the electric wheelchair being removed. During interview on 7/22/26 at 2:08 p.m., IDON stated R73 has had ongoing problems with her electric wheelchair, the ombudsman had been involved, and family was aware. IDON stated she is unsure why the electric wheelchair was not removed when it was discovered that a new community safety assessment was needed. IDON stated the electric wheelchair should have been removed on 7/13/26, until a new safety assessment could be completed. IDON stated this would have been important to ensure R73's safety. A facility policy on accidents was requested but not received.		