STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245184	A. Building B. Wing	07/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rochester East Health Services	501 Eighth Avenue Southeast Rochester, MN 55904

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 0573 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Let each resident or the resident's legal representative access or purchase copies of all the resident's records. (continued on next page)

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

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0573 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review the facility failed to ensure 1 of 1 resident (R1) received a copy of their medical record per request in a timely manner, within 2 working days upon request excluding weekends and holidays. Findings include:R1's admission Minimum Data Set (MDS) dated [DATE], noted R1 had moderately impaired cognition. Section F identified preferences for customary routine and activities. Interview for daily preferences indicated it was very important to have family, or a close friend involved in discussions about your care.R1's Medical Record Request form dated 7/1/25, identified family member (FM)-A requested R1's entire medical record from 5/19/25 until 6/11/25. The facility form was signed by FM-A and director of nursing (DON) on 7/1/25.During a phone interview on 7/23/25 at 1:09 p.m., FM-A stated for the last three- and one-half weeks, she had been trying to get R1's medical records and still had not received them. FM-A indicated she spoke with the DON on 7/1/25, she had her fill out a medical request form and told her no problem we will get those records for you. FM-A stated she called the executive director on 7/9/25 and was told she didn't know anything about it, and she would get it taken care of. FM-A stated she tried to call the corporate office on 7/14/25, and when she called no one answered and there was no voicemail option to leave a message. FM-A indicated she had called the DON to try and get an update on 7/22/25 and left a voicemail and had not heard back from anyone why it was taking so long to receive R1's medical records. During an interview on 7/24/25, at 3:20 p.m. DON stated FM-A had reached out asking for R1's medical records, FM-A signed a medical release form on 7/1/25. FM-A did reach out to several of us at the facility wanting R1's medical records in the last two to three weeks. DON explained we can't just send the medical records when requested, we have to send the request to corporate and then they take care of it. DON stated FM-A should have received the medical records by now.A facility policy titled Release of Medical Records, implemented 7/24/23, identified medical records will be released with a valid request and in accordance with state and federal laws.1. Medical Records are a collection of documents prepared and maintained during the course of a resident's stay in the facility that records the clinical/medical care of the resident. These documents can be written or electronic information and include progress notes, physician orders, nursing notes, consultations, laboratory and diagnostic reports, and plans of care. These documents do not include risk management reports such as incident reports, investigation reports, witness statements, or other quality assurance documents such as skin reports, weight loss reports, etc. 2. Requests for records should immediately be emailed to North Shore Healthcare's Medical Records request inbox at medrecords@nshorehc.com, along with a copy of the relevant legal document and/or authority for the requestor to obtain copies of said records. If no legal papers are in the possession of the facility, the facility should request copies of any legal papers necessary to authenticate authority. The Director of Nursing for said facility shall be copied on said communications. 3. Upon request to access or obtain copies of the medical record, the legal department shall review the authorization to ascertain access rights of that person. Authority to access or release records is only granted by the resident or the resident's legal representative. 4. A valid request for medical information concerning a resident, by a party other than the resident, includes: a. Name of resident, b. Name and address of facility, c. Name and address of individual or organization requesting information, d. Specific information and reports requested, e. Period of stay for which information is to be released, f. Date of the request, and g. Signature of the resident or legally appointed representative authorizing release of information. 5. The legal department will advise the facility if it should complete the request on its own or if the request will be completed by legal staff at the Support Center. Records should not be released prior to discussion with Support Center staff, to further validate authenticity of the request. 6. Upon receipt of a request for medical record copies, the designee (facility or legal department as deemed in #5, above) should notify the requesting party, in writing, of the cost for obtaining records and that records are available two days after receipt of payment for the copies. Copies should not be released prior to the receipt of payment for copying charges, if applicable. 7. Fees for copying medical records are determined according to state regulations. See specific state codes for state specific release information and allowable charges. 8. Once a request for records is received, all records for that resident should be gathered and secured in a place inaccessible to anyone except the Legal Department, Administrator, Director of Nursing or designee. If the resident is a current resident, the minimum required information should be maintained at the nurse's station. As the active medical record is thinned, those documents should be filed with the secured record. 9

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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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review the facility failed to ensure the baseline care plan was revised and updated as needed to meet 1 of 1 resident (R1) toileting needs reviewed for falls.R1's admission Evaluation dated 5/19/25, identified under section J., R1 was incontinent of bladder more than a month, but less than a year. R1 was wet one to two times daily during the day and the nighttime, also exhibited dribbling. Bladder incontinence care plan identified a goal will be maintained in as clean and dry dignified state as possible. Continence in the last 14 days identified R1 was frequently incontinent of bladder daily but some control present.R1's baseline care plan dated 5/19/25, at 7:30 p.m., identified initial goals were to rehab and go home. Section titled, Personal Care, had a list of tasks going down the page vertically, that included: bath/shower, skin care, brushing teeth/dentures, shaving, hair care, dressing/undressing, walking, bathroom needs, eating, exercise and moving in chair/bed and other. Next to each task there was a header titled, How often, and Provided by. Under, How Often, next to bath/shower were the handwritten words, daily/weekly, with a long arrow going all the way down the page through all of the tasks. Header titled, Provided by, there was handwritten word, nursing, with a long arrow going all the way down the page through all of the tasks. R1's corresponding electronic health record (EHR) care plan identified a focus dated 5/19/25, that identified activity of daily living (ADL) self-care deficit as evidenced by needing assistance completing self-care tasks related to generalized weakness and lack of coordination secondary to multiple strokes. Interventions dated 5/19/25, assist of one with bed mobility and personal hygiene, and assist of two staff with toileting. On 5/22/25, assist of two staff with gait belt and front wheeled walker for transfers. An additional focus dated 5/22/25, for urinary incontinence related to (r/t): (specify) dated 5/19/25. Under interventions it was blank. R1's EHR care plan also identified a focus date 5/19/25, at risk for falls related to Arteriovenous Malformation (AVM)- (a condition where an abnormal tangle of blood vessels connecting arteries and veins, bypassing the normal capillary network in the brain that can cause bleeding and a lack of oxygen to reach the tissues which can put the person at risk for hemorrhage or ruptures that can lead to a stroke), hydrocephalus-(a condition where cerebrospinal fluid (CSF) builds up in the brain's ventricles, leading to increased pressure on brain tissue that can cause headaches, nausea, vomiting, vision problems, and difficulty with walking and balance), and medications. Interventions dated 5/19/25, included to encourage to transfer and change positions slowly, reinforce wheelchair safety as needed such as locking brakes, report development of pain, bruises, change in mental status, ADL function, appetite, or neurological status post fall, reinforce need to call for assist and scoop mattress. On 5/22/25, interventions included anti-rollbacks to wheelchair, fall mat beside bed-left side toward door, medications as ordered, medication regiment review, soft touch call light and therapy eval and treat as ordered. On 6/11/25, intervention included to do frequent purposeful rounding. R1's baseline care plan did not include measurable person-centered interventions to manage bowel/bladder incontinence such as type of incontinent garment usage and toileting routines. R1's progress note dated 5/23/25 at 5:50 p.m., identified R1 had an unwitnessed fall, was on heparin injections every eight hours, had a history of metabolic encephalopathy, was able to move all extremities, denied hitting his head, neuro at baseline, and no bruises noted on head. Skin tear to left elbow measuring 3 centimeters (cm) x 2 cm x 0.5 cm. R1 was sent to the hospital for evaluation due to being on a blood thinner. R1's admission Minimum Dat Set (MDS) dated [DATE], noted R1 had moderately impaired cognition with diagnoses of AVM, metabolic encephalopathy- (a condition that causes brain dysfunction that can cause confusion, memory problems, and changes in mood or behavior), hydrocephalus, and cognitive deficit following a brain bleed. Further identified R1 had one fall with no injury, needed substantial to maximal assist of one staff with mobility transfers and toileting and was occasionally incontinent of bladder and bowel. R1's Care Area Assessments (CAA) for falls and incontinence were signed as completed on 5/28/25. In review of R1's record there was no indication after the MDS was completed on 5/23/25 there was no indication R1's base line care plan interventions for falls and urinary/bladder incontinence were reviewed for appropriateness or effectiveness; no new interventions were added until after R1 returned from the hospital on 6/9/25. R1's readmission Evaluation dated 6/9/25, identified under section J., R1 was incontinent longer than a year. R1 was wet one to two times daily during the day and the nighttime. Further identified small amount of urine (spots on clothes/bed). R1's baseline care plan dated 6/9/25, at 2:00 p.m., identified initial goals were for comfort care, maintain quality of life and dignity. Section titled, Personal Care, had a list of tasks going down the page vertically, that included:

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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 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. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review the facility failed to ensure a comprehensive care plan was developed to maintain or restore bladder continence for 1 of 3 residents (R2) reviewed for falls. Findings include:R2's admission Evaluation dated 5/2/25, identified under section J., R2 was continent of bladder.R2's Daily Skilled progress notes from 5/3/25 to 7/2/25, identified R2 was both incontinent and continent of bladder. R2's admission Minimum Data Set (MDS) dated [DATE], identified R2 had severe cognitive impairment and was occasionally incontinent of bladder and bowel. R2 had diagnoses of stroke with hemiplegia and urinary retention. R2's Care Area Assessment (CAA) dated 5/9/25, identified actual Urinary incontinence. Type of incontinence identified was functional (can't get to toilet in time due to physical disability, external obstacles, or problems thinking or communicating). Alteration in urinary elimination r/t occasional incontinence with need for assistance to complete task. Noted to have underlying hemiplegia, diabetes mellitus (DM), acute Kidney Injury (AKI), chronic kidney disease (CKD), medication, that could affect his elimination status. Staff will continue with assistance as needed. Monitor for any changes in elimination status, s/s of infection or skin issues r/t incontinence. It is expected that R2 will regain his continence and toileting independence as he regains strength. Interventions ongoing per care plan.R2's care plan identified a focus dated 5/9/25, identified an alteration in elimination (Urinary Retention) related to probable neurogenic bladder secondary to cerebral vascular accident and incontinence. Interventions dated 5/9/25, identified to encourage fluids if not contraindicated, evaluate for urinary complaints, monitor for abdominal distention, monitor for signs and symptoms of urinary tract infection (UTI), and report any urinary concerns to the provider.An additional focus dated 5/2/25, identified an alteration in self-care related to right sided hemiplegia and right sided hemiparesis secondary to a cerebral vascular accident. Also related to right shoulder and right foot pain. Interventions dated 5/2/25, identified R2 needed assist of 1 with bed mobility, personal hygiene, dressing, transfers and toileting.R2's care plan did not identify measurable appropriate interventions to maintain/restore continence such as a toileting program/prompted voiding schedule, cognitive cuing, easy to remove clothing. R2's progress note dated 5/11/25, at 3:11 p.m., identified R2 was found seated between the leg rest of his wheelchair, R2 stated, I was trying to go to the bathroom.R2's medical doctor (MD) progress note dated 5/22/25, identified R2 had diagnosis of urinary retention. Since R2's stroke, there has been some concern for urinary retention. It is sometimes difficult for R2 to initiate a stream, and he feels the urge to urinate frequently. Likely has an element of neurogenic bladder, not yet evaluate by urology. Currently on doxazosin (medication given to improve urination for those with an enlarged prostate). R2 wears disposable absorbent briefs. Review of R2's care plan did not include identification, goals or interventions for urinary retention diagnosis, nor identify R2 wore absorbent briefs. R2's Kardex printed 7/24/25, identified R2 required assist of 2 with toileting.During an interview on 7/23/25 at 3:35 p.m., nurse manager (NM)-A indicated R2 does have bladder incontinence. NM-A stated R2's care plan should have measurable person-centered interventions addressing his incontinence.During an interview on 7/24/25 at 3:18 p.m., director of nursing (DON) stated R2 does have bladder incontinence, and the care plan should have measurable person-centered interventions addressing R2's incontinence and verified it does not have that.During an interview on 7/28/25 at 11:10 a.m., nursing assistant (NA)-B stated she was the aide scheduled to take care of R2. NA-B stated she had not helped R2 to the bathroom today because she thought he was independent with toileting. NA-B reviewed R2's kardex and indicated he should have 1 assist with toileting. But it doesn't say how often to offer toileting. NA-B stated R2 was incontinent at times but usually takes himself to the bathroom. Facility policy, Comprehensive Care Plan, revised 9/23/22, identified It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment. 1. The care planning process will include an assessment of the resident's strengths and needs and will incorporate the resident's personal and cultural preferences in developing goals of care. Services provided or arranged by the facility, as outlined by the comprehensive care plan, shall be culturally competent and trauma informed. 2. The comprehensive care plan will be developed within 7 days after the completion of the comprehensive MDS assessment. Care Assessment Areas (CAAs) triggered by the MDS will be considered in developing the plan of care. Other factors identified by the interdisciplinary team, or in accordance with the resident's preferences, will also be

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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 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. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review the facility failed to ensure a comprehensive fall care plan was revised for 2 of 3 residents (R2 and R3) reviewed for falls. Findings include:R2's care plan identified a focus dated 5/2/25, at risk for falls related to right sided hemiplegia and right sided hemiparesis secondary to a cerebral vascular infarction. Interventions dated 5/2/25, included to encourage to transfer and change positions slowly. 5/9/25 have commonly used articles within easy reach, therapy eval and treat as ordered and use wheelchair for independent locomotion and walker with gait belt and assist of 1 for ambulation. R2's CAA dated 5/9/25, identified Falls an actual problem. No falls noted since admission. Care plan considerations identified R2 had alteration in mobility with risk for falls following hospital stay for pneumonia, underlying hemiplegia, DM, acute kidney injury (AKI), chronic kidney disease (CKD), right foot pain, medications that could affect his overall mobility status. R2 continues to work with PT/OT for rehab. Currently needs assist with completing ADL's, toileting, and mobility tasks. Lives with his son with plan to return back to that living situation, pain management continues to be ongoing, noted to have right foot and shoulder pain. Staff will continue with ongoing assistance. Interventions remain ongoing per care plan to assist with preventing any future falls.R2's progress note dated 5/11/25 at 3:11 p.m., identified R2 was found sitting between the leg rest of the wheelchair, R2's shoe Velcro was caught in leg rest. R2 stated he was trying to go to the bathroom and denied hitting head. R2's IDT Clinical review progress note dated 5/12/25 at 9:41 a.m., identified root cause was to catch Velcro on the wheelchair. Intervention was to make sure Velcro was trimmed and remove the foot pedals. R2's medical record was reviewed and identified no indication care plan interventions were reviewed for effectiveness and no new person-centered intervention was developed on R2's care plan for fall prevention. R2's care plan did not include a toileting plan even though he required assist of 1 staff with toileting and the medical record identified he fell trying to get to the bathroom. R2's progress note dated 6/4/25 at 3:56 p.m., identified that activity manager reported that R2 was on the floor. R2's care plan was revised on 6/6/25 to include have resident evaluated by therapy as needed to assist for safe transfers and walking and an intervention added on 6/10/25 re-educate resident on need to not use wheelchair for a walker. However no interventions were added to addressed R2's toileting needs.R2's quarterly MDS dated [DATE], identified R2 had severely impaired cognition, diagnoses of ischemic stroke with hemiplegia affecting right dominant side, dysarthria-a motor speech disorder that makes it difficult to speak clearly due to impaired muscle control in the face, mouth, or respiratory system that can impact articulation, voice quality, and speech rhythm, diabetic neuropathy-nerve damage caused by diabetes, often leading to numbness, tingling, and pain in the extremities, particularly the hands and feet, osteoarthritis of right knee, pain in right shoulder and right foot, and urinary retention. R2 required limited assist with bed mobility, transfers and toileting. R2 had two or more falls without injury.During an interview on 7/23/25 at 3:35 p.m., NM-A stated the fall prevention intervention should have been developed/implemented for R2's fall on 5/11/25, to identify toileting since R2 needed assist with toileting. NM-A stated for R2's fall on 6/4/25, his care plan lacked the development and implementation of a fall prevention intervention.During an interview on 7/24/25 at 3:20 p.m., DON indicated the fall prevention intervention should have been revised for R2's fall on 5/11/25 to identify toileting since R2 needed assist with toileting. DON stated R2's care plan for his fall on 6/4/25, lacked a fall prevention intervention.R3's care plan identified a focus date 6/2/25, at risk for falls due to: Parkinsonism, dementia with cognitive losses, restless leg syndrome, bladder incontinence, constipation, decline in mobility status. Interventions dated 6/10/25, included to report development of pain, bruises, changes in mental status, ADL function, appetite, or neurological status post fall, reinforce need to call for assistance, medications as ordered, have commonly used articles within easy reach, fall risk and encourage to transfer and change positions slowly. R3's admission MDS dated [DATE], identified R3's cognition was intact and had diagnoses of dementia, parkinsonism-a syndrome that can cause a collection of symptoms that resemble Parkinson's disease, including tremors, stiffness, and slow movement, history of traumatic brain injury, and generalized anxiety disorder. R3 required staff assist with mobility, transfers and toileting. R3 had falls a month prior to admission and 2 to 6 months prior to admission. R3's CAA dated 6/8/25, identified section 11. Falls, actual problem. No falls noted since admission. Care plan considerations identified R3 had an alteration in mobility with risk for falls: noted to have history of multiple falls at home, found on the floor at home with resulting rhabdomyolysis, underlying parkinsonism, dementia with cognitive

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to comprehensively assess each fall, identify causal factors to determine reason for falls, identify potential effective interventions to decrease the risk for falls, and failed to comprehensively evaluate and implement fall interventions for 3 of 3 residents (R1, R2, and R3) reviewed for resident safety. The facility's failures resulted in an immediate jeopardy (IJ) for R1 who sustained fractures after his first and second fall.The IJ began on 5/23/25, when the facility failed to complete a comprehensive fall assessment along with root cause analysis and implement appropriate interventions after R1 attempted to self-transfer, resulting in an unwitnessed fall requiring hospitalization with a right frontal sinus fracture. Upon return from the hospital, on 6/10/25, R1 again attempted to self-transfer resulting in an unwitnessed fall requiring hospitalization where R1 sustained two left pubic bone fractures with bleeding and hematoma formation surrounding the fractures. The vice president of success (VPS)-A, vice president of human resources (VPHR)-A and director of nursing (DON) were notified of the IJ on 7/24/25 at 5:51 p.m. The IJ was removed on 7/28/25 at 2:02 p.m. after it could be verified that the facility had implemented an acceptable removal plan, however, non-compliance remained at D isolated severity level, which indicated no actual harm with potential for more than minimal harm that is not immediate jeopardy.Findings include:R1's admission Evaluation dated 5/19/25 at 6:00 p.m., identified that R1 verbalized understanding of call light/bell and was unable to use devices so a soft touch call light was provided. R1's activity of daily living (ADL) care plan identified R1 required extensive assist of one staff with bed mobility and personal hygiene. R1 required extensive assist of two staff with transfers and toileting. R1 was alert to person and was aphasic (difficulty finding words, nonsensical speech). R1 had bladder incontinence one to two times daily during the day and evening. R1 exhibited, dizziness or lightheadedness, vertigo (feeling of spinning or whirling), impulsivity or poor safety awareness, and moved too quickly. R1 exhibited gait and balance problems.R1's care plan identified a focus date 5/19/25, at risk for falls related to Arteriovenous Malformation (AVM)-(a condition where an abnormal tangle of blood vessels connecting arteries and veins, bypassing the normal capillary network in the brain that can cause bleeding and a lack of oxygen to reach the tissues which can put the person at risk for hemorrhage or ruptures that can lead to a stroke), hydrocephalus-(-condition where cerebrospinal fluid (CSF) builds up in the brain's ventricles, leading to increased pressure on brain tissue that can cause headaches, nausea, vomiting, vision problems, and difficulty with walking and balance, and cognitive deficit following a brain bleed), and medications. Interventions dated 5/19/25, included to encourage to transfer and change positions slowly, reinforce wheelchair safety as needed such as locking brakes, report development of pain, bruises, change in mental status, ADL function, appetite, or neurological status post fall, reinforce need to call for assist and scoop mattress. On 5/22/25, interventions included anti-rollbacks to wheelchair, fall mat beside bed-left side toward door, medications as ordered, medication regiment review, soft touch call light and therapy to eval and treat as ordered.R1's medical doctor (MD) progress admission note dated 5/22/25, identified reason for admission was hydrocephalus and metabolic encephalopathy- (a condition that causes brain dysfunction that can cause confusion, memory problems, and changes in mood or behavior). COGNITION: R1 exhibited a severe to profound cognitive-communication impairment characterized by deficits in orientation, attention (focused, sustained, alternating, divided), memory (immediate, delayed), visual perceptual skills (L inattention), problem solving/reasoning (insight/awareness, safety), and significantly delayed processing speed. R1 was impulsive and motor restless, requiring consistent redirection. No vital signs were taken for this visit and R1 was drowsy, but arousable and largely unintelligible. Further identified R1 had a fall within the last year.R1's admission Minimum Data Set (MDS) dated [DATE], noted R1 had moderately impaired cognition. Further identified R1 needed substantial to maximal assist of one staff with bed mobility, transfers and toileting. R1 had one fall with no injury and was occasionally incontinent of bladder and bowel. R1's Unwitnessed Fall document dated 5/23/25 at 5:50 p.m., identified R1 was found sitting on the floor in an upright position with legs extended next to his wheelchair in his room. R1 was wearing shoes and had his tray table in front of him. Family member (FM)-A reported she left R1 for a moment to get water and when she came back R1 was sitting on the floor and staff were in the room. Immediate Action taken: R1 was assessed, initial blood pressure (B/P) was elevated, but after assisting into bed B/P was checked and was 128/78. Heart Rate (H/R) was 113, Respiratory Rate (RR) was 20, Temp was 98.1, oxygen (O2) saturations 96% on 3 liters per nasal canula

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	245184	A. Building B. Wing	07/29/2025

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Rochester East Health Services	501 Eighth Avenue Southeast Rochester, MN 55904

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 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. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review the facility failed to complete a comprehensive assessment and implement individuals interventions to ensure a resident who was continent of bladder upon admission received appropriate treatment and services to maintain/restore or prevent increased incontinence for 1 of 3 residents (R2) reviewed for falls.Findings include:R2's admission Evaluation dated 5/2/25, identified under section J., R2 was continent of bladder.R2's admission Minimum Data Set (MDS) dated [DATE], identified R2 had severe cognitive impairment and was occasionally incontinent of bladder and bowel. R2 had diagnoses of stroke with hemiplegia and urinary retention.R2's Care Area Assessment (CAA) dated 5/9/25, identified actual urinary incontinence. Type of incontinence identified was functional (can't get to toilet in time due to physical disability, external obstacles, or problems thinking or communicating). Alteration in urinary elimination related to (r/t) occasional incontinence with need for assistance to complete task. Noted to have underlying hemiplegia, diabetes mellitus (DM), acute kidney injury (AKI), chronic kidney disease (CKD), medication, that could affect his elimination status. Staff will continue with assistance as needed. Monitor for any changes in elimination status, signs/symptoms (s/s) of infection or skin issues r/t incontinence. It is expected that R2 will regain his continence and toileting independence as he regains strength. Interventions ongoing per care plan. Review of R2's record identified, although CAA dated 5/9/25 identified R2 was occasionally incontinent and directed to Monitor for any changes in elimination status the assessment did not identify R2's change from being continent (except for [R2] will regain his continence) according to the admission Evaluation dated 5/2/25 . Further, there was no indication a comprehensive bladder assessment was completed to determine causal factors of R2's new incontinence and determination of R2's normal voiding routines in order to establish and implement appropriate interventions that included but not limited to individualized toileting program to restore/maintain/ or prevent worsening urinary incontinence (R2's bladder assessments and voiding diaries were requested and not received). Additionally, although the CAA identified R2 It is expected that R2 will regain his continence and toileting independence , review of R2's care plan did not include individualized appropriate interventions to reduce R2's risks of incontinence and restore or prevent worsening of R2's bladder function while R2 regained his strength. R2's care plan focus dated 5/2/25, identified an alteration in self-care related to right sided hemiplegia and right sided hemiparesis secondary to a cerebral vascular accident. Also related to right shoulder and right foot pain. Interventions dated 5/2/25, identified R2 needed assist of 1 with bed mobility, personal hygiene, dressing, transfers and toileting. R2's care plan identified a focus dated 5/9/25, identified an alteration in elimination (Urinary Retention) related to probable neurogenic bladder secondary to cerebral vascular accident and incontinence. Interventions dated 5/9/25, included encourage fluids if not contraindicated, evaluate for urinary complaints, monitor for abdominal distention, monitor for signs and symptoms of urinary tract infection (UTI), and report any urinary concerns to the provider. R2's care plan did not include an individualized toileting program or routine. R2's Kardex printed 7/24/25, identified R2 required assist of 2 with toileting. No other interventions were included. R2's Daily Skilled progress notes (completed while R2 was receiving therapy) from 5/3/25 to 7/2/25 identified R2 had a fall on 5/11/25 at 3:11 p.m. when he was trying to go the bathroom. Progress notes also identified R2 was both incontinent and continent of bladder. R2's medical doctor (MD) progress note dated 5/22/25, identified R2 had diagnosis of urinary retention. Since R2's stroke, there has been some concern for urinary retention. It is sometimes difficult for R2 to initiate a stream, and he feels the urge to urinate frequently. Likely has an element of neurogenic bladder, not yet evaluate by urology. Currently on doxazosin (medication given to improve urination for those with an enlarged prostate). R2 wears disposable absorbent briefs.In review of R2's record following the MD visit on 5/22/25 that identified diagnosis of urinary retention, there was no indication of assessments, monitoring, and care plan revisions with interventions such as bladder assessment to determine post-void residuals, monitoring the effectiveness of the doxazosin, monitoring urinary patterns for frequency/urgency/and difficulty voiding, and scheduled toileting program or prompted voiding. During an interview on 7/23/25 at 3:35 p.m., nurse manager (NM)-A stated upon admission the aides complete a 72-hour bladder diary. NM-A stated she does not take the data from this form to assess the residents need for a toileting plan to maintain continence and stated she should be doing that. NM-A indicated R2 does have bladder incontinence and R2's care plan should have measurable person-centered interventions addressing his incontinence such as a scheduled toileting plan During an

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F 0730 Level of Harm - Potential for minimal harm Residents Affected - Many	Observe each nurse aide's job performance and give regular training. Based on interview and document review, the facility failed to complete annual performance evaluations for 4 of 5 nursing assistants (NA-A, NA-B, NA-C and NA-D) who had been employed by the facility for over one year.Findings include:NA-A staff listing identified a hire date of 8/22/1996. An annual performance evaluation was requested and not received.NA-C staff listing identified a hire date of 3/12/2019. An annual performance evaluation was requested and not received.NA-D staff listing identified a hire date of 1/11/2024. An annual performance evaluation was requested and not received.NA-E staff listing identified a hire date of 1/4/2023. An annual performance evaluation was requested and not received.During an interview on 7/28/25 at 11:32 a.m., NA-D stated she had been an employee at the facility for a bout a year and a half and did not remember ever receiving a performance review. During interview on 7/28/25 at 12:30 p.m., NA-A stated she had been employed at the facility for almost 19 years and was unaware of when her last annual performance review was done. During an interview on 7/29/25 at 10:27 a.m., director of nursing (DON) stated she would be responsible to ensure annual performance evaluations are performed on nursing staff and would typically be done on their anniversary date. DON stated she did not do yearly performance evaluations for NA-A, NA-C, NA-D and NA-E. DON further stated once a performance evaluation is completed it would put in the employee's personnel file.Policies regarding performance reviews requested, not received.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many Note: The nursing home is disputing this citation.	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations (including nights and weekends) and emergencies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to review and update the facility assessment to identify the facility's staffing plan for number of staff needed to ensure sufficient qualified staff were available to meet residents' needs. This deficient practice had the potential to affect all 51 residents residing in the facility. Findings include:The facility assessment dated [DATE], identified Staffing Levels Process: As potential residents are referred for intake into our community, they are evaluated by the nursing department, DON, Unit Manager, in conjunction with other members of the IDT Team to assure that we are capable of meeting their individual needs. We may also review the potential resident with our regional directors for guidance and support. If necessary, a call can be made to our Medical Director. At times a face-to-face assessment may be attained. The staffing ratios are fluid and vary day to day and shift to shift. The staffing is based on resident need. Needs such as two person transfers, lift and Hoyer use as well as resident level of cognition and or need for 1-1. These instances will increase or decrease the need for staffing levels. Special unit of memory care is on our third-floor special consideration for staffing based on resident cognition and behaviors change the ratios of staffing to resident need.The facility assessment did not identify minimum or baseline number of direct care staff and licensed staff that would be required and sufficient to provide care and services based resident's diagnoses, assessed needs, and comprehensive care plan daily and across all shifts in order to maintain or attain their highest practicable physical, functional, mental, and psychosocial well-being and meet current professional standards of practice. The assessment did not address staffing hours per resident day (PPD) goals or the division/breakdown of the PPD between licensed staff and direct care staff that would be required to meet the needs of their resident population. During an interview on 7/28/25 at 3:04 p.m., scheduler (S)-A stated she will staff nursing based off of what the DON directs her to staff daily. S-A stated for the last year I have been told to staff for 3.35 per patient day (PPD), about a year ago she was staffing at about 3.4 PPD. S-A stated for day shift we staff at least 3 nurses and one trained medication aide (TMA) and 5 nursing assistants. It would be one nurse on first floor, 2 nurses on each wing on second floor and a TMA or nurse on third floor locked unit. In addition, we would staff two nursing assistants for 3rd floor and second floor and one aide for first floor. We would staff the same for evening shift. Night shift should have two nurses, and 2 aides scheduled. S-A stated sometimes depending on census we will have to send people home early, so an aide would be sent home early that was scheduled on the 1st floor. S-A stated the problem with that is if a TMA is working the 3rd floor and they need a nurse up there form a fall or something, the first floor nurse will have to go to 3rd floor to do the assessments and that leaves no scheduled staff on 1st floor, so they would have to pull one of the aides from second floor to cover first floor. S-A stated she was unsure if the facility assessment identified the number of nursing staff to staff daily. During an interview on 7/29/25 at 9:23 a.m., vice president of success (VPS)-A stated the facility assessment does not identify a staffing plan for number of staff needed to ensure sufficient qualified staff were available to meet residents' needs.During an interview on 7/29/25 at 10:27 a.m., director of nursing (DON) stated every day she reviews the resident census and acuity. However, DON then stated based on the acuity she will tell S-A how many nursing staff to schedule for resident care needs; we use the low end of the PPD, it should not be higher than 3.3 and 3.4 PPD (hours per patient day between licensed staff and direct care staff) for the entire building. DON indicated the facility assessment does not identify a staffing plan for number of staff needed or type of staff (RN/LPN/NA/TMA) to ensure sufficient qualified staff were available to meet residents' needs.Facility assessment policy requested but not received.

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a plan that describes the process for conducting QAPI and QAA activities. (continued on next page)

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Based on interview and record review, the facility failed to ensure the Quality Assessment and Assurance committee effectively identified quality deficiencies, developed and implemented appropriate actions; and provided its written Quality Assurance and Performance Improvement plan when requested at the time of survey. This deficient practice had the potential to affect all 51 residents in the facility at the time of the survey.Findings include:During an interview on 7/29/25 at 10:56 a.m., documentation and evidence of the facilities ongoing QAPI program was requested. [NAME] president of success (VPS)-A stated she would have to check with the corporate office due to QAPI minutes being protected by their legal team. The director of nursing (DON) stated the QAA team meets monthly, the committee members include myself, the executive director, pharmacist, medical director, social worker, managers from nursing, dietary, housekeeping, medical records personnel, scheduler, human resources, maintenance, and the business office manager. DON was unable to articulate the date of the last meeting but stated it was in June 2025 sometime. DON indicated that the executive director was the contact person for the QAA committee, was responsible for documentation of QAPI meeting minutes and was currently on vacation.Undated Facility form, Rochester East QAPI Report: May 2025 Meeting (April 2025 Data), was blank with no information on the form. Attached was an undated form, North Shore Healthcare QAPI Agenda and Meeting Minutes. Under the title of the form identified in the left-hand column each QAPI Committee member name, the second column identified the job title, and the third column identified a signature. The signatures included 11 committee members: medical records, unit manager, scheduler, business office manager, human resources, executive director, infection control nurse, MDS, social worker, medical director and maintenance. Undated Facility form, Rochester East QAPI Report: June 2025 Meeting (May 2025 Data), was blank with no information on the form. Attached was an undated form, North Shore Healthcare QAPI Agenda and Meeting Minutes. Under the title of the form identified in the left-hand column each QAPI Committee member name, the second column identified the job title, and the third column identified a signature. The signatures included 8 committee members: medical records, unit manager, scheduler, business office manager, DON, executive director, MDS and medical director.Facility quality form that was not dated included a header Topic Summary of analysis Should include Trends and Root Cause Analysis. Under the header included Center Specific Topics: with a listing of months across the page. Underneath was a section labeled Summary of Analysis Trending and Root Cause and Analysis and Action plans with months listed. The topics listed included infection prevention rates (Urinary tract infections rates were identified for March and April 2025) with no corresponding analysis, infection control prevention activity, or plans identified. Health associated antibiotic orders for current month; antibiotics were listed with no identification of usage and analysis was completed however there was no ongoing infection control activities, plans, or audit results; kitchen sanitation audit was blank, lab report was blank; environmental rounding audits was blank, skills competency was blank, center culture was blank was blank, Current performance improvement plans (PIPs)- this section was blank, Support center visits, and drills was blank. 1) Under the header included Center Specific Topics: with a listing of months across the page; there was no topic. Underneath was a section labeled Summary of Analysis Trending and Root Cause and Analysis and Action plans with months listed. 1st page no topic was identified but had January 2025 through March included None and April included customer service expectations/training/planning. Committees are in. Focus Quality measures flagging over 75%. Although according to there were no recorded quality measures over 75% there were quality measure percentages above the state and/or national average. The from did not identify and it could not be ascertained if any of the areas listed were quality performance projects; the form did not include action plans for any of the quality measures listed and no other information was provided. Topic Fall Incidence had entries for March and April. Recorded for March 13 falls, all falls were on the day shift, 1 person had 2 fall; in the section Proceed to Action plan/PIP Y/N - plan of correction for state. Recorded for April 14 falls for the month, 3 were unwitnessed falls. 5 before noon, 1 close to. No action plan was identified. May through July were blank. During an interview on 7/29/25 at 11:58 a.m., VPS-A stated the executive director was currently on vacation and was unable to find any documentation of QAPI plan documented activities that were requested.Facility policy, Quality Assurance Performance Improvement (QAPI), revised 7/11/22, identified the purpose of QAPI is to take a proactive approach to continually improving the way we care for and engage with our residents, team members, and other partners so that we may realize our mission of being the premier health services

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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 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Based on observation, interview, and record review, the facility failed to ensure the Quality Assessment and Performance Improvement (QAPI) plan and program identified, analyzed, implemented corrective actions, and re-evaluated corrective actions to address adverse events and quality deficiencies. This deficient practice had the potential to affect all 51 residents in the facility. Actual harm occurred related to the quality of care to one resident (R1).Findings include:During an interview on 7/29/25 at 10:56 a.m., the director of nursing (DON) stated the QA committee meets monthly. We discuss quality issues and get feedback form our IDT team. DON indicated the facility was cited previously for failure to comprehensively assess falls, root cause analysis, putting appropriate interventions in place and failure to implement the care plan. DON stated after the last fall citation the facility received their plan of correction identified to do fall audits from 2/12/25 to 3/11/25. DON indicated as part of the audit they ensured a fall intervention was put in place and ensured the interventions was updated to the care plan. DON indicated the audits did not include comprehensive fall assessments and root cause analysis. DON stated they stopped doing audits on falls because the audits showed they did not have any concerns indicating deficient practice and that was what they put in their plan of correction. DON was unsure where the executive director kept documentation of the facility's QAPI plan. See F689, facility failed to comprehensively assess each fall and identify causal factors to determine reason for falls, identify potential effective interventions to decrease the risk for falls, failed to comprehensively evaluate and implement fall interventions for 3 of 3 residents (R1, R2, and R3) reviewed for resident safety. The facility's failures resulted in an immediate jeopardy (IJ) for R1 who sustained fractures after his first and second fall. Further review of R1, R2 and R3's falls revealed a lack of analysis of its root causes, and there were no implemented corrective actions, and re-evaluated corrective actions to address adverse events and quality deficiencies.Undated Facility form, Rochester East QAPI Report: May 2025 Meeting (April 2025 Data), was blank with no information on the form. Attached was an undated form, North Shore Healthcare QAPI Agenda and Meeting Minutes. Under the title of the form identified in the left-hand column each QAPI Committee member name, the second column identified the job title, and the third column identified a signature. The signatures included 11 committee members: medical records, unit manager, scheduler, business office manager, human resources, executive director, infection control nurse, MDS, social worker, medical director and maintenance. Undated Facility form, Rochester East QAPI Report: June 2025 Meeting (May 2025 Data), was blank with no information on the form. Attached was an undated form, North Shore Healthcare QAPI Agenda and Meeting Minutes. Under the title of the form identified in the left-hand column each QAPI Committee member name, the second column identified the job title, and the third column identified a signature. The signatures included 8 committee members: medical records, unit manager, scheduler, business office manager, DON, executive director, MDS and medical director.The facility provided two undated quality reporting worksheets which included a header Topic Summary of analysis Should include Trends and Root Cause Analysis.1) Under the header included Center Specific Topics: with a listing of months across the page; there was no topic. Underneath was a section labeled Summary of Analysis Trending and Root Cause and Analysis and Action plans with months listed. 1st page no topic was identified but had January 2025 through March included None and April included customer service expectations/training/planning. Committees are in. Focus Quality measures flagging over 75% did not include falls. Topic Fall Incidence had entries for March and April. Recorded for March 13 falls, all falls were on the day shift, 1 person had 2 fall; in the section Proceed to Action plan/PIP Y/N - plan of correction for state. Recorded for April 14 falls for the month, 3 were unwitnessed falls. 5 before noon, 1 close to. No action plan was identified. May through July were blank. 2) undated quality reporting worksheet with the headings and columns for recording quality information and activity. This worksheet did not include a fall topic nor any fall prevalence, action plan, or activity. During an interview on 7/29/25 at 11:58 a.m., vice president of success (VPS)-A stated the executive director was currently on vacation and was unable to find any documentation of QAPI plan documented activities that were requested.Facility policy, Quality Assurance Performance Improvement (QAPI), revised 7/11/22, identified the purpose of QAPI is to take a proactive approach to continually improving the way we care for and engage with our residents, team members, and other partners so that we may realize our mission of being the premier health services provider and employer in each of the communities we serve. To do this, all employees will participate in ongoing QAPI efforts which supports us by establishing a culture based on our values of Trust, Engagement, Respect, Passion and

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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 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly (continued on next page)

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F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Based on interview and record review, the facility failed to ensure that its Quality Assessment and Assurance Committee (QAA) consisted of the required members and to meet at least quarterly, which had the potential to affect all 51 residents residing in the facility.Findings include:During an interview on 7/29/25 at 10:56 a.m., the director of nursing (DON) stated the QAA team meets monthly, the committee members include myself, the executive director, pharmacist, medical director, social worker, managers from nursing, dietary, housekeeping, medical records personnel, scheduler, human resources, maintenance, and the business office manager. DON was unable to articulate the date of the last meeting but stated it was in June 2025 sometime. DON indicated that the executive director was the contact person for the QAA committee, was responsible for documentation of QAPI meeting minutes and was currently on vacation.The facility provided quality meeting documentation, including QAPI Committee attendance signature logs for meetings held between January 2025 and June 2025. However, the documentation did not clearly distinguish which meetings were routine monthly sessions and which were designated quarterly meetings. As required under F867, committee members must meet at least quarterly. Furthermore, no attendance signature logs were provided for March 2025. Facility form, North Shore Healthcare QAPI Agenda and Meeting Minutes 1/19/25 (December 2024 Data.) Under the title of the form identified in the left-hand column each QAPI Committee member name, the second column identified the job title, and the third column identified a signature. The signatures included 11 committee members: medical records, unit manager, scheduler, business office manager, human resources, executive director, infection control nurse, MDS, social worker, life enrichment director and director of nursing. Form indicated those not in attendance included, medical director, maintenance director, dietician, and pharmacy consultant.Facility form North Shore Healthcare QAPI Agenda and Meeting Minutes dated 2/20/25, identified all members were present except for the DON. The facility provide two forms that were not dated1) Undated facility form North Shore Healthcare QAPI Agenda and Meeting Minutes identified all members were present except for the DON 2) Undated facility form North Shore Healthcare QAPI Agenda and Meeting Minutes idenified members not present were human resources, infection control nurse, and the social worker. Undated Facility form, Rochester East QAPI Report: was blank with no information on the form. Attached was an undated form, North Shore Healthcare QAPI Agenda and Meeting Minutes. Under the title of the form identified in the left-hand column each QAPI Committee member name, the second column identified the job title, and the third column identified a signature. The signatures included 11 committee members: medical records, unit manager, scheduler, business office manager, human resources, executive director, infection control nurse, MDS, social worker, medical director and maintenance. Undated Facility form, Rochester East QAPI Report: June 2025 Meeting (May 2025 Data), was blank with no information on the form. Attached was an undated form, North Shore Healthcare QAPI Agenda and Meeting Minutes. Under the title of the form identified in the left-hand column each QAPI Committee member name, the second column identified the job title, and the third column identified a signature. The signatures included 8 committee members: medical records, unit manager, scheduler, business office manager, DON, executive director, MDS and medical director. Those not in attendance included human resources and admissions, infection control nurse, and social worker.During an interview on 7/29/25 at 11:58 a.m., vice president of success (VPS)-A stated the executive director was currently on vacation and was unable to find any documentation of QAPI plan documented activities that were requested.During a phone interview on 8/4/25 at 11:24 a.m., executive director stated she only had QAPI sign in sheets for 1/19/25, 2/20/25 and 6/24/25. The executive director stated she was pretty sure we had QAPI meeting in May of 2025, she couldn't find the sign in sheet. Executive director further stated she usually keeps the QAPI data in her computer but couldn't find the documentation. Executive director indicated she had a QAPI book where department heads send me things from each department quarterly. Facility policy, Quality Assurance Performance Improvement (QAPI), revised 7/11/22, identified the purpose of QAPI is to take a proactive approach to continually improving the way we care for and engage with our residents, team members, and other partners so that we may realize our mission of being the premier health services provider and employer in each of the communities we serve. To do this, all employees will participate in ongoing QAPI efforts which supports us by establishing a culture based on our values of Trust, Engagement, Respect, Passion and Competence. The QAPI committee consists of representatives from all departments including nursing, dietary, life enrichment, social services, environmental services, maintenance, therapy, human resources