STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245222	A. Building B. Wing	09/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Estates at Chateau LLC	2106 Second Avenue South Minneapolis, MN 55404

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 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. (continued on next page)

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

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

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F 0627 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 an adequate discharge planning process was maintained to ensure resident preference for discharge was met for 1 of 2 residents (R46) reviewed for discharge planning.Findings include:R46's quarterly Minimum Data Set (MDS) assessment, dated 7/2/25, identified R46 had intact cognition with no behaviors or hallucinations or delusions. Section Q indicated there was no active discharge planning occurring for resident to return to the community. During an interview on 9/15/25 at 12:27 p.m., R46 stated she wants to move closer to family. R46 stated her family lived in a neighboring state and believed the facility was trying to find a place but hadn't heard any updates recently. R46's care plan, printed 9/18/25, indicated R46's current discharge plan is to move closer with family and family was looking for a SNF (skilled nursing facility) in the area of interest with an initiation date of 4/3/25. The focus/goal included the following interventions with initiation dates: - Mnchoice referral was completed for community-based services. 4/24/25- Referrals are being sent to SNF in [NAME] WI for facility transfers 7/10/25- Resident and family will be invited to care conferences quarterly or as needed, andd/c planning options will be discussed as needed. 4/4/25- Staff will make necessary referrals as needed in order to carry out resident's d/cgoals. 4/3/25The care plan lacked any information on where the referrals were sent, updates on referrals sent or outcome from referral made from MNchoice assessment. R46's progress notes, dated 4/2/25 to 9/16/25, were reviewed and included the following: -4/22/25: care conference note indicated a MNchoice assessment will be made.-4/21/25: referral sent to a facility-4/24/25: referral for MNchoice assessment was completed for community- based services for resident to discharge.-6/26/25: a referral was sent to facility per request of family and resident-6/30/25: referral to facility on 6/26/25 was denied and recommended two facilities-7/2/25: a referral was sent to facility (one of which was recommended) near R46's familyThe progress notes lacked information on response from referral sent 7/2/25 or 4/21/25, follow up from referral sent for assessment on 4/24/25, any additional referrals to nursing facilities for R46 to discharge since 7/2/25, and communication with R46's family regarding updates on discharge. R46's care conference, dated 7/2/25, identified R46, family, social services, nurse manager and physical therapy were present for the care conference. The document identified resident wants to transfer to another facility closer to family, multiple referrals have been sent to surrounding area, resident wants to be in independent housing and will need services set up. During an interview on 9/16/25 at 12:42 p.m., nursing assistant (NA)-A stated R46 talks about how she wants to go out in the community more. NA-A was unaware if R46 was planning on moving to another facility or if this was a goal of R46.During an interview on 9/17/25 at 1:15 p.m., social services director (SSD)-A reviewed R46's electronic medical record (EMR). SSD-A stated the EMR lacked evidence of any follow up on discharge plans, referrals, etc since R46's care conference's 7/2/25. SSD-A stated there should have been follow up since the care conference over 2 months ago as it was known resident wants to discharge. During an interview on 9/18/25 at 10:06 a.m., director of nursing (DON) stated when a resident expressed a desire to discharge from the facility the expectation would be to get social services involved, resources set up for a safe discharge in a reasonable amount of time and stated this was an ongoing process until the discharge happens. A facility policy titled Discharge Planning Policy, dated 1/2025, indicated the purpose of the policy was to identify each resident's discharge goals and needs, developing and implementing interventions to address them, and continuously evaluating them throughout the resident's stay to ensure a successful discharge.

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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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on interview and document review, the facility failed to provide a written bed hold notice for 2 of 2 residents (R3, R70) reviewed for hospitalization. Findings Include: R3 R3's significant change Minimum Data Set (MDS) assessment, dated 9/8/25, indicated R3 had intact cognition with no hallucinations or delusions and no behaviors. On 9/15/25 at 5:18 p.m., R3 was observed sitting outside. R3 declined to talk with surveyor.R3's admission record, dated 9/18/25, did not identify R3 as having a health care power of attorney (POA). R3's census log, printed 9/18/25, indicated R3 was on hospital leave the following dates:-7/5/25 with return on 7/8/25-7/22/25 with return on 8/1/25-8/8/25 with return on 8/15/25-8/19/25 with return on 8/26/25 R3's progress notes, dated 7/4/25 to 8/27/25 were reviewed and indicated the following: -7/5/25 at 5:51 p.m.: resident sent to the hospital due to confusion and found on the floor.-7/8/25 at 6:52 p.m.: resident returned to the facility-7/22/25 at 9:42 p.m.: resident was sent to the emergency room for evaluation.-8/1/25 at 11:30 p.m. : resident returned from the hospital.-8/8/25 at 4:40 p.m.: hospital transfer note indicated resident was transferred to the hospital for left groin surgical dehiscence.-8/15/25 at 10:59 p.m.: a default progress note was entered for wound vac for resident.-8/19/25 at 10:48 p.m.: resident did not come back from the appointment this evening. There is a possibility she might be going through another surgery. -8/26/25 at 12:43 a.m.: note indicated an as needed Tylenol (pain reliever) medication was administered pain.The progress notes between 7/5/25 through 7/8/25, 7/22/25 through 8/1/25, 8/8/25 through 8/15/25, 8/9/25 through 8/26/25 lacked evidence that a bed hold was completed prior to being sent to the hospital or a bed hold was sent to the hospital after resident was transferred.R3's Hospital Transfer Form, dated 7/22/25, identified R3 was transferred to the hospital on 7/22/25 for left leg swelling with beige color discharge. Section 1a contains radio buttons to indicate what forms were sent with resident with one of the options was bed hold form which was not marked. The form lacked evidence that a bed hold was sent with or discussed with resident prior to transfer to the hospital. R3's Hospital Transfer Form, dated 8/8/25, identified R3 was transferred to the hospital on 8/8/25 for left groin surgical dehiscence. Section 1a contains radio buttons to indicate what forms were sent with resident with one of the options was bed hold form which was not marked. The form lacked evidence that a bed hold was sent with or discussed with resident prior to transfer to the hospital. The electronic medical record (EMR) lacked evidence that Hospital Transfer Forms were completed for 7/5/25 or 8/19/25. During a review of R3's EMR, the EMR lacked documentation a written bed hold was sent to any of the R3's following hospital stays 7/5/25, 7/22/25, 8/8/25, and 8/19/25. R70R70's quarterly MDS assessment, dated 8/26/25, indicated R70 had intact cognition with no hallucinations or delusions and no behaviors.R70's admission record, dated 9/18/25, did not identify R70 as having a health care power of attorney (POA).R70's census log, printed 9/18/25, indicated R70 was currently on a hospital leave as of 9/11/25. R70's progress notes, dated 9/11/25 to 9/18/25 were reviewed and indicated the following:-9/11/25 at 10:25 a.m.: R3's family member was notified of R3's current condition and transferred to the hospital.-9/11/25 at 10:03 a.m.: hospital transfer note indicated resident was transferred to the hospital for severe tremors and complaints of dizzinessThe progress notes lacked evidence that a bed hold was completed prior to being sent to the hospital or a bed hold was sent to the hospital after resident was transferred.R70's Hospital Transfer Form, dated 9/11/25, identified R70 was transferred to the hospital on 9/11/25 for severe tremors and complaints of dizziness with history of cardiac complications. Section 1a contains radio buttons to indicate what forms were sent with resident with one of the options was bed hold form which was not marked. The form lacked evidence that a bed hold was sent with or discussed with resident prior to transfer to the hospital. On 9/16/25 at 1:34 p.m., surveyor called R70's family member (FM)-A but unable to connect.R70's EMR lacked evidence a bed hold was completed for hospital leave on 9/11/25.During an interview on 9/16/25 at 11:30 a.m., registered nurse (RN)-C stated when a resident transfers to the hospital, the nurse completes the Hospital Transfer Form, along with the bed hold form. RN-C stated a copy of the bed hold form is sent with the hospital and was unsure if facility keeps a copy but thinks so. RN-C stated if a copy was kept it would be uploaded into the EMR. Furthermore, RN-C stated if a bed hold was completed, the Hospital Transfer Form would indicate this as there was a box that to check that it was completed. During an interview on 9/17/25 at 1:41 p.m. licensed practical nurse manager (LPN)-A stated the expectation was nurses would obtain the bed hold when transferring a resident to the hospital. LPN-A stated a copy of the bed hold was sent to the hospital for coordination of care and a copy was scanned into the EMR. LPN-A stated if verbal consent for a bed hold was obtained, this would be written on

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to ensure routine personal hygiene (i.e., showers, hair care, shaving) were completed for 2 of 5 residents (R7, R1) reviewed for activities of daily living (ADLs) and who were dependent on staff for their care.Findings include: R7 R7's quarterly minimum data set (MDS) dated [DATE], indicated R7 was cognitively intact and had no hallucinations or delusions. R7 had impairments to both upper and lower extremities and used a wheelchair for mobility. They were frequently incontinent of bowel and bladder and was dependent on staff for all personal hygiene, to include shaving, toileting, baths, and oral hygiene. R7’s pertinent diagnosis included a central spinal cord syndrome (the spinal cord was bruised or damaged in the middle, at the level of the fourth vertebra in the neck and affects the arms more than the legs). R7’s care plan dated 5/30/22, identified a selfcare deficit related to maxillary fracture, cervical stenosis with central cord syndrome, weakness and preferred to keep fingernails long. R7 was dependent on one staff for bathing, dressing, grooming and personal hygiene. R7’s care plan lacked shaving preferences or their dependence on staff to perform such task. The third-floor nursing care sheets for group one, dated 5/15/25, identified dressing, grooming, oral hygiene, and bathing, but lacked instructions or preferences for resident’s dependent on staff for shaving. R7’s weekly skin assessment dated [DATE], 8/24/25, 8/31/25, and 9/14/25 all indicated a bed bath was given, but lacked shaving documentation. R7’s weekly skin assessment dated [DATE] indicated a shower was given but lacked shaving documentation. R7’s follow-up question report dated 8/1/25 through 9/17/25 indicated R7 was dependent on staff for shaving but lacked documentation shaving was completed. During an observation and interview on 9/15/25 at 1:23 p.m., R7 stated a shower was scheduled for Sundays, staff provided bed baths during the week, and R7 preferred to be cleaned shaven, but staff didn’t know how to do it. R7’s beard was approximately two inches long, curly, dark grey and full; covering the entire face and part of neck. During an interview on 9/16/25 at 10:52 a.m., registered nurse (RN)-B stated some residents preferred to shave themselves and those residents that needed assistance would be listed on the nursing assistance care sheets. RN-B confirmed R7 was dependent on staff for shaving. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 9/17/25 at 7:36 a.m., nursing assistant (NA)-A stated R7 had been asking staff for a few weeks to be shaved, but they were too busy, pointing to the call lights and stated it’s been like Christmas around here. NA-A stated she asked R7 if he was growing their beard for winter and that R7 told her no they had asked staff to shave it off, but that no one could get to it. NA-A stated she used a disposable razor this morning and that staff should shave R7 when he requested. During an interview on 9/17/25 at 11:43 am., the director of nursing (DON) stated the expectation was for resident to be shaved when and if they asked. Staff were here to provide cares, and it was expected staff create time to shave residents. R1 R1’s admission Minimum Data Set (MDS) assessment, dated 8/7/25, indicated R1 had intact cognition with no hallucinations, delusions or behaviors. R1 required staff set up for oral hygiene, upper body dressing, bed mobility, and personal hygiene, staff supervision for eating and required moderate staff assistance for toileting, lower body dressing and transfers. R1’s diagnosis report, printed 9/18/25, included the following diagnoses: acute respiratory failure with hypoxia (lungs can’t get enough oxygen to the body leading to low blood oxygen levels), dysphagia (difficulty swallowing), fracture of thoracic vertebra (a break in one of the bones in your spine) and adult failure to thrive (general decline in older adults). R1’s care plan, printed 9/18/25, indicated R1 had a self-care deficit related to diagnosis including but not limited to acute respiratory failure with hypoxia and facture of thoracic vertebra with a goal of “resident will be dressed, groomed and bathed per preferences,” with the following interventions: - “Assist of 1 with bathing and dressing” - “Assist of 1 with personal hygiene and oral hygiene” The care plan lacked any preferences. Furthermore, the care plan lacked evidence of refusals of accepting of assistance of staff or refusals of bathing. R1’s nursing assistant care sheet, printed 9/16/25, indicated R1 required assist of 2 staff for pivot transfers to wheelchair, and was incontinent of bowel and bladder with assist of 1 to toilet every 2-3 hours. In addition, R1 required assist of 1 staff for dressing, grooming, bathing and oral hygiene. R1’s weekly skin assessments indicated the following which were answered with radio-buttons: -8/7/25: refused bath -8/14/25: refused bath -8/21/25: refused bath (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-8/24/25: bed bath completed -8/28/25: refused bath -9/4/25: refused bath -9/11/25: refused bath R1’s progress notes, dated 7/28/25 to 9/16/25, were reviewed. Progress notes lacked evidence of R1 refusing showers/baths or staff assistance with ADLs. Furthermore, lacked documentation of staff offering an additional showers/bed bath/partial bath since last documented bath/shower on 8/24/25. During an observation and interview on 9/15/25 at 3:25 p.m., R1 declined to talk about showering/bathing with surveyor. R1 was observed and appeared to be frail and disheveled with a large dense, knotted clump of hair that covered approximately half to three quarters of the back of her head. On 9/16/25 at 2:02 p.m., R1 was observed outside the front of the facility. R1 continued to be appear disheveled with the front of her hair appearing shiny and the back continued to have the large dense, knotted clump of hair. During an interview on 9/16/25 at 11:42 a.m., registered nurse (RN)-A stated the nursing assistant care sheets were what the nursing assistants and the nurses used to get information about the residents. RN-A verified the nursing assistant care sheets provided to surveyor were up to date as they provided them to surveyor. During an interview on 9/16/25 at 12:47 p.m., nursing assistant (NA)-A stated when R1 first admitted to the facility, she needed assistance but had become more independent. NA-A stated R1 would refuse assistance but would ask for assistance if she needed it. NA-A if a resident refuses a shower, they let the nurse know so they could document it, but they attempted numerous times. NA-A did not answer if they had ever given R1 a shower/bath. During an interview on 9/17/25 at 8:30 a.m., NA-E stated they were familiar with R1, and stated R1 could become upset easily. NA-E would ask for assistance if she needed it. NA-E stated they had not given R1 a shower, adding it must not be scheduled on a day they work with her but would think she would need some level of assistance in the shower. NA-E stated R1's hair was “matted” in the back. During an interview on 9/18/25 at 9:38 a.m., licensed practical nurse manger (LPN)-A stated R1 refused assistance. LPN-A stated R1's hair was “matted,” and verified it did not appear as though it had been washed. LPN-A stated R1 would require staff to at least stand in the shower room for safety during a shower. LPN-A reviewed R1's electronic medical record (EMR) and verified the last documented shower/bath/bed bath was on 8/22/25, which was almost 4 weeks ago. LPN-A stated the expectation would be to provide showers at least weekly, if a resident refused then staff should keep offering. LPN-A stated staff must get creative sometimes to help residents maintain their hygiene and what works for them. LPN-A stated the expectation would be that any interventions and reapproaches be documented in the progress notes. LPN-A stated showering/hygiene is important as it helps prevent infections and help people feel better about themselves. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 9/18/25 at 10:10 a.m., director of nursing (DON) stated the expectation would be to offer a shower/bath weekly and if a resident refused it should be reattempted. DON stated staff should still attempt to groom in a way they will accept and this should be documented. A facility policy titles Activities of Daily Living (ADLs)/Maintain Abilities Policy, dated 3/31/23, indicated “Based on the comprehensive assessment of a resident and consistent with the resident’s needs and choices, the facility will provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable.”

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. (continued on next page)

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F 0684 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 comprehensively monitor and assess for edema (swelling caused by fluid retention) so intervention effectiveness could be determined, and new interventions could be developed if needed, and ensure recommended edema management interventions were followed as appropriate for 1 of 1 residents (R29) assessed for edema management. Findings include: R29's quarterly Minimum Data Set (MDS) dated [DATE], indicated R29 had intact cognition and was diagnosed with heart and respiratory failure.R29's care plan dated 5/28/25, indicated R29 was receiving a diuretic and had a history of edema. The care plan did not include a plan for edema monitoring. R29's order summary dated 7/3/25, included an order for thigh-high compression stockings that were to be applied to R29's bilateral lower extremities during the day and then removed at night for edema. The summary included an order for 40 milligrams (mg) of torsemide (a diuretic, used to treat fluid retention) daily for localized edema. The order summary did not include orders for monitoring the severity of R29's edema or for the use of [NAME] wraps. R29's treatment administration record (TAR) dated 9/1/25 through 9/16/25 at 1:59 p.m., indicated R29 had an order for thigh-high compression stockings that were to be applied to R29's bilateral lower extremities during the day and then removed at night for edema. The TAR indicated the stockings had been applied daily and did not indicate R29 had refused the stockings. The TAR did not include edema monitoring or a treatment record for lymphedema (swelling from an accumulation of protein-rich fluid usually drained by the body's lymphatic system) wraps. R29's occupational therapy note dated 6/15/25, indicated the occupational therapist had assessed R29 and had noted lymphedema in her bilateral toes to thighs. On 7/2/25, [NAME] wraps (an adjustable compression garment used for treating lymphedema and chronic venous disease that uses Velcro and multilayer bandaging) were used on R29's lower extremities, and a printed PDF was hung in R29's room to assist R29 and staff members with donning and doffing the wraps. On 7/19/25, the occupational therapist noted that R29 would require assistance applying the wraps and should wear them during the daytime and take them off at night. On 7/27/25, the occupational therapist noted that the directions on how to don and doff the [NAME] wraps were gone from R29's wall, but nursing staff stated they had been assisting R29 with the garment. The OT noted that R29 stated that it at times took staff a long time to apply the [NAME] wraps. R29's medical record was reviewed and did not include edema monitoring. During an interview and observation on 9/15/25 at 1:14 p.m., R29 stated that staff were supposed to apply her compression wraps, pointing at a box containing multilayered wraps with Velcro, every morning. R29 stated this rarely happened as she felt the staff were too busy and/or did not know how to apply them. R29 was observed with gripper socks on, and the skin of her lower extremities was observed with no compression wraps on. During an observation and interview on 9/16/25 at 1:21 p.m., registered nurse (RN)-C confirmed she was the nurse in charge of R29's care this shift. RN-C stated she had never applied RN-C's compression wraps as she thought this was something only therapy was supposed to do. RN-C acknowledged that directions were on the wall for application but still thought that therapy was the only person who was supposed to apply her wraps. RN-C confirmed she had also not applied the compression stockings, as she thought therapy was supposed to come every morning to apply the wraps instead. During an interview and observation on 9/17/25 at 10:48 a.m., licensed practical nurse (LPN)-B confirmed she was the nurse in charge of R29's care this shift. LPN-B stated she was unsure if staff were to assess R29 for edema. LPN-B confirmed she had reviewed R29's medical record and did not see that staff had been assessing R29's edema, and so she did not know if R29's edema had improved or declined. When asked how much edema R29 had, LPN-B was observed to look and, without touching R29, stated some.During an interview on 9/16/25 at 1:33 p.m., the director of rehabilitation, physical therapy assistant (PTA)-A stated that therapy staff would assist R29 in applying the wraps if she had therapy that day and they were not applied by the time they saw her, but she only had therapy three to five times a week. PTA-A stated this was why the occupational therapist had put instructions for application on R29's wall, to assist nursing staff. On 9/17/25 at 11:42 a.m., PTA-A confirmed she had reviewed R29's medical record, and nursing staff were supposed to be assisting R29 in applying her compression wraps at the beginning of each day and then assisting her in removing them every evening.During an interview on 9/17/25 at 2:17 p.m., the nurse manager for the floor, LPN-A, confirmed she had reviewed R29's medical record and was unable to find out if nursing staff were to be applying the compression stockings or wraps, but thought it was appropriate for each nurse to decide

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Estates at Chateau LLC	2106 Second Avenue South Minneapolis, MN 55404

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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 - 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 observation, interview and document review, the facility failed to ensure a resident who had several documented incidents of smoking in the facility was free from potential smoking accidents for 1 of 3 residents (R4) reviewed for smoking. Findings include: R8's quarterly minimum data set (MDS), dated [DATE], indicated R8 was admitted to the care facility on 3/27/25. The MDS further indicated R8 refused to be interview for mental status but was assessed with okay long term and short-term memory and was able to recall season, location, staff names and faces and where she lived.R8's care plan, dated 7/30/25, indicated R8 was able to smoke independently, with the following interventions: Resident smoked in room, No smoking signs in place, and will not allow removal of cigarettes. R4's care conference note, dated 6/16/25, indicated R4 had been smoking in her room at times. R4's smoking assessment, dated 9/3/25, indicated the assessment was completed due to smoking violations of smoking in her room and further indicated resident smoking materials will be kept at the nursing station.During observation and interview on 9/16/25 at 11:02 a. m., a plastic cup and a container of coffee grounds were observed on the back of R4's toilet. The wall of R4's bathroom shared a wall with the oxygen tank fill room next door. The plastic cup contained a dark, opaque liquid with tar-colored streaks along the inner surface. It appeared to be approximately three-quarters full and was topped with what looked like coffee grounds, partially concealing the contents beneath. The room was permeated by a strong, persistent odor of smoke, which lingered heavily in the air. The floor in her room appeared to be covered in loose tobacco and a zip lock baggie of what R8 stated was loose tobacco was on her wheelchair seat. R4 stated she rolled her own cigarettes and kept all of her smoking materials in her room. During an interview on 9/16/25 at 11:23 a.m., trained medication aide (TMA)-G stated she had heard that R4 smoked in her bathroom. TMA-G stated R4 spent a lot of time in her bathroom and staff could smell something that smelled to them like cigarette smoke. TMA-G stated R4 would not let staff in her room without knocking and waiting for a response. During an interview on 9/18/25 at 8:15 a.m., registered nurse (RN)-D stated she had completed R4's smoking assessment and assessed R4 has not being safe with her own smoking materials due to her smoking in her room. RN-D stated she had asked R4 to sign the smoking policy and a risk versus benefit of smoking in her room but R4 had refused to have her smoking materials held at the nursing station. During an interview on 9/18/25 at 11:01 a.m., the administrator and director of nursing confirmed it was the policy of the facility to ensure residents only smoke in the designated smoking areas. A facility policy titled Resident Smoking Policy, dated 10/2024, indicted any residents who do not comply with this policy may lose smoking privileges. Privileges can be reevaluated upon resident request and the facility must document in the care plan and/or progress notes other attempted interventions to manage and accommodate smoking needs before revoking smoking privileges.

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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	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that one of one resident (R2), reviewed for catheter use, had documented clinical decision-making regarding the use of an indwelling urinary catheter including the reason for insertion, justification for continued use, and evidence of periodic reassessment. In addition, the facility failed to attempt and document a trial removal of the catheter, despite the resident experiencing repeated urinary tract infections associated with catheter use. Findings include: R2's annual minimum data set (MDS), dated [DATE], indicated R2 was admitted to the care facility on 11/3/23 and was cognitively intact. The MDS further indicated R2 was independent with his activities of daily living and had an indwelling catheter. R2's diagnoses list, dated 11/3/23, indicated R2 had the following medical diagnoses: urethral stricture, anterior urethral stricture (an abnormal narrowing of the first part of the male urethra caused by scar tissue, leading to symptoms like a weak urine stream, spraying urine, pain, and sometimes blood or UTIs. Treatment options often include urethral dilation, urethrotomy (endoscopic cutting), or urethroplasty (surgical reconstruction)), obstructive and reflux uropathy (describes a urinary tract condition where urine flow is both obstructed and flows backward from the bladder into the ureters. Catheters, stents, or nephrostomy tubes can provide short-term relief by allowing urine to bypass the blockage. Surgery may be needed to correct the underlying cause, such as an enlarged prostate or structural issues with the ureters.)R2's Order List contained orders, dated 8/26/25 and 8/27/25 to change R2's indwelling catheter every month and to monitor output every shift. R2's care plan, dated 11/6/23, indicated R2 had alteration in elimination related to long term foley catheter use.R2's electronic medical record (EMR) lacked any evidence the facility had attempted any trial removal of R2's catheter since admission or had seen urology to provide further details on catheter plan and management. The EMR further indicated R2 had at least two urinary tract infections in the past 9 months, one in February requiring hospitalization due to going septic from the urinary tract infection, and another in April requiring antibiotics. During an interview on 9/15/25 at 2:54 p.m., R2 stated he had a history of getting urinary tract infections and felt like he had one currently. R2 stated he had his indwelling catheter for a couple of years and the plan was to have it in place until R2's knees get better and he can stand up and care for himself. During an interview on 9/18/25 at 8:22 a.m., nurse manager and registered nurse (RN)-A confirmed the facility has not attempted a trial removal of R2's catheter as he had had it in place for a long time. RN-A stated they received a referral yesterday from his primary care provider to see urology. RN-A also stated a progress noted was put in yesterday regarding a conversation with R2 regarding his catheter. R2's progress noted, dated 9/17/25, indicated R2 liked to have his catheter in place because he could not yet stand to use the toilet, stating regardless he was told a long time ago from a doctor in Duluth that the catheter would be permanent. During an interview on 9/18/25 at 11:01 a.m., the director of nursing confirmed R2's catheter should be assessed for continued use. A policy was 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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to follow developed nutritional interventions to ensure nutritional status was maintained or improved for 3 of 4 residents (R22, R60, R66) reviewed for nutrition. In addition, the facility failed to ensure an order for fluid restriction was followed for 1 of 1 resident (R8) reviewed for fluid restrictions. Findings include: R22’s comprehensive Minimum Data Set (MDS) dated [DATE], indicated R22 had intact cognition and was diagnosed with diabetes and hypertension. R22's order dated 1/16/25, indicated R22 was to receive a diet with a regular texture and included the directions for large portions. R22's care plan dated 8/20/25, indicated R22 had increased nutritional needs related to a stage three pressure ulcer in the gluteal fold. R22's progress note dated 9/9/25 at 1:02 p.m., indicated R22 had a recent significant weight gain related to increased oral intake with a history of weight loss. The note indicated R22 was to receive double portions per resident request. R60’s quarterly MDS dated [DATE], indicated R60 had intact cognition and was diagnosed with Crohn’s disease and malnutrition. R60’s order summary dated 9/16/25, indicated R60 had an order for a regular diet and did not include an order for yogurt or cottage cheese with meals. R60’s care plan dated 6/9/25, indicated R60 had a potential for an alteration in nutrition related to Crohn’s disease, malnutrition, a “malabsorptive GI [gastrointestinal] condition”, and food insecurity. The care plan indicated that yogurt and cottage cheese were added to R60’s meals as R60 had refused supplements. R60’s dietary progress note dated 9/2/25, indicated R60 requested to discontinue the “magic cup” with a plan to replace it with cottage cheese and yogurt. R66’s comprehensive MDS dated [DATE], indicated R66 had moderately impaired cognition and had a diagnosis of malnutrition. R66’s MDS indicated she was admitted to the facility on [DATE]. R66's order dated 8/15/25, indicated R66 was to receive a diet with a regular texture and included the directions for large portions. R66’s care plan dated 8/8/25, indicated R66 had a potential for an alteration in nutrition related to extreme fatigue, polysubstance use, and a gastric bypass, leading to chronic diarrhea and malabsorption. The care plan indicated R66 was to receive large portions as she was at risk for malnutrition. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 9/15/25 at 12:36 p.m., R22 stated regarding food, there isn't enough of it. R22 went on to state he was supposed to get extra food with each meal, but did not think this was happening. R22 stated that if he wanted extra food, he had to buy it out of the vending machine. During an observation on 9/15/25 at 12:50 p.m., a room tray was observed to be dropped off at R22's room. The meal slip was observed to say, double portions on two plates, but only one food plate was noted. The plate was observed with one small scoop of what appeared to be a pasta dish, one small scoop of what appeared to be a cucumber salad, and one small scoop of what appeared to be another type of pasta. R22's tray was also observed to have one brownie and two bowls of a hot liquid. During an interview and observation on 9/15/25 at 1:16 p.m., R60 stated she wanted to gain weight but felt like she was not receiving enough food. R60 stated she had met with the dietician a couple of weeks ago and was supposed to get either cottage cheese or yogurt with her meals but had never gotten them. R60 was observed with a room tray with a small scoop of a pasta dish, one small scoop of what appeared to be a cucumber salad, and one small scoop of what appeared to be another type of pasta with no yogurt or cottage cheese observed on the tray. R60’s portions appeared to be the same size as R22’s. R60 confirmed that cottage cheese or yogurt had not been received with the lunch meal. During an interview on 9/15/25 at 4:10 p.m., R66 stated the facility was supposed to give her double portions for her meals, but that never happened. During an observation and interview on 9/16/25 at 12:10 p.m., Dietary aid (DA)-B was observed in the kitchen plating the lunch meals with pasta, green beans, one bread stick, and chocolate pudding with whipped cream. All plates appeared to be prepared in the same fashion and appeared to have the same portions. The plates were set onto three-tiered carts, two by two on each of the three levels. The resident meal tickets were in a uniform stack near the serving station. DA-A took the stack of meal tickets and placed a ticket with each of the plates after the meals were plated. During an observation on 9/16/25 at 12:18 p.m., R60's meal tray was observed with a small breadstick and a small serving of green beans, pasta, and pudding. No yogurt or cottage cheese was observed on R60's tray. At 12:26 p.m., R22’s meal tray was observed with similarly sized portions of a small breadstick and a small serving of green beans, pasta, and pudding. R22’s tray had the addition of two bowls with a hot liquid. At 12:31 p.m., R66’s meal tray was observed with similarly sized portions for the small breadstick and a small serving of green beans, pasta, and pudding, as both R22 and R66. During an interview and observation on 9/17/25 at 12:51 p.m., nursing assistant (NA)-A confirmed she had observed other resident meals, and R22 had not received large portions, as it looked the same as the other residents and felt the serving size was smaller than it should be. Room trays for R22 (order for large portions), R29 (no order for large portions), R60 (no order for large portions), and R66 (order for large portions) were observed, all with similar-sized portions for the piece of whole meat, cooked carrots, and potatoes. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 9/17/25 at 12:58 p.m., the culinary director (CD) stated that culinary staff were supposed to split the portions when plated so residents could visually tell when a double or large portion was given, as they had some complaints that these larger portions were not being received. The culinary director stated that a large portion meant that a portion and a half would be given to a resident and confirmed that it would appear visually larger than a regular portion, and confirmed if it did not, a regular portion was likely received. The CD stated he became aware that R60’s yogurt/cottage cheese was being missed at mealtimes today, and it was going to be taken care of. The CD stated that the facility had been out of the yogurt that was ordered to be served for R60 during lunch time, but staff could have substituted cottage cheese for this. During an interview on 9/17/25 at 1:16 p.m., the registered dietician (RD) confirmed she had assessed R66 for malnutrition on admission and had started her on a supplement and added large portions. The RD stated she had met with R66 again since then, and R66 had voiced concern that she was not getting large portions, so she had asked the CD to follow up with her and had increased her supplement intake. The RD stated that the supplements and large portions were to assist R66 in gaining weight, and without the large portions, she would be concerned that she may not be getting enough calories to reach this goal. At 1:19 p.m., the RD stated that for R60’s malnutrition, she had started a magic cup for her, but R66 didn’t like it, so a couple of weeks ago, she had ordered it to be changed to either yogurt or cottage cheese at mealtimes. At 1:23 p.m., the RD stated R22 was on large portions due to a previous downtrend in weight and for wound healing. The RD stated R22's weight had been going up this month, so she was not concerned about R22's caloric intake but did think it was important that R22 received large portions at meals, as that was his preference. The facility's Dietary Guidelines policy dated 9/2012, indicated that food and nutritional needs of the residents would be met in accordance with the attending physician's orders. The policy indicated that therapeutic diets would be prepared and served as prescribed by the attending physician and with the supervision or consultation of the qualified dietitian. R8’s quarterly minimum data set (MDS), dated [DATE], indicated R8 was admitted to the care facility on 3/27/25. The MDS indicated R8 refused to be interview for mental status but was assessed with “okay” long term and short-term memory and was able to recall “season, location, staff names and faces and where she lived.” R8’s Order list in the electronic [NAME] record (EMR) indicated an order, dated 6/23/25 for an 1800 milliliter (mL) fluid per day related to hyponatremia (when your blood sodium (salt) level is lower than it should be). R8’s care plan, revised 9/15/25, indicated R8 was on a fluid restriction, indicating R8 could have 300 mL of fluid each meal and 900 mL of extra fluid per day. R8’s medication administration record (MAR) from September indicated R8 was “independent” with her fluid restriction. R8’s EMR lacked evidence a risk versus benefit or education was done with her on the importance of her prescribes fluid restriction. During observation on 9/15/25 at 1:51 p.m., R8 was sitting in her room, drinking from a mug approximately ¼ full of an orange-colored liquid. The mug held 500 mL of liquid. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 9/16/25 at 1:58 p.m., trained medication aide (TMA)-G stated she was aware R8 was on a fluid restriction but stated nursing staff were unable to monitor her fluid intake because she was independent with her activities of daily living and could obtain fluids on her own. Durin and observation on 9/17/25 at 10:00 a.m., R8 was again observed drinking freely out of a clear, plastic jug that held 500 mL of fluids. During an interview on 9/18/25 at 8:15 a.m., nurse manager and registered nurse (RN)-D stated it would be expected that the resident’s fluid intake was monitored and that noncompliance would be documented. RN-D stated she would look for any documentation of education or a risk versus benefit regarding R8’s fluid intake as it would be expected if R8 was documented as independent with her fluid restriction. During an interview on 9/18/25 at 8:38a.m., R8 stated she was aware she was on a fluid restriction because she was made aware from an outside provider, stating nobody at the facility has talked with her about it, educated her on how to maintain her fluid restriction, the importance of following it or the risks of not if she did not. A facility policy titled Fluid Restriction Guidelines was received but did not address fluid restrictions of 1800 mL.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. (continued on next page)

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F 0698 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 implement or maintain an appropriate communication and collaboration system with an outside dialysis clinic to promote continuity of care and reduce the risk of complication (i.e., missed orders, insufficient preparation for treatment) for 2 of 2 resident (R5, R24) reviewed for dialysis care. Furthermore, the facility failed to provide snacks/meals as ordered for 1 of 1 resident on dialysis days.Findings include:R5's quarterly Minimum Data Set (MDS), dated [DATE], identified R5 had intact cognition and diagnoses including anemia, high blood pressure, visual impairment and renal insufficiency and/or renal failure. In addition, the MDS outlined R5 received dialysis care while a resident at the care center.R5's provider orders dated 4/9/25, directed staff to send a dialysis communication form with resident, review upon return two times a day every Monday, Wednesday, and Friday. R5's care plan dated 6/28/24, identified potential for complications related to dialysis and included an intervention to send communication folder to dialysis with each run. A review of R5's medical record lacked consistent communication between the facility and the dialysis center. Dialysis communication logs were scanned for the following dates: 5/2/25, 5/5/25, 5/7/25, 5/9/25, 5/12/25, 5/14/25, 5/16/25, 5/19/25, 5/21/25, 5/30/25, 6/2/25, and 6/4/25. The record lacked communication from 6/4/25 through 9/15/25.During interview on 9/16/25 at 10:33 a.m., R5 verified he was on dialysis. R5 explained he went to an offsite clinic for treatment multiple times per week and wasn't aware of a process for communication between the care center and the dialysis unit and ate lunch after he returned from dialysis.During interview on 9/16/25 at 11:59 a.m., registered nurse (RN)-B stated R5 left during the night shift (early morning) and wasn't aware of the communication process between the care center and the dialysis facility. RN-B stated at one point there was a plan in place for the dialysis center to fax treatment and communication logs at the end of each week and that all nurses were responsible to monitor the electronic fax folder and upload documents into the resident's medical record. RN-B was not able to confirm if the process was still in place or describe the current process for communication. RN-B verified she was working as the floor nurse while R5 was at dialysis on 9/15/25 and had not received any communication from the dialysis center after his return. RN-B confirmed R24 had no communication log either or a binder when she returned from dialysis 9/16/25. The dialysis residents were suppose to receive a snack and bag lunch, but this was done before she arrived on the night shift and that it was the kitchens responsibility to send up snacks and bags for dialysis residents. No snacks were available on the unit and R24 returned close to lunch time and could just go eat lunch. On 9/16/25 at 12:59 p.m., registered nurse (RN)-E confirmed she was the charge nurse at the dialysis center where R5 received dialysis cares. RN-E confirmed R5 did not bring a communication log to the dialysis facility with current vital signs or weights and that this was common practice for the facility. RN-E stated if the dialysis center had an issue with R5 they would reach out directly to the facility. On 9/17/25 at 7:31 a.m., R5's dialysis binder was on the nurse station desk and R5 was out of the facility for dialysis. On 9/17/25 at 2:24 p.m., RN-B verified R5 did not take a communication binder to dialysis or bring any communication logs back from dialysis. R24R24's admission Minimum Data Set (MDS) dated [DATE], identified R24 had intact cognition and diagnoses including anemia, diabetes, high blood pressure, heart failure and renal insufficiency and/or renal failure. In addition, the MDS outlined R24 received dialysis care while a resident at the care center.R24's provider orders dated 8/25/25, identified the shift nurse collected the dialysis binder from the resident and placed referral sheets into the medical records to be scanned, called dialysis to fax a copy of the run if resident didn't have it, and the resident had dialysis every, day shift, Tuesday Thursday and Saturday. In addition, staff were to send a snack or sack lunch with resident to dialysis, every night shift every Monday, Wednesday and Friday.R24's care plan dated 8/11/25, identified the potential for complications related to dialysis and included an intervention to send communication folder to dialysis with each run. R24's care plan lacked information to send a snack or sack lunch to dialysis.On 9/16/25 at 10:56, R24 stated dialysis was this morning, I'm starving no snack or sack lunch was provided and they have never given a snack or sack lunch. On 9/16/25 at 12:07 p.m., the nurse manager, registered nurse (RN)-A stated assessments were completed before residents left for dialysis and a communication log, kept in a binder, was sent with each dialysis resident. Upon returning from dialysis nurses checked the dialysis site, obtained vital signs, and reviewed the communication logs. RN-A stated if a resident returned without communication, the nurse could call the dialysis center or tell the nurse manager. On 9/16/25 at 12:18 p.m., the registered dietician (RD) stated the

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. (continued on next page)

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F 0699 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 compressively assess a resident with several mental health diagnoses including post-traumatic stress disorder to ensure, if needed, accurate interventions were in place to prevent traumatization. The facility further failed to ensure collaboration with a resident's outside psychiatric provider for 1 of 2 residents (R8) reviewed for trauma informed care. Findings include:R8's quarterly minimum data set (MDS), dated [DATE], indicated R8 was admitted to the care facility on 3/27/25. The MDS indicated R8 refused to be interview for mental status but was assessed with okay long term and short-term memory and was able to recall season, location, staff names and faces and where she lived. The MDS further indicated R8 was on the following medication types: antipsychotic, antianxiety, hypnotic, hypoglycemic, and anticonvulsant.R8's diagnoses list, dated 3/27/25, indicated R8 had several medical diagnoses including bipolar disorder, major depressive disorder, anxiety disorder, and post-traumatic stress disorder.R8's Orders indicated an order, dated 7/23/25, for target behavior monitoring which included the following target behaviors: anxious, restlessness, smoking in room, substance use, yelling at staff, room hoarder, and agitation.R8's treatment administration record (TAR) from September lacked any documentation of target behaviors, indicating R8 had none despite target behaviors being present during survey.R8's care conference notes, dated 4/4/25 and 6/16/25 (a care conference note was started but not completed on 9/2/25), indicated R8 did not request ACP [Associated Clinic of Psychology] services.R8's primary provider order, dated 8/19/25, indicated the provider had decreased Seroquel (an antipsychotic medication used to treat mental health conditions such as schizophrenia, bipolar disorder, and major depressive disorder) to 300mg every evening per GDR [gradual dose reduction] recommendations. Will defer to ACP pending outcome of reduction. R8's first trauma assessment in her chart was dated 8/25/25 and indicated R8 reported a traumatic experience with law enforcement when she was hospitalized by the facility in May. The trauma assessment lacked any assessment of R8's PTSD diagnosis or past history of trauma and abuse.During observation on 9/16/25 at approximately 1:00 p.m., R8 was getting on the elevator, yelling loudly at a staff member, I don't want you on the elevator over and over, yelling that she was not comfortable being around this staff member.During an interview and observation on 9/17/25, R8 was laying on her bed, food trays with leftover food were on her bed and the floor was covered in resident's clothing, blankets, shoes and what appeared to be garbage and loose tobacco. R8 started crying, talking about her past traumas and history of abuse prior to admitting to the facility. R8 stated she saw an outside psychiatric provider but could not confirm if she saw the provider virtually or in person. R8 stated she did not like to talk with SS-A about her past traumas. The DON was present for the interview. During an interview on 9/17/25 at 1:23 p.m., the director of social services (SS)-A stated it is expected when a resident admitted that social services reviewed diagnoses for any evidence of past trauma and review hospital paperwork to help understand them [the residents]. SS-A stated part of the admission process is asking residents if they want to see ACP, stating there are trauma forms to use but most [residents] don't tell us they are having trauma. SS-A stated she had to catch her [R8] on a good day to get her to talk to her but that R8 should have had a trauma assessment done with all her diagnoses, stating I am not sure why we didn't catch that right away. SS-A stated there was a trauma assessment completed in August about some concerns that R8 brought up about her hospitalization in May, but nothing that referenced her past traumas. SS-A stated she was unaware of who R8 saw as an outside psychiatric provider because R8 refused to tell her, stating it would be nursing's responsibility to communicate with R8's primary care provider about R8 not seeing the facility ACP providers.During survey, SS-A attempted to assess R8 for her traumas, however documented R8 refused to discuss them with her.During an interview on 9/18/25 at 8:15 a.m., nurse manager and registered nurse (RN)-D stated staff should be accurately recording R8's behaviors even if they seem like baseline behaviors for her, confirming R8 had exhibited target behaviors over the past few days. RN-D stated an accurate assessment of R8's behaviors is important to ensure R8 is receiving proper treatment. RN-D stated it was the responsibility of social services to coordinate ACP, stating she was not sure if R8 saw an outside psychiatric provider. RN-D stated she has seen notes from R8's primary provider referring to ACP for medication management however was not sure if she meant R8's outside psychiatric provider.During an interview on 9/18/25 at 11:01 a.m., the director of nursing agreed that R8 should have been assessed for trauma at admission and will assess if someone other than SS-A would be able to interview R8 on her past

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	245222	A. Building B. Wing	09/18/2025

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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 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on observation, interview, and document review, the facility failed to ensure non-pharmacological interventions were attempted and recorded prior to the administration of as-needed (PRN) narcotic medication to help facilitate person-centered care planning and reduce the risk of complication (i.e., constipation, sedation) for 2 of 6 residents (R1, R46) reviewed for unnecessary medication use.Findings include:R1R1's admission Minimum Data Set (MDS) assessment, dated 8/7/25, identified R1 had intact cognition with no hallucinations, delusions or behaviors. R1 required staff set up for oral hygiene, upper body dressing, bed mobility, and personal hygiene, staff supervision for eating and required moderate staff assistance for toileting, lower body dressing and transfers. In addition, the MDS outlined R1 received both scheduled and PRN pain medications during the review; however, did not receive any non-medication intervention for pain. Further, R1 indicated they had occasional pain which they rated at six (6) out of 10 (10 being the worst possible). R1's care plan, printed 9/18/25, identified R1 had an alteration in comfort and a listed goal of adequate relief from pain as evidenced by verbalization and freedom from signs/signs of non-verbal indicators of pain. The care plan listed inventions to help R1 meet this goal which included, provide non medicinal forms of pain relieve such as positioning, rest, massage, etc., and pain medication as ordered by MD, and document on effectiveness of pain medication.R1's September Medication Administration Report (MAR) included the following:-oxycodone (narcotic pain medication) 5 milligrams (mg) tablet-give one (1) tablet by mouth every twelve (12) hours as needed for breakthrough pain starting 9/11/25 which had been administered three (3) times. Administrations documented with an e indicating effective along with a pain scale prior to administration. There was no documentation on the MAR of nonpharmacological interventions prior to administration.-oxycodone 5 mg tablet-give one (1) tablet by mouth every eight (8) hours as needed for breakthrough pain starting 9/4/25 and ending 9/11/25 which had been administered eleven (11) times. Administrations documented with an e indicating effective along with a pain scale prior to administration. There was no documentation on the MAR of nonpharmacological interventions prior to administration.-oxycodone 5 mg tablet-give one (1) tablet by mouth one time for breakthrough pain for one day on 9/11/25 which was administered one (1) time. Administrations documented a pain scale prior to administration. There was no documentation on the MAR of nonpharmacological interventions prior to administration.-oxycodone 5 mg tablet-give one (1) tablet by mouth every eight (8) hours as needed for breakthrough pain starting 8/29/25 and ending 9/4/25 which had been administered seven (7) times. Administrations documented with an e indicating effective along with a pain scale prior to administration. There was no documentation on the MAR of nonpharmacological interventions prior to administration.The MAR also included the following Non-Pharmacological Pain Interventions:0: No intervention needed1: Ice2: Heated blankets3: Massage4: Repositioning5: Music6: Essential Oils7: Food/Drink8: Relaxation BreathingEvery shift starting 7/28/25The MAR was documented with a 0 every shift from 9/1/25 through 9/15/25 indicating no intervention needed. R1's progress notes, dated 7/28/25 to 9/16/25, lacked evidence of non-pharmacological interventions were offered or attempted prior to administration.R1's medical record was reviewed and lacked evidence of what, if any, non-pharmacological interventions were offered or attempted prior to the administration of the PRN narcotic medication all the administered doses from 8/1/25 to 9/16/25. On 9/15/25 at 3:10 p.m., R1 was observed sitting in her wheelchair. R1 stated she had constant pain due to an accident prior to arriving at facility. R1 stated she took pain medication to help manage the pain. R1 stated she had not been offered any alternatives to pain medication such as ice, heat or massage.During an interview on 9/17/25 at 8:30 p.m., nursing assistant (NA)-E stated R1 had a history of reported pain. R46 R46's quarterly MDS assessment, dated 7/2/25, identified R46 had intact cognition with no hallucinations, delusions or behaviors and required staff assistance with some ADLs. In addition, the MDS outlined R1 received pain scheduled during the review; however, did not receive any non-medication intervention for pain. Further, R46 indicated they had occasional pain which they rated at four (4) out of 10 (10 being the worst possible). R46's care plan, printed 9/18/25, identified R46 had an alteration in comfort and a listed goal of adequate relief from pain as evidenced by verbalization and freedom from signs/signs of non-verbal indicators of pain. The care plan listed inventions to help R1 meet this goal which included, provide non medicinal forms of pain relieve such as positioning, rest, massage, etc, encourage resident to verbalize discomfort, monitor for potential medication side effects related to pain medication usage including constipation, nausea and vomiting, sedation, lethargy, anorexia and increased confusion, pain medication as

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Based on observation, interview, and document review, the facility failed to ensure monitoring and timely removal of facility food stored in refrigerators was completed to reduce the risk of foodborne illness. In addition, the facility failed to ensure the refrigerator and cooler temperatures were properly monitored and maintained to reduce the risk of foodborne illness. This had the potential to affect all 64 residents who consumed meals from the main kitchen.Findings include:UNLABLED FOODDuring the initial kitchen observation with the dietary aid (DA)-A on 9/15/25 at 11:41 a.m., the following foods were found in a double-door refrigerator in the first-floor kitchen.-One gallon of skim milk, half full, manufacture expired date 9/10/25.-Unlabeled open plastic bag of pre-made salad consisted of brown lettuce, orange carrots, purple cabbage, brown juice on the bottom of the bag.-A plastic container of opened sour cream, manufacture expired date 8/27/25, labeled 9/14/25.-A plastic container of opened deli salad, manufacture expire date 9/8/25, labeled 8/5/25. A second unlabeled opened container was marked with a manufacture expire date of 9/24/25.-Unlabeled box with approximately 10 fresh green peppers.-Unlabeled thawed, uncooked chicken covered in a plastic container. Labeled placed 9/15/25 during walk through.-One opened serving bowl of fruit cocktail, labeled 9/11/25.-One opened bag of ham slices, labeled 9/8/25.-One tall white cylinder container with thawed uncooked chicken, labeled 9/12/25.-One plate of thawed, uncooked chicken thighs labeled 9/7/25, placed on the same baking sheet as a container of chicken soup unlabeled, a bowl of beef broth labeled 9/13/25, and an uncovered bowl of hard boil eggs, labeled 9/14/25.-One sliver container, uncovered with chunks of cooked ham and pineapple, labeled 9/8/25.-Unlabeled plates (3) with lettuce and tomatoes. -Unlabeled, opened bag of uncooked hotdogs.-Unlabeled, plate of two sandwiches.-Unlabeled, five pitchers of pre-made juice.-Unlabeled personal items, one can of Pepsi, one pre-packaged caramel apple, one bottle of vanilla creamer.-An open plastic bag of uncooked bacon, labeled 9/11/25.-Unlabeled, large bowl of pasta salad with vegetables.The following food was observed on the prep table in the first- floor kitchen.-Unlabeled, opened plastic container of butter with a knife inside the container.During an observation and interview on 9/15/25 at 11:43 a.m., DA-A opened all the coolers and freezers during the initial tour. DA-A verified the dates for the skim milk, deli salads and fruit cocktail and discarded the items, the pre-made bagged salad had no date and was removed. DA-A stated many of the items were prepared for today's meal or would be used by today and couldn't explain the process for labeling or storing food. A can of Pepsi, bottle of vanilla creamer and a prepackaged caramel apple were in the miscellaneous cooler and DA-A stated they put their personal things in the miscellaneous cooler and the items were not removed during the initial walk through. During an observation on 9/15/25 at 11:45 a.m., DA-B was observed removing the unlabeled items identified for the dinner meal (three plates of salad, uncooked chicken, pasta salad, sandwiches, prepared juice), labeling them with the date of 9/15/25, and placing them back in the refrigerator. The expired sour cream remained in the refrigerator. The dietary aids could not identify if expired foods were used to prepare meals for residents.During an interview on 9/15/25 at 12:30 p.m., culinary director (CD) stated all items in the refrigerator should have a label and date when the item was received, opened, or prepared. The CD was not able to explain the process for labeling or storing food but added that prepared items were good for 48 hours and other items were good for 57 hours and indicated all prepared food should be thrown away within seven days. During a follow up interview on 9/17/25 at 8:57 a.m., the CD stated thawed, uncooked chicken could be refrigerated for three days. CD stated sour cream and all dairy products should be thrown away by the expired date but could not explain why the expired sour cream had not been thrown away. CD stated premade bagged salads should be used or discarded on the date which they were opened and unopened prepared bagged salad could be kept for two days in the refrigerator. Uncooked bacon could be kept for seven days. The CD acknowledged temperature logs were not properly completed, and temperatures were not checked daily and the facility lacked any type of monitoring system that would confirm the temperatures did not rise above 41 degrees.REFRIGERATOR TEMPERATURESThe following labeled refrigerators and freezers lacked temperature monitoring. -vegetable freezer-log present missing month/location information/temperatures-bread and dessert freezer-no temperature log-milk and dairy cooler-no temperature log-fresh fruit and vegetable cooler-log present missing month/location information/temperatures. -miscellaneous cooler-log present missing month/location information/temperatures.-meat freezer-no temperature logDuring an observation and interview on 9/15/25 at 12:15 p.m., DA-A confirmed the facility lacked temperature logs for refrigerators and freezers. Three temperature logs were removed from a clear

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or get specialized rehabilitative services as required for a resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to provide rehabilitative services as ordered for 1 of 1 residents (R7) reviewed for therapy services.Findings include:R7's quarterly Minimum Data Set (MDS) dated [DATE], indicated R7 was cognitively intact. R7's pertinent diagnoses included central spinal cord syndrome (the spinal cord was bruised or damaged in the middle, at the level of the fourth vertebra in the neck and affects the arms more than the legs). R7's MDS indicated speech therapy was provided from 3/20/25 through 5/15/25, physical therapy (PT) was provided from 3/21/25 through 4/8/25, and R7 received occupational therapy (OT) during the quarterly MDS assessment period.R7's PT notes dated 4/8/25, indicated all goals were met and R7 was care planned for range of motion (ROM). The note identified up for meals and that sitting up was the best ROM for large joints. R7's care plan revised on 5/30/25, directed staff to follow PT instructions and orders, as well as complete passive range of motion (PROM) per orders as it pertained to R7's alteration in mobility related to cervical stenosis with central cord syndrome.R7's progress note identified a care conference was completed on 8/26/25, the resident, power of attorney (POA), family, nurse manager, and social worker were present for the care conference. The family requested R7 have physical therapy due to resident being able to move his feet. The social worker and nurse manager explained to the family a provider order was needed for physical therapy.R7's current provider orders, reviewed on 9/17/25, identified an order for PT to treat and evaluate was placed on 8/27/25.During an interview on 9/15/25 at 1:13 p.m., R7 stated that therapy had been working with their hands, but they were able to move their lower extremities a little and felt that therapy should have focused more on their lower legs.During an interview on 9/17/25 at 10:56 a.m., the director of rehab (PTA)-A stated R7 was picked up for PT on 3/21/25 through 4/8/25 because the provider wanted R7 to be mobile and up and out of bed for meals but met goals and was discharged . R7 was currently on case load for OT who worked with R7's hands and upper extremities daily. PTA-A stated being up in a wheelchair was more effective to the large muscle groups than a range of motion plan performed by nursing staff. PTA-A confirmed a functional maintenance program (FMP) was written 7/10/24, but that staff were no longer following that plan since there was an order for R7 to be up and out of bed. During an interview on 9/17/25 at 2:40 p.m., LPN-A stated the provider visited with R7 and family after the care conference on 8/26/25 and entered an order to be evaluated by PT dated 8/27/25. LPN-A spoke with therapy regarding the PT order and confirmed that R7 was not evaluated by therapy after the order was written on 8/27/25 and stated, the order fell through the cracks.During an interview on 9/18/25 at 10:59 a.m., the director of nursing (DON) stated once a provider issued a therapy order, the expectation was for the therapy department to evaluate the resident within 72 hours. The department was also expected to communicate the resident's therapy plan to the nursing staff within one week. If the resident had already been evaluated prior to the new or current order, the therapy department was expected to either re-evaluate the resident or follow up with the provider.A policy for therapy was requested but not received.