STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245234	A. Building B. Wing	05/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Good Samaritan Society - Waconia and Westview Acre	333 Fifth Street West Waconia, MN 55387

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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and document review, the facility failed to ensure pharmacy consultant (PharmD) gradual dose reduction (GDR) recommendation was communicated to the Hospice prescriber for 1 of 5 residents (R43) reviewed for unnecessary medications. Findings include: In review of R43's Order Summary Report (print date 5/27/25) indicated the diagnoses of: dementia, visual hallucinations, psychotic disturbance, mood disturbance and anxiety. R43's quarterly Minimum Data Set (MDS), dated [DATE], identified R43 had severely cognitive impairment. R43 was admitted to Allina Hospice with the diagnosis of vascular dementia [due to] CVA (cerebral vascular accident - stroke) on 1/29/25, with the orders to use hospice agency standing orders. In review of R43's Order Recap Report (printed 5/20/25) resident was and is receiving Quetiapine Furmarate (and anti-psychotic medication with the following order changes: The following orders were prescribed on the dates indicated to the facility: 3/26/25 Quetiapine Fumarate Oral Tablet 50 milligrams (mg) (Quetiapine Fumarate) Give 100 mg by mouth every 6 hours as needed for agitation or hallucinations. AND Give 50 mg by mouth two times a day for agitation, hallucinations 4/1/25 Quetiapine Fumarate Oral Tablet 25 MG (Quetiapine Fumarate) Give 25 mg by mouth two times a day for agitation, hallucinations Administer with 50mg. A review of R43's PharmD recommendation (dated 4/14/25) requested the following: This resident is currently on the anti-psychotic quetiapine 100 mg [every] 6 hours [as needed] with the diagnosis: agitation/hallucinations. Start 3/26/26. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Number of times used: 2. *Please add verbiage (times) 14 days for [as needed] anti-psychotic orders* Please evaluate current diagnosis, behavior and usage patterns and evaluate continues need. PRN [as needed] anti-psychotic orders cannot exceed 14 days and require direct prescriber evaluation of continuation. The PharmD noted went on to indicate choices to consider: 1. Discontinue [as needed quetiapine 2. New order for [as needed: _____(include duration (14 days) and rationale) 3. Adjust routine order to _____ A review of R43's electronic medical record (EMR) lacked documentation this recommendation had been reviewed by the prescribing physician. During interview on 5/21/25 at 10:33 a.m., nurse manager (RN)-A the facility does not do gradual dose reductions (GDRs) when a resident is receiving hospice services. Those are to be addressed by the hospice nurse / hospice provider. A review of R43's hospice folder, kept at the facility for communication purposes, lacked documentation the recommendation by the PharmD had been addressed. In a further telephone interview on 5/27/25 at 12:47 p.m., hospice registered nurse (Hospice) stated that hospice service had never received the PharmD communication for R43. Hospice stated had they received the recommendation, the prescribing hospice provider would have addressed this concern. In review of the facility's policy, entitled: Hospice - Provided Services - [Resident Services, [Long Term Care], [Assisted Living], last revised 11/1/24 indicated the following under Procedure section: 5. The social worker or licensed nurse or [assisted living] Nurse/Manager will facilitate communication between resident and/or his/her family and hospice employees.

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to ensure incidents were reported timely to the State agency (SA) for 2 of 4 residents (R213 and R214) whose incidents were reviewed. Findings include: R213's admission Minimum Data Set (MDS) dated [DATE], identified R213 had moderate cognitive impairment and was dependent on staff for activities of daily living (ADLs). Diagnoses included depression, anxiety, radiation sickness, lung cancer, breast cancer, thyrotoxicosis (a condition where there is too much thyroid hormone in the body), muscle weakness, metabolic encephalopathy (a condition where a change in brain function, like confusion or decreased consciousness, is caused by an underlying metabolic or chemical imbalance in the body), diabetes and acute kidney failure. R213's care plan revised 5/4/25, indicated R213 had potential to develop pressure sores related to impaired mobility and incontinence with an intervention instructing staff to reposition R213 from side to side when in bed every two to three hours and as needed (PRN). the care plan also indicated R213 had an ADL self-care deficit related to weakness, recent bladder infection (UTI), recent cancer treatment and need for staff assistance with all ADLs. ALD interventions included bed-mobility assitance of two staff with positioning up in bed and turning from side to side, toileting assistance of one to two staff with sit-to-stand lift, large harness to use toilet, resident incontinent or urine and directed staff to anticipate toileting needs/check/change/toilet R213 PRN. A Facility Reported Incident (FRI) was submitted to the SA on 5/4/25 at 12:12 p.m., (approximately 12 hours after facility staff discovered incident occurred) which identified R213 had been placed on a bedpan by nursing assistant (NA)-C at about 1:30 p.m. on 5/3/25. NA-C failed to return to R213 to check on status and did not report to NA-D that R213 was on the bedpan at change of shift. NA-D reported she asked R213 how she was doing, brought R213 food and fluids and repositioned in bed, however, NA-D failed to check/change R213 during her shift. At about 12:00 a.m. 5/4/25, registered nurse (RN)-C checked R213 for toileting needs, found R213 still had bedpan underneath her. R213 developed a deep tissue injury (a type of pressure injury where the underlying tissue is damaged, but the skin may appear intact. It's characterized by a localized discoloration, often purple or maroon, and may have a blood-filled blister. DTI can develop into a larger, open wound, but it's initially a localized injury.) due to the bedpan being placed for eleven and a half hours. When interviewed on 5/22/2025 at 2:10 p.m., NA-D stated she worked with R213 one other time two weeks prior, at that time R213 was fully responsive and communicated her needs. NA-D stated she had assumed R213 would utilize her call light and express her needs independently. NA-D had not been informed there were any changes in R213's status, R213 had not communicated any needs when NA-D was in the room nor did R213 inform staff she was on the bedpan. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	When interviewed on 5/27/25 at 10:05 a.m., nurse manager (RN)-A stated she had been in the building morning of 5/4/25, had been informed by RN-C of the incident, went to R213 observed stage one pressure sore (the initial stage of skin breakdown caused by prolonged pressure on a specific area of the body) on R213's buttocks in the outline of the bedpan, expected the area would progress to a deep tissue injury. RN-A stated incidents of abuse, neglect and significant bodily harm were to be reported to the SA within 2 hours from when suspicion was formed, but the nurses did not have access to submit reports to the SA, this was completed by the administrator, director of nursing (DON) or social worker. R214 R214's discharge Minimum Data Set (MDS) dated [DATE], indicated R214 had intact cognition, and had diagnoses of hypertension (high blood pressure), atrial fibrillation (irregular heartbeat that originates in the heart's upper chambers), anemia (low red blood cells) and depression. A report was received by the SA, dated 5/1/25 at 12:59 p.m., which indicated R214 was seen in the clinic last week (4/22/25) for a visit after R214 was discharged from the transitional care unit (TCU) at facility. According to the report, R214 had been in and out of the facility twice prior to her being seen in clinic. R214 brought all her medications with her from home to her appointment and it was then discovered there were two bubble medication cards that had medications missing and a few remaining labeled with another resident's name. R214 reported to provider that she had been taking these medications at home. According to the report, one of the medications was to lower blood pressure and R214 was recently in the hospital for low blood pressure. R214 also reported to provider a couple of falls between discharge from her last TCU stay and follow-up appointment in the clinic. According to the report, the incorrect medication R214 was taking could have contributed to R214 falling at home. According to the report, the reporter called the facility and reported this incident with RN-E. During interview on 5/20/25 at 12:13 p.m., RN-D stated R214 came to clinic for a follow up appointment and brought all her medications with her for the provider to review. Included were medications cards R214 received from the facility upon R214's discharge from the TCU. R214 stated she was taking all medications that she brought with her to the clinic. RN-D stated there were two medications (Lisinopril and Atorvastatin) prescribed to a person who was not R214, they kept and destroyed in the clinic. RN-D stated R214 reported couple incidents of being dizzy and falling at home since second discharge from the facility. RN-D stated R214 ingested approximately at least 11 doses of incorrect medications at home, resulting in low blood pressure that led to R214 falling four times in four days while at home, prompting and emergency department visit on 3/31/25. During interview on 5/27/25 at 11:14 a.m., RN-D stated she called the facility and spoke with RN-E and informed them of the medication error. During interview on 5/27/25 at 11:42 a.m., RN-E stated R214's clinic called and informed her that R214 had brought medications into her clinic appointment that were not prescribed to R214. RN-E stated medications were prescribed for another resident residing at the facility. RN-E stated she believed medications were sent with R214 during discharge on [DATE]. RN-E stated she notified nurse manager immediately. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 5/27/25 at 4:32 p.m., RN-A stated incident was not reported to the SA and should have been reported to the SA immediately after being made aware of incident. RN-A stated, it was an error on our part. During interview on 5/27/25 at 5:03 p.m., administrator stated reports to SA can be completed by herself, the director of nursing and the nurse managers. The nurses and nursing assistants could call in the report, but expectation was to call administrator or DON who would file the report online. Administrator was informed about the incident with R213 at 9:26 a.m. on 5/4/25, completed the report at 12:12 p.m. after she had spoke with the nurse consultant who stated the incident was harm and reportable to the SA. Administrator stated the time frame for reporting was two hours for bodily harm and 24 hours for everything else. Administrator stated incident with R214 should have been reported as soon as the facility was made aware of the incident. The facility Abuse and Neglect policy, dated 4/7/25, indicated if an employee receives an allegation of abuse, neglect, exploitation or misappropriation of resident/client property or witnesses suspected abuse, neglect or misappropriation of resident/client property, the employee will take measures to protect the resident/client, provided the safety of the employee is not jeopardized. The employee will then report the allegation to a supervisor. The program coordinator, charge nurse or licensed nurse will be notified immediately, assess the situation to determine whether any emergency treatment or action is required and complete an initial investigation. If this is an injury of unknown origin, he or she also will attempt to determine the cause of the injury. The coordinator or charge nurse also will ensure that any potential for further abuse is eliminated by taking one of the following actions: a. If this is an allegation of employee to resident/client abuse, the employee will be removed from providing direct care to all residents/clients. Additionally, the employee will be placed on suspension pending the results of the internal investigation. Another employee will be assigned to complete the care of the resident/client. Contact the Human Resources Advisor for the location to assist with corrective action. b. If it is an allegation of resident/client to resident/client abuse, the residents/clients will be separated immediately, and both ensured a safe environment. Determine if a room change needs to be made. c. If family or other visitors are suspected of alleged abuse, they may not be allowed to visit the resident/client, or in any other way have access to the location, pending the results of the investigation. A designated individual will enter the event into the SAFE Event Reporting Portal per the Event Reporting Resident, Visitor, Employee policy. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notification procedures: a) Designated agencies will be notified in accordance with state law, including the State Survey and Certification Agency. If applicable, Adult Protective Services will be notified where state law provides for jurisdiction in long-term care centers. - If there is an allegation of abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident/client property, and/or there is serious bodily injury, then it will be reported immediately, but not later than two hours after the allegation is made. - If there is an allegation that does not involve abuse and there is no serious bodily injury, then it will be reported not later than 24 hours after the allegation is made. b) After the initial documentation of the event, if there is a need for additional documentation, this will be completed within the SAFE Event Reporting Portal per the Event Reporting Resident, Visitor, Employee policy. c) The investigation team (social worker, administrator and director of nursing services) will review all events no later than the next working day following the event. d) Ensure that someone is assigned to complete the investigation and that the care plan has been updated with any new interventions put into place. The investigation team will determine whether further investigation is needed. The social worker or the designated person will notify the designated agency(ies) in the state as soon as possible after reviewing the event; if designated agency(ies) have not been notified, the social worker or the designated person also will complete and submit any reports required by the designated agencies.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review the facility failed to thoroughly investigate and protect residents from an allegation of neglect for 1 of 4 residents (R214) whose incidents were reviewed. Findings include: R214's discharge Minimum Data Set (MDS) dated [DATE], indicated R214 had intact cognition, and had diagnoses of hypertension (high blood pressure), atrial fibrillation (irregular heartbeat that originates in the heart's upper chambers), anemia (low red blood cells) and depression. A report was received by the SA, dated 5/1/25 at 12:59 p.m., which indicated R214 was seen in the clinic last week (4/22/25) for a visit after R214 was discharged from the transitional care unit (TCU) at facility. According to the report, R214 had been in and out of the facility twice prior to her being seen in clinic. R214 brought all her medications with her from home to her appointment and it was then discovered there were two bubble medication cards that had medications missing and a few remaining labeled with another resident's name R214 reported receiving the bubble medication cards when she discharged from the TCU. R214 reported to provider she had been taking these medications at home. According to the report, one of the medications was to lower blood pressure, R214 was recently in the hospital for low blood pressure. R214 also reported to provider a couple of falls between discharge from her last TCU stay and follow-up appointment in the clinic. According to the report, one of the incorrect medication R214 was taking could have contributed to R214 falling at home. The facility was called and reported this incident with RN-E. During review on 5/27/25, 214's electronic health record (EHR) lacked documentation of investigation of medication error that was reported to the facility by an external party. During interview on 5/27/25 at 11:14 a.m., RN-D stated she called the facility and spoke with RN-E and informed them of the medication error. During interview on 5/27/25 at 11:42 a.m., RN-E stated R214's clinic called and informed her R214 had brought medications into her clinic appointment that were not prescribed to R214. RN-E stated medications were prescribed for another resident residing at the facility. RN-E believed the medications were sent with R214 during discharge on [DATE]. RN-E notified the nurse manager immediately. During interview on 5/27/25 at 4:32 p.m., RN-A stated incident should have been reported to the SA and investigation should have been started immediately after being made aware of incident. RN-A stated, it was an error on our part. During interview on 5/27/25 at 5:03 p.m., administrator stated report can be completed by herself, the director of nursing and the nurse managers. Administrator stated she would want staff to let the DON know so she could file the report and start an investigation. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility Abuse and Neglect policy, dated 4/7/25, indicated if an employee receives an allegation of abuse, neglect, exploitation or misappropriation of resident/client property or witnesses suspected abuse, neglect or misappropriation of resident/client property, the employee will take measures to protect the resident/client, provided the safety of the employee is not jeopardized. The employee will then report the allegation to a supervisor. The program coordinator, charge nurse or licensed nurse will be notified immediately, assess the situation to determine whether any emergency treatment or action is required and complete an initial investigation. If this is an injury of unknown origin, he or she also will attempt to determine the cause of the injury. The coordinator or charge nurse also will ensure that any potential for further abuse is eliminated by taking one of the following actions: a. If this is an allegation of employee to resident/client abuse, the employee will be removed from providing direct care to all residents/clients. Additionally, the employee will be placed on suspension pending the results of the internal investigation. Another employee will be assigned to complete the care of the resident/client. Contact the Human Resources Advisor for the location to assist with corrective action. b. If it is an allegation of resident/client to resident/client abuse, the residents/clients will be separated immediately, and both ensured a safe environment. Determine if a room change needs to be made. c. If family or other visitors are suspected of alleged abuse, they may not be allowed to visit the resident/client, or in any other way have access to the location, pending the results of the investigation. A designated individual will enter the event into the SAFE Event Reporting Portal per the Event Reporting Resident, Visitor, Employee policy. Notification procedures: a) Designated agencies will be notified in accordance with state law, including the State Survey and Certification Agency. If applicable, Adult Protective Services will be notified where state law provides for jurisdiction in long-term care centers. b) After the initial documentation of the event, if there is a need for additional documentation, this will be completed within the SAFE Event Reporting Portal per the Event Reporting Resident, Visitor, Employee policy. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	c) The investigation team (social worker, administrator and director of nursing services) will review all events no later than the next working day following the event. d) Ensure that someone is assigned to complete the investigation and that the care plan has been updated with any new interventions put into place. The investigation team will determine whether further investigation is needed. The social worker or the designated person will notify the designated agency(ies) in the state as soon as possible after reviewing the event; if designated agency(ies) have not been notified, the social worker or the designated person also will complete and submit any reports required by the designated agencies.

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F 0628 Level of Harm - Actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff interviews, and policy review, the facility failed to ensure that medications were accurately identified and dispensed upon discharge, resulting in one resident (R214) being sent home with another resident's (R221) medications. This failure led to R214 ingesting medications not prescribed to her. This resulted in actual harm when R214 required emergency medical intervention and hospitalization due to hypotension (low blood pressure). Findings include: R214's discharge Minimum Data Set (MDS) dated [DATE], indicated R214 had intact cognition, and had diagnoses of hypertension (high blood pressure), atrial fibrillation (irregular heartbeat that originates in the heart's upper chambers), anemia (low red blood cells) and depression. R214 was admitted to the transitional care unit (TCU) for rehab, on 3/14/25, following hospitalization with a primary diagnosis of hypertension with shortness of breath. R214's Discharge or Therapeutic Leave Medication List assessment dated [DATE], lacked a verified of medication reconciliation. Assessment identified the form of education that was provided to resident at time of discharge was paper handouts with no verbal education indicated. Hospital records dated 3/31/25, confirmed R214 had fallen four times in the last four days with one fall causing acute facial trauma which required sutures. Records also indicated R214 was experiencing orthostatic hypotension (drop in blood pressure with change in position) that was likely contributing to her falls. R214 was readmitted to the facility's TCU for rehab, on 4/4/25, following hospitalization from 3/31/25 to 4/4/25 with a primary diagnosis of orthostatic hypotension. R214's Discharge summary, dated [DATE], lacked verification of medication reconciliation and listing of current medications. Clinic visit note, dated 4/22/25, indicated orthostatic hypotension, [R214's] blood pressure readings have remained soft, with a recent measurement of 102/76. It was discovered that she was mistakenly given another patient's medication upon TCU discharge [3/27/25], including lisinopril 20 mg, which is a blood pressure-lowering agent. This error may have contributed to her second hospitalization [3/31/25-4/4/25] (med pack of lisinopril she was taking was dated late February) and may have contributed to her falls. She has been advised to discontinue the use of lisinopril immediately. A follow-up with Good Samaritan will be conducted to address this medication error. Blood work will be ordered today to monitor her kidney function and potassium levels. R221's electronic medication record (EMR) indicated R221 prescribed Lisinopril was not available from 3/29/25 to 4/2/25. (continued on next page)

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F 0628 Level of Harm - Actual harm Residents Affected - Few	During interview on 5/20/25 at 12:13 p.m., registered nurse (RN)-D from R214's primary care provider's office stated R214 came to clinic for a follow up appointment and brought all her medications with her for the provider to review. R214 stated she was taking all medications that she brought with her. RN-D stated there were two medications (Lisinopril and Atorvastatin) with R221's name on them. These medications were kept and destroyed in the clinic. RN-D stated R214 reported a couple incidents of being dizzy and falling at home since second discharge from the facility. RN-D stated R214 ingested approximately 11 doses of incorrect medications at home, resulting in low blood pressure that led to R214 falling four times in four days while at home, prompting an emergency department visit on 3/31/25 and hospitalization. During interview on 5/27/25 at 11:26 a.m., FM-B stated medications which did not belong to R214 were sent with her after being discharged on 3/27/25 with one medication that lowered blood pressure. FM-B stated R214 thought the other resident's name on the label of medications was the name of the ordering provider and did not think anything of it and assumed she was supposed to take the medications as they were sent home with her. FM-B stated R214 had intact cognition with no memory concerns. FM-B confirmed R214 had taken the incorrect medication that was sent home by facility after the first discharge and also after the second discharge. During interview on 5/27/25 at 11:37 a.m., RN-A stated the nurse manager (NM) obtained orders from the provider for discharge. NM then put together information in a discharge folder with information regarding other services to be provided in the home if applicable. RN-A stated the discharging nurse would notify the resident of any upcoming appointments which was also included in their discharge folder. Any medications in the facility, belonging to the resident, were sent with the resident and a fax was sent to the resident's preferred pharmacy with a seven-day order for all medications. RN-A stated the list of medications was placed in discharge folder. During interview on 5/27/25 at 11:42 a.m., RN-E stated R214's clinic called and informed her R214 had brought medications into her clinic appointment that were not prescribed to R214. RN-E stated medications were prescribed for R221. RN-E believed the medications were sent with R214 during discharge on [DATE]. RN-E notified the nurse manager immediately. RN-E stated when a resident discharged from the facility, she followed the facility's discharge checklists and sent all ordered medications with the resident. Attempts to contact R214 were unsuccessful. During interview on 5/27/25 at 3:46 p.m., RN-A stated she would expect the discharging nurse to go through each and every medication and ensure each medication was prescribed for the correct patient and was the correct medication and reviewed with the resident at time of discharge. RN-A stated the discharge medication list was placed in the discharge folder with the current medications and the last time medications was taken. During interview on 5/27/25 at 5:59 p.m., medical director (MD) stated she was not made aware of this situation. MD stated she would expect that each medication is reviewed with the current medication orders and also reviewed with the resident at the time of discharge and the medication list should be printed for the resident. MD stated medications are sent home with the resident at the time of discharge. (continued on next page)

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F 0628 Level of Harm - Actual harm Residents Affected - Few	The facility Discharge and Transfer policy, dated 3/28/25, indicated the charge nurse or designated individual will: a. Complete a progress note - discharge b. Obtain an order from the physician for discharge to home with medications. c. Complete the Discharge or Therapeutic Leave Medication List UDA. d. Complete Miscellaneous Information section of the admission Record. e. Complete and review any relevant portions of the PN - Teaching - Resident/Family. f. Complete the Discharge Summary.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to ensure the Minimum Data Set (MDS) was accurately coded with the potential for inaccurate federal reimbursement and resident care planning for 2 of 2 residents (R49 and R59) reviewed for MDS accuracy. Findings include: R49's quarterly MDS dated [DATE], indicated under Section J (J1700-B) Falls documented R49 did not have any falls since the last MDS Assessment (admission MDS, submitted 1/14/25). In review of R49's electronic medical record (EMR), it was noted R49 had two falls since admission: 2/2/25 - R49 rolled out of bed and onto the floor 2/4/25 - R49 self transferred from wheel chair and fell to the floor During an interview on 5/21/25 at 10:33 a.m., nurse manager (RN)-A and interim director of nursing (DON)-A stated R49's two falls should have been documented on the 4/10/25 quarterly MDS. R59's Discharge Return Not Anticipated MDS submission dated 3/6/25, indicated under Section A (A2105) Discharge Status documented R59 was discharge to :Short-Term General Hospital. In review of R59's electronic medical record (EMR), documented the following in R59's progress notes: 3/6/2025 [1:33 p.m.] Discharge -Home, Assisted Living, Other Facility, Involuntary Destination: Home Method of transportation and who accompanied resident, included their relationship to resident: daughter and son in law transported resident home via own vehicle at [12:30 p.m.]. Medications reviewed. Notes: 1 card of 28 tramadol [tablets] and own bottle of tramadol 7 [tablets] sent home with resident. During an interview on 5/21/25 at 10:33 a.m., nurse manager (RN)-A and interim director of nursing (DON)-A, RN-A stated the discharge MDS submission was coded incorrectly. and verified R59 had discharged to home. A facility' policy on MDS completion was requested, however, none was received.

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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 **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to complete and implement a baseline care plan within 48 hours of admission for 3 of 5 residents (R35. R41 and R215) reviewed for care plans. Findings include: R35's admission Minimum Data Set (MDS) dated [DATE], identified R35 had intact cognition and required assistance with all activities of daily living (ADLs). R35's diagnoses included end stage renal disease, heart failure, hypertension, cirrhosis, diabetes mellitus, arthritis, depression, dependence on renal dialysis, and chronic pain. R35's electronic health record (EHR) indicated R35 was admitted to the facility on [DATE]. EHR lacked evidence a baseline care plan had been initiated within 48 hours of admission. EHR indicated baseline care plan was developed on 4/18/25 and indicated R35 was dependent on staff for transfers, toileting and grooming/bathing. R41's admission MDS dated [DATE], identified R41 had moderate cognitive impairment and required assistance with ADL's. R41's diagnoses included acute on chronic systolic (congestive) heart failure, atrial fibrillation, coronary artery disease, heart failure, hypertension, renal failure, localized edema, presence of prosthetic heart valve, and presence of coronary angioplasty implant and graft. R41's EHR indicated R41 was admitted to the facility on [DATE]. EHR lacked evidence a baseline care plan had been initiated within 48 hours of admission. EHR indicated baseline care plan was developed on 4/29/25 and indicated R41 and indicated R41 was dependent on staff for transfers, toileting and grooming/bathing. R215's admission MDS dated [DATE], identified R215 had intact cognition and required moderate assistant with ADL's. R215's diagnoses included hypertension, renal failure, fracture, anxiety disorder and depression. MDS also indicated R215 was receiving dialysis services. R215's EHR indicated R215 was admitted to the facility on [DATE]. EHR lacked evidence a baseline care plan had been initiated within 48 hours of admission. EHR indicated baseline care plan was developed on 5/13/25 and indicated R215 was dependent on staff for transfers, toileting and grooming/bathing. During interview on 5/27/25 at 3:49 p.m., registered nurse manager (RN)-A stated baseline care plans should be completed within 24 hours of admission to the facility. RN-A confirmed a baseline care plan had not been completed with 48 hours of admission for R35, R41 and R215. RN-A stated baseline care plans are important to complete for resident safety and so staff know how to care for the resident. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility Care Plan facility, dated 12/2/24, indicated facility would develop a comprehensive care plan using an interdisciplinary team approach and to provide guidance to the interdisciplinary team in developing the initial care plan. Baseline care plan includes instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. A baseline care plan will be developed upon admission according to federal and state regulations. The location must provide the resident and resident representative with a written summary of the baseline care plan.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to revise the care plan to include current behaviors for 1 of 1 residents (R51), toileting needs for 1 of 1 residents (R20), discontinued medications for 1 of 1 residents (R24), resident receiving tube feedings for 1 of 1 residents (R7), and falls for 1 of 1 residents (R55) in the sample whose care plans were reviewed. Findings include: R51's Face Sheet printed 5/27/25, indicated the diagnoses of Alzheimer's disease, dementia with behavioral disturbances, anxiety disorder, restlessness and agitation. R51's admission minimum data set (MDS) dated [DATE], identified R50 was cognitively impaired and required extensive assistance with activities of daily living. During observation and interview on 5/18/25 at 4:24 p.m., it was observed that R51 had long finger nails on all fingers and thumbs. Some of which were 1/4 inched in length. R51 was also noted to have been unshaven, noting a rechargeble razor on resident's bed. R51 stated, I was meaning to cut them (finger nails). R51 stated he had just completed his shaving. General observations thoughout each day (5/19/25 and 5/20/25), noted no change in R51's nail length nor shaving. An interview on 5/20/25 at 11:57 a.m., nursing asistant (NA)-A stated R51 was independent with his cares, with reminders for clean clothes and showering in his room. NA-A stated R51 refused to have staff assist with his care. NA-A stated staff have tried to shave and trim R51's nails, but he would not allow. NA-A stated reisdnet nails are usually trimmed on bath days. During an interview on 5/20/25 at 1:01 p.m., the bath aid - trained mdication assistant (TMA)-A stated R51's bath day (shower) is scheduled for Thursdays. TMA-A stated R51 will not allow staff to assist with his shower, however, she freqently checked on this due to his confusion, becomes easily distracted 1/2 way through and does not complete the task. She has not been able to trim his nails or shave him, as he stated he is able to. In review of the R51's assessment, Functional Abilities and Goals - Admission/Start of Skilled Care Complete Admission, dated 2/22/2025, the following was documented: - Self Care - Needed Some Help - Resident needed partial assistance from another person to complete activities. - Functional Cognition - Needed Some Help - Resident needed partial assistance from another person to complete activities - Personal Hygiene: The ability to maintain personal hygiene, including combing hair, shaving, applying makeup, washing/drying face and hands (excludes baths, showers, and oral hygiene). - admission Performance - Substantial/maximal assistance (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In review of R51's care plan, the document lacked both resident's needs in care provision, as well as resident's behavior of care assitance refusal. In an interview on 5/21/25 at 11:03 a.m., nurse manager (RN)-A stated R51 is not independent with his cares and needs set up, cues and reminders. RN-A stated 51's care plan is lacking residents behavior to complete and/or allow staff to assist with his care. RN-A stated this will need further assessment and input from resident family and facility staff. R20's Clinical Physicians Orders, printed 5/27/25, indicated R20's main diagnosis was other mechanical complication of implanted electronic neurostimulator of spinal cord electrode (lead). R20's admission MDS dated [DATE], identified R20 was cognitively intact and required extensive assistance with activities of daily living, including toileting During an interview on 05/19/25 at 9:16 a.m., R20 stated since her back surgery, she has needed a lot of help with her toileting, and was expecially concerned about her bowels not being regulated approrpriately. In review of R20's Functional Abilities - Current Performance assessment dated [DATE], indicated R20 required supervison or touching assistance with toileting. In an interview on 5/21/25 at 9:11 a.m., registered nurse (RN)-B stated R20 has had ongoing issues with bowel movements, more so, not wanting to be toileted. RN-B stated R20 had been refusing to be toileted and or have her incontinence brief changed, regardless if she was incontinent of urine or stool. RN-B stated she made an agreement with R20 that staff would be allowed to check and change R20, and provide peri-care at that time, shiftly. Review of R20's Care Plan last revised 5/2/25, lacked information on R20's toileting needs and the assistance needed to be provided. During interview on 5/21/25 at 11:09 a.m., RN-A stated R20 should have had toileting needs and interventions added to her care plan. R24's Order Recap Report, printed 5/20/25, indicated the diagnoses of malignant neoplasm of breast, with lumps / masses of head and neck, anxiety disorder and changes in cognitive function. R24 was receiving hospice services. R24's significant change minimum data set (MDS) dated [DATE], identified R50 was severely cognitively impaired and required extensive assistance with activities of daily living. R24's anastrozole was dicontinued on 2/24/25. R24 was admitted to Ridgeview Hospice for comfort cares on 2/26/25. In review of R24's Care Plan last revised 4/14/25, the following care plan concern was documented: - The resident has an alteration in hematological (related to the study of blood and blood-forming tissues, including the bone marrow, spleen, and lymph nodes) status [related to] [history of] breast cancer {and the] use of anastrozole (is a nonsteroidal aromatase inhibitorused in the treatment of breast cancer). (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During interview on 5/21/25 at 11:00 a.m., RN-A stated R24's anastrozole was discontinued, after having a discussion with residents family, when R20 enrolled into hospice services. The anastrozole was not a covered medication while on hospice. RN-A stated R24's care plan should have been updated. R7 R7's quarterly MDS dated [DATE], indicated R7 was cognitively intact, was independent with activities of daily living (ADLs) and had a feeding tube. R7's face sheet printed 5/18/25, indicated R7 had diagnoses of dysphagia (difficulty swallowing), gastrostomy status (opening into the stomach from the abdominal wall, made surgically for the introduction of food.) gastro-esophageal reflux disease (GERD), and hypertension. R7's care plan last revised 11/17/24, indicated R7 had a self-care deficit related to tube feeding with an intervention of nothing by mouth (NPO) - tube feeding. Care plan also indicated R7 required tube feeding related to dysphagia with and intervention of no water pitcher at bedside due to NPO status. On 1/10/25, R7 received a new order for regular diet, regular texture, with thin liquids. Resident desired regular diet for quality of life. Okay to provide any food items per resident request. However, R7's care plan was not updated regarding change in NPO status. When interviewed on 5/18/25 at 5:11p.m., R7 stated he ate food for pleasure, tended to request easy to swallow foods like scrambled eggs and mashed potatoes. R7 hoped to increase his oral intake and eventually have the tube feeding removed. When interviewed on 5/21/25 at 11:15 a.m., nurse manager (RN)-A stated care plans were to be updated by the nurse manager as soon as they were notified of a change or during the next assessment period. RN-A stated R7's care plan should have been updated when diet order was changed in January 2025, diet change on care plan was also not completed during assessment period for quarterly MDS in March 2025. R55 R55's admission MDS dated [DATE], indicated R55 had moderate cognitive impairment and required extensive assistance with ADL's. R55's face sheet printed 5/18/25, indicated R55 had diagnoses of dementia, neurocognitive disorder with Lewy bodies (a progressive brain disorder characterized by cognitive decline, fluctuating alertness, visual hallucinations, and Parkinsonism symptoms), age-related macular degeneration, difficulty walking and repeated falls. R55's fall care area assessment (CAA) dated 4/13/25, identified R55 had no recent falls, was at risk for falls related to wandering behavior, impaired cognition, and new admission. R55's care plan last revised 5/2/25, indicated R55 had an actual fall related to forgetfulness and not wearing proper footwear. With interventions which required staff to ensure R55 wore gripper socks if shoes not worn dated 4/17/25; sign connected to walker with reminder to bring walker with dated 4/24/25; and staff to complete frequent checks on resident throughout the day dated 5/2/25. However, there was no indication the fall care plan or interventions were updated regarding R55's frequent falls. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R55 admitted to the facility on [DATE]. Review of progress notes and incident indicated R55 had 18 or more falls since he was admitted to the facility. R55 was sent to the emergency room on 5/11/25 due to repeated falls, hospital Discharge summary dated [DATE] indicated R55 had fallen at least 12 times in the past three days without injury. When interviewed on 5/27/25, at 4:06 p.m. RN-A stated she had reviewed R55's care plan but was unable to speak to why the care plan had not been updated regarding frequent falls or any interventions that may have been changed due to the other nurse manager that was responsible for the unit R55 resided on was no longer employed at the facility. The expectation was the care plan should have been updated when falls were reviewed, and new interventions were put into place. A facility Comprehensive Care Plan and Care Conferences- Rehab/Skilled, Therapy and Rehab policy dated 1/31/25, indicated the purpose to provide an ongoing method of assessing, implementing, evaluating and updating the residents care plan to help maintain the residents highest practicable level of function. The policy directs care plans to be reviewed and revised with each MDS completed, in addition care plans must be revised as the residents needs or status changed.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to ensure as needed (PRN) medications were administered per physician's order for 1 of 1 resident (R20) reviewed for edema. Findings include: R41's admission Minimum Data Set (MDS) dated [DATE], identified R41 had moderate cognitive impairment and required assistance with activities of daily living (ADL)'s. R41's diagnoses included acute on chronic systolic (Congestive) heart failure, atrial fibrillation, coronary artery disease, heart failure, hypertension, renal failure, localized edema, presence of prosthetic heart valve, and presence of coronary angioplasty implant and graft R41's physician orders with print date of 5/19/25, indicated R41 had an order for daily weights in the morning for heart failure with reduced ejection fraction (HFrEF) and to update physician assistant (PA) or medical doctor (MD) if increased of three pounds in a day or five pounds in a week. R41 also had an order for Torsemide 20 milligrams (mg) as needed (PRN) for HFrEF daily if weight exceeds 116.0 pounds with a start date of 5/13/25. During review of R41's electronic health record (EHR), noted EHR lacked documentation of administration of PRN medication on 5/13/25, 5/14/25, 5/15/25, 5/16/25, 5/17/25, 5/18/25 and 5/19/25 when it was noted R41's weight exceeded 116.0 pounds. R41's weight documentation, in EHR, indicated increased weight gain overnight on the following dates: -5/13/25 at 8:20 a.m., weight was documented as 116.6 lbs. (pounds) - based on order PRN torsemide should have been administered due to weight gain over 116.0 lbs. -5/14/25 at 8:48 a.m., weight was documented as 116.2 lbs. - based on order PRN torsemide should have been administered due to weight gain over 116.0 lbs. -5/15/25 at 9:06 a.m., weight was documented as 116.8 lbs. - based on order PRN torsemide should have been administered due to weight gain over 116.0 lbs. -5/16/25 at 1:20 p.m., weight was documented as 117.8 lbs. - based on order PRN torsemide should have been administered due to weight gain over 116.0 lbs. -5/17/25 at 12:21 p.m., weight was documented as 118.8 lbs. - based on order PRN torsemide should have been administered due to weight gain over 116.0 lbs. -5/18/25 at 9:28 a.m., weight was documented as 116.8 lbs. - based on order PRN torsemide should have been administered due to weight gain over 116.0 lbs. -5/19/25 at 10:33 a.m., weight was documented as 117.2 lbs. - based on order PRN torsemide should have been administered due to weight gain over 116.0 lbs. (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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R41's progress notes lacked documentation of increased weight and indicated: - 5/12/25 indicated R41 had an appointment at Minneapolis Heart and orders were changed for Torsemide as needed order to once daily as needed for weight excess of 116 pounds and an order for compression stockings to bilateral lower extremities daily for edema. - 5/19/25 at 11:19 p.m., indicated R41 was sent to the emergency department for low oxygen saturations of 84% and complaints of shortness of breath. - 5/20/25 indicated R41 was hospitalized with pneumonia and fluid overload. R41's electronic medical administration record (MAR) lacked documentation of administration of as needed Torsemide as ordered by cardiologist. During observation on 5/18/25 at 3:17 p.m., R41 had 2+ pitting edema noted in his bilateral lower extremities. During observation and interview on 5/19/25 at 3:30 p.m., R41 was seated in a wheelchair in his room with oxygen on flowing at two liters per minute via nasal cannula, which he did not have on previously. R41 had edema noted in his bilateral lower extremities. R41 stated he had a dry cough and stuffy nose that started on 5/19/25 and it was harder for him to breath today. During interview on 5/20/25 at 8:10 a.m., registered nurse (RN)-E stated R41 was sent to the ER on [DATE] in the evening. RN-E stated R41 had low oxygen saturations all day on 5/19/25 with his breathing getting worse as the day went on. RN-E updated provider and obtained an order for a chest x-ray to be completed and an order for Mucinex. RN-E stated R41 had daily weights due to his diagnoses of congestive heart failure and there were no parameters of prn orders related to daily weights. RN-E stated R41 had edema and his scheduled torsemide order was increased approximately a week and a half ago. RN-E reviewed R41's orders and stated oh, there is a prn order of torsemide. RN-E confirmed R41 should have received the prn dose of torsemide for the past seven days due to his weights being above 116.0. RN-E stated R41's increased shortness of breath could have been caused by not receiving the prn dose of torsemide as ordered. During interview on 5/20/25 at 11:02 a.m., R41's primary physician stated R41 had a history of congestive heart failure and was a very high-risk patient due his CHF. Physician stated the prn order of Torsemide was ordered by R41's cardiologist but he would expect the facility to administer medication as ordered. Physician stated he saw R41 the morning of 5/19/25 with R41 having crackles in lower lobes and localized edema in bilateral lower extremities. Physician stated he ordered a chest x-ray to be obtained as R41 can go into an acute exacerbation very quickly and can decompensate at any time. During interview on 5/21/25 at 8:41 a.m., health unit coordinator (HUC) stated she was responsible for processing and entering new orders and once entered it would be checked by a nurse. HUC stated PRN orders are added to the existing scheduled orders and should pop up for nursing on the MAR. During interview on 5/21/25 at 8:25 a.m., licensed practical nurse (LPN)- B stated R41 had orders for daily weights to be completed and there were no parameters of prn orders related to daily weights. (continued on next page)

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	245234	A. Building B. Wing	05/27/2025

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 5/21/25 11:29 a.m., registered nurse manager (RN)-A stated orders are processed by the HUC and a nurse would double check the order. RN-A stated if resident had a scheduled dose of ordered medication, the prn order would be added to the scheduled dose. RN-A stated the parameters for the prn dose would be displayed on the bottom on the EMAR (electronic medication administration record). RN-A reviewed R41's EMAR and stated nursing would not have seen the prn order with the way it was entered. Nursing would have to go into the PRN tab to see if R41 had a PRN dosage. The prn order should have been entered as a separate order or with the daily weights, so staff were aware of available medication. RN-A reviewed R41's weights and stated R41 should have received seven doses of prn torsemide in the past seven days as weight was over 116.0. RN-A stated R41 was hospitalized for shortness of breath and fluid on his lungs and the prn dose could have made a difference with managing his symptoms. Attempted to contact R41's prescribing cardiologist on 5/20/25 at 12:27 p.m., 5/21/25 at 9:59 a.m., and again on 5/21/25 at 2:08 p.m. with no success. The facility Medication Administration policy, dated 4/8/25, indicated the facility would promote resident/family understanding of medication therapy, would administer medications correctly and in a timely manner and would schedule medications effectively. When PRN medications are given, facility would evaluate and document the efficacy of the medication. If using non-licensed personnel to dispense medications, the follow-up should be done by a licensed nurse.

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review the facility failed to assure that 1 of 3 residents (R213) reviewed for pressure ulcers received care and services to prevent occurrence of newly developed pressure ulcer. This failure resulted in actual harm to R213 when the facility failed to follow R213's care plan resulting in the development of a deep tissue injury (a type of pressure injury where the underlying tissue is damaged, but the skin may appear intact. It's characterized by a localized discoloration, often purple or maroon, and may have a blood-filled blister. deep tissue injury can develop into a larger, open wound, but it's initially a localized injury). Although noncompliance was present at the time of the event, the facility implemented appropriate corrective action prior to the survey resulting in a finding of past-noncompliance for R213. Findings include: A Facility Reported Incident (FRI) was submitted to the State Agency (SA) on 5/4/25 at 12:12 p.m., (approximately 12 hours after facility staff discovered incident occurred) which identified R213 had been placed on a bedpan by nursing assistant (NA)-C at about 1:30 p.m. on 5/3/25. NA-C failed to return to R213 and did not report to NA-D that R213 was on the bedpan at change of shift. NA-D reported she had asked R213 how she was doing, brought R213 food and fluids and repositioned in bed, however, NA-D failed to check/change R213 during her shift. At about 12:00 a.m. on 5/4/25, registered nurse (RN)-C checked R213 for toileting needs, found R213 still had bedpan underneath her. R213 developed a deep tissue injury due to the bedpan being in place for eleven and a half hours. R213's admission Minimum Data Set (MDS) dated [DATE], identified R213 had moderate cognitive impairment and was dependent on staff for activities of daily living (ADL's). Diagnoses included depression, anxiety, radiation sickness, lung cancer, breast cancer, thyrotoxicosis (a condition where there is too much thyroid hormone in the body), muscle weakness, metabolic encephalopathy (a condition where a change in brain function, like confusion or decreased consciousness, is caused by an underlying metabolic or chemical imbalance in the body), diabetes and acute kidney failure. R213's care plan revised 5/4/25, indicated R213 had potential to develop pressure sores related to impaired mobility and incontinence with an intervention instructing staff to reposition R213 from side to side when in bed every two to three hours and as needed (PRN). The care plan also indicated R213 had an ADL self-care deficit related to weakness, recent bladder infection (UTI), recent cancer treatment and need for staff assistance with all ADL's. ALD interventions included bed-mobility assistance of two staff with positioning up in bed and turning from side to side, toileting assistance of one to two staff with sit to stand lift, large harness to use toilet, resident incontinent or urine and directed staff to anticipate toileting needs/check/change/toilet R213 PRN. Resident Kardex dated 5/6/25, indicated R213 required assistance of one to two staff to turn and repositioning side to side when in bed every two to three hours and PRN. R123 required assistance of one to two staff with standing lift, used large harness when toileted. Resident was incontinent or urine, wore large briefs. Staff were directed to check/change/toilet R213 PRN. Staff were directed to anticipate toileting needs. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	A facility wound assessment dated [DATE] at 12:54 p.m., indicated R213 had a suspected deep tissue injury to buttock. Area described as red in color, warm to the touch, and was non-blanchable (discoloration or redness that does not fade or turn white when pressed). A facility wound data collection assessment dated [DATE] at 2:47 p.m., identified R213 had an area on left lower lateral (outer) buttock that measured 1.25 centimeters (cm) by 0.6 cm was red, warm and inflamed. On left upper lateral buttock there was an area measured as 0.8 cm by 0.4 cm was red and warm to touch. On left upper medial (closer to center) buttock deep tissue injury measured at 1.5 cm by 1 cm red and warm to the touch. On right buttock a vertical deep tissue injury measured 24 cm by 2 cm that was non-blanchable red and purple in color, warm to touch with induration (hardening or thickening of the skin). Left buttock had vertical deep tissue injury measured at 26 cm by 4 cm, area was non-blanchable red and purple in color, was warm to the touch, with induration of skin. Progress note dated 5/4/25 at 7:42 p.m., indicated R213 was sent to the hospital due to change in mental status, was not alert and was very lethargic (sluggish, lack energy, drowsy, and decreased mental status). Hospital note dated 5/5/25, wound assessment indicated R213 appeared to have been left on a bedpan or similar device. The deep tissue pressure injury evolved into a stage two pressure injury (partial-thickness skin loss with the epidermis (top layer) and dermis (underneath layer) affected) in 3 areas. Deep tissue pressure injuries can continue to progress even when the pressure is relieved as the damage is already done. induration noted on both sides of injury. On 5/12/25, deep tissue injury was purple, top left area developed eschar (layer of dead tissue typically black in color.) When interviewed on 5/22/2025 at 2:10 p.m., NA-D stated had worked with R213 one other time two weeks prior, at that time R213 was fully responsive and communicated her needs. NA-D stated she had assumed R213 would utilize her call light and express her needs independently. NA-D stated they had not been informed there were any changes in R213's status, R213 had not communicated any needs when NA-D was in the room nor did R213 inform staff she was on the bedpan. When interviewed on 5/27/25 at 10:05 a.m., nurse manager (RN)-A stated she had been in the building morning of 5/4/25, had been informed by RN-C of the incident, went to R213 observed stage one pressure sore (the initial stage of skin breakdown caused by prolonged pressure on a specific area of the body) on R213's buttocks in the outline of the bedpan. RN-A stated had expected the area would progress to a deep tissue injury. RN-A stated R213 used the bed pan or was incontinent, refused to get out of bed to use the bathroom. RN-A reviewed R213's care plan, verified R213's care plan did not identify R213 used the bed pan, care plan stated R213 was incontinent of urine, wore a brief, staff were directed to check and change R213. RN-A stated did not appear R213 was aware there was a bed pan under her buttocks, R213 had not been herself on 5/3/25, was more fatigued. RN-A had spoken with the involved staff, NA-D had not seen a bed pan under R213, NA-C had fastened brief in place with the bedpan inside the brief. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Although the facility failed to ensure R213 received care and services to prevent newly developed pressure ulcers, the facility had immediately assessed R213's skin, and the two NA's were suspended from work. The facility assessed other residents in the facility who used a bedpan or other alternative toileting devices and/or required assistance by staff to be turned and repositioned in bed, the facility completed audits for those identified residents. The facility gave corrective action to NA-C and NA-D, the facility educated nursing staff on what ADL's included, how to read and understand a resident care plan/kardex, how provided cares were documented, how incorrect documentation was avoided, and what neglect of a resident included. The facilities corrective action was verified during the onsite survey on 5/27/25, as having been implemented as of 5/6/25, therefore this deficiency is being cited as Past Non-compliance.

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. Based on observation, interview and document review, the facility failed to consistently post the census on the nurse staff posting. This had the potential to affect all 69 residents residing in the facility and/or visitors who may wish to view the information. Findings include: On 5/18/25 at 11:05 a.m., unable to locate a staff posting when arrived at facility. On 5/18/25 at 6:35 p.m., staff posting was observed in a magnetic clip on the metal doorframe of the administration office on first floor. The posting identified nursing staff shifts, census and number of staff assigned each shift. On 5/19/25 at 3:00 p.m., the staff posting with the current date was clipped to the administration office doorframe, clip was positioned about six feet off the floor. On 5/20/25 at 12:28 p.m., the staff posting was positioned on the doorframe about six feet from the floor dated Monday 5/19/25. At 2:15 p.m., the staff posting was updated with current date, continued to be clipped about six feet from the floor. On 5/21/25 at 11:40 a.m., the staff posting was dated 5/20/25, continued to be about six feet from the floor. At 1:16 p.m., the staff posting was updated with current date, continued to be clipped about six feet from the floor. On 5/27/25 at 9:10 a.m., No staff posting was located on the administration office doorframe. At 11:48 a.m., staff posting with current date was in magnetic clip on administration office doorframe, continued to be about six feet from the floor. When interviewed on 5/27/25 at 1:39 p.m., administrator stated she was responsible for posting the staff posting. Administrator stated the positing was put up about 9:00 am during the week, on weekends the entire weekend was posted. When asked about height of staff posting administrator stated the posting was too high for anyone in a wheelchair to have easy access to read the posting. A facility Nursing Staff Daily Posting Requirements policy dated 12/2/24, indicated the staff posting must be prominently displayed daily in a clear, readable format where residents, staff members andthe public may view.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure proper hand hygiene was performed during dining services for 1 of 1 resident (R1) reviewed for assistance with meal set-up. Findings include: R1's quarterly Minimum Data Set (MDS) dated [DATE], identified R1 had moderate cognitive impairment and required assistance with all activities of daily living (ADLs). R1's diagnoses included hypertension, neurogenic bladder, diabetes mellitus, arthritis, cerebral palsy, epilepsy, atrial fibrillation and depression. During observation on 5/19/25 at 5:14 p.m., nursing assistant (NA)-D assisted R1 with applying ketchup to his bun. NA-D took individual ketchup packets from the middle of the table and removed the top of R1's hamburger bun off, applied ketchup and used the ketchup packet to spread the ketchup around and placed the top bun on pulled pork sandwich. NA-D did not sanitize hands before or after assisting R1 and did not wear gloves. During interview on 5/19/25 at 5:23 p.m., NA-D stated when she helps with meal set-up, she was expected to wear gloves and sanitize hands before and after assisting resident with meal. NA-D confirmed that she did not wear gloves or sanitize hands when assisting R1 and used ketchup packets off the table to spread the ketchup on bun. During interview on 5/27/25 at 3:59 p.m., infection preventionist (IP) stated staff were expected to wash their hands and wear gloves when assisting residents with meals. RN-A stated it was not appropriate to use ketchup packets to spread ketchup as the packets could have been touched by multiple other people and was an infection control issue. The facility Food Handling policy reviewed 6/25/24, indicated food is handled in a manner that minimizes the risk of contamination. Foods are never touched with bare hands. Proper utensils such as tissue, spatula, tongs, and single-use gloves are used for food handling. Hands are properly washed, and gloves will only be worn when appropriate. All food items are handled appropriately for food safety, including all food prepared for meals and snacks regardless of where the item is served or stored.