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	03/26/2026

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to develop and implement comprehensive, person-centered care plans that included all identified needs and appropriate interventions for 4 of 18 residents (R10, R25, R72, and R88) reviewed for care planning.Findings include:R10R10's admission Minimum Data Set (MDS), dated [DATE], identified R10 had intact cognition and required assistance with all activities of daily living (ADLs). R10's diagnoses included anxiety disorder (excessive worry), depression (persistent sadness), PTSD (post-traumatic stress disorder; stress after trauma), and mild cognitive impairment of unknown etiology (early memory/thinking changes with unclear cause). Review of R10's comprehensive care plan, print date of 3/26/26, failed to include person-centered interventions related to R10's trauma history, including approaches to minimize triggers, promote emotional safety, or individualized care preferences. During interview on 3/26/26 at 9:55 a.m., the Director of Nursing (DON) and Social Services Designee (SSD) confirmed R10 had a known trauma history; however, this had not been incorporated into the care plan with personalized, resident-specific information. R25R25's admission MDS, dated [DATE], identified R25 had moderate cognitive impairment and required assistance with all ADLs. R25's diagnoses included non-Alzheimer's dementia (cognitive decline not caused by Alzheimer's disease), muscle weakness (reduced strength), abnormalities of gait and mobility (difficulty walking), hypertension (high blood pressure), arthritis (joint inflammation causing pain), and insomnia (difficulty sleeping). Review of R25's comprehensive care plan, print date of 3/26/26, revealed no interventions addressing edema management, including but not limited to monitoring, limb elevation or use of compression stockings During interview on 3/25/26 at 3:40 p.m., Registered Nurse (RN)-B reviewed the medical record and stated R25 had non-pitting edema in the right and left lower extremities. RN-B confirmed edema was not included on R25's care plan. During interview on 3/26/26 at 10:46 a.m., the DON stated edema should have been included on the care plan so it was clearly identified to staff and safe care could be provided. R72R72's admission MDS, dated [DATE], identified R72 had intact cognition and required assistance with ADLs. R72's diagnoses included urinary tract infections (infection in the urinary system), viral hepatitis (inflammation of the liver caused by a virus), enterocolitis due to Clostridium difficile (inflammation of the intestines caused by a bacterial infection leading to diarrhea), Sjogren syndrome with vasculitis (an autoimmune disorder causing dry eyes/mouth and inflammation of blood vessels), vasculitis limited to the skin (inflammation of blood vessels affecting only the skin), and retention of urine (inability to fully empty the bladder). The MDS indicated the resident had a Stage 1 pressure ulcer (early skin injury with non-blanchable redness). Review of R72's comprehensive care plan, print date of 3/26/26, failed to include Enhanced Barrier Precautions (EBP) interventions, including use of gown and gloves for high-contact care activities, availability of personal protective equipment (PPE), or appropriate signage. During interview on 3/25/26 at 4:01 p.m., the DON confirmed R72 was on EBP; however, this had not been included in the care plan. R88R88's admission MDS, dated [DATE], identified R88 had intact cognition and required assistance with ADLs. R88's diagnoses included dependence on renal dialysis (requires routine dialysis treatment to perform (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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	kidney function), chronic kidney disease stage 5 (severe kidney failure where the kidneys no longer function adequately), and presence of other vascular implants and grafts (surgically placed devices or vessels used to support blood flow, often for dialysis access). Review of R88's comprehensive care plan, print date of 3/26/26, failed to include EBP interventions, including use of gown and gloves for high-contact care activities, availability of PPE, or appropriate signage. During interview on 3/25/26 at 3:55 p.m., the Director of Nursing (DON) confirmed R88 was on EBP; however, this had not been included in the care plan. A facility care plan policy was requested but 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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure a resident was treated with dignity and respect by continuing use of a Wander Guard device in a manner that caused ongoing distress and failed to attempt alternative placement to reduce discomfort for 1 of 3 residents reviewed for dignity (R25).Findings include:R25's admission Minimum Data Set (MDS), dated [DATE], identified R25 had moderate cognitive impairment and required assistance with all activities of daily living (ADLs). R25's diagnoses included non-Alzheimer's dementia (cognitive decline not caused by Alzheimer's disease), muscle weakness (reduced strength), abnormalities of gait and mobility (difficulty walking), hypertension (high blood pressure), arthritis (joint inflammation causing pain), and insomnia (difficulty sleeping). During observation on 03/23/2026 at 2:44 p.m., R25 was observed with a Wander Guard applied to the left wrist. R25 stated, I have to have this on so I don't go anywhere. I have gone outside once before, but it's not like I can go anywhere. During observation on 03/24/2026 at 12:59 p.m., R25 was observed sitting in the dining room eating ice cream. R25 stated it was not going well because they won't let me leave and I have this ?stupid thing on my wrist.' The Wander Guard remained in place on the left wrist. During observation on 03/24/2026 at 3:26 p.m., R25 was observed waiting outside the elevator, then entered the elevator and traveled to the third floor. During observation on 03/24/2026 at 3:33 p.m., R25 returned to the second floor and self-propelled around the main living room area. R25 approached the surveyor, grabbed the Wander Guard, and stated, I still have this thing on, they won't let me leave. During observation on 03/24/2026 at 6:48 p.m., R25 was observed in the living room area talking with two nursing assistants while self-propelling. The Wander Guard remained on the left wrist. During observation on 03/25/2026 at 8:33 a.m., R25 was observed sitting in the dining room reading a newspaper. R25 stated breakfast was good and warm. The Wander Guard remained in place on the left wrist. During observation on 03/25/2026 at 3:13 p.m., R25 was observed sitting outside the elevator waiting to go downstairs. The Wander Guard remained on the left wrist. R25 grabbed the device, shook it, and stated, They won't let me go home and I still have this stupid thing on. Review of R25's medical record and care plan lacked evidence the facility assessed or addressed the resident's ongoing distress related to the Wander Guard. There was no documentation indicating alternative placement options or less intrusive interventions were considered or implemented. During an interview on 03/25/2026 at 3:18 p.m., Nursing Assistant (NA)-C stated R25 did not like the Wander Guard, frequently verbalized wanting it removed, and was constantly fidgeting with the device. During an interview on 03/25/2026 at 3:19 p.m., Registered Nurse (RN)-A stated the Wander Guard really bugs him and confirmed R25 frequently asked for it to be removed. During an interview on 03/25/2026 at 3:40 p.m., RN Case Manager (RN)-B stated Wander Guards could be placed on the wrist or ankle and should be monitored for proper placement and effectiveness. During an interview on 03/26/2026 at 10:46 a.m., the Director of Nursing (DON) stated Wander Guard placement should be individualized and should not cause distress to the resident. The DON acknowledged that if the device was causing distress, it could be a dignity concern and alternative placement, such as the ankle, should have been attempted. The facility's Resident Dignity policy, dated 12/18/25, indicated the facility would promote care for residents in a manner that maintained or enhanced each resident's dignity and respect.

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F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow resident to participate in the development and implementation of his or her person-centered plan of care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to conduct the initial and quarterly care conferences for 1 of 18 residents (R60) reviewed for care conferences.Findings include:R60's annual Minimum Data Set (MDS) dated [DATE], indicated R60 was admitted on [DATE], cognitively intact, and had the following diagnoses: peripheral vascular disease (poor circulation in the limbs), benign prostatic hypertrophy (enlarged prostrate), renal insufficiency, hyperlipidemia (elevated level of fat in the blood stream), and depression.R60's medical record lacked evidence a care conference was offered or conducted since admission.On 3/25/26 at 8:03 a.m., the administrator confirmed the facility had no record of any care conferences being conducted for R60.On 3/26/26 at 9:55 a.m., the social work designee (SW)-A and the director of nursing (DON) stated care conferences were organized by the social worker in cooperation with the MDS coordinator and should have been conducted within 3 days of admission, quarterly, with a significant change, or at family request. SW-A and the DON confirmed R60 had not had any care conferences and stated they were missed during a staff change over. SW-A stated the importance of conducting care conferences were to ensure the residents received what they needed and their family members/representatives provided input into their care. The DON stated they expected the initial care conference to have been conducted within 3 days of admission and then quarterly, with a significant change or at family request. The DON stated the importance of completing care conferences was to have clear communication and collaboration with the families.The facility Comprehensive Care plan and Care Conferences Policy last reviewed 12/29/25, indicated the facility will establish a baseline care plan and provide the resident and/or representative with a written summary of the care plan, and document the meeting occurred with the resident and representative and any significant discussion that occurred.

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F 0568 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Properly hold, secure, and manage each resident's personal money which is deposited with the nursing home. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to provide quarterly statements to 1 of 1 resident (R36) reviewed for personal funds. Findings include:R36's quarterly Minimum Data Set (MDS) dated [DATE], indicated R36 admitted [DATE], cognitively intact, and had the following diagnoses: heart failure, hypertension (high blood pressure), renal insufficiency, diabetes, and schizophrenia.On 3/23/26 at 1:20 p.m., R36 stated the facility was responsible for management of their money, but they had no idea what was going on with the account and the facility received their statements.On 3/26/26 at 12:12 p.m., the business office manager (BOM) stated they received monthly statements at R36's request and then met with the resident to explain and provide the documents to them. Additionally, the BOM confirmed they had no documentation to confirm conversations or explanations occurred.R36's medical record lacked evidence of agreement or statements were provided or explained to R36.On 3/26/26 at 12:50 p.m., administrator stated they expected personal fund account summaries were provided per regulations. It was important to provide documents to residents and document all conversations regarding accounts. Residents needed to be informed of account balances and facility needed documentation to refer back to.The facility Resident Trust Account Policy last revised 5/23/24, indicated as fiduciary of resident funds the location must hold, safeguard, manage, and account for the funds as well as ensure they are handled in accordance with state and federal regulation.

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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. Based on interview and document review, facility failed to contact provider for 1 of 2 residents (R82) who expressed a plan to discharge against medical advice (AMA).R82's care plan dated 1/9/26, indicated R82 wished to return home in community pending therapy outcomes. Interventions included facility to make arrangements with required community resources to support independence post-discharge for example home care, physical and/or occupational therapy. R82 required assistance with dressing, transfers, ambulation, bathing and toile use.R82's face sheet undated, indicated R82 had diagnoses which included diabetes, dizziness, anxiety, chronic pain, muscle weakness, falls, abnormal gait and mobility, need for assistance with personal care. Care conference progress note dated 1/26/26, at 11:35 indicated therapy planned to end 1/28/26, therapy recommended assisted living facility for medication management, eating and cognitive concerns on living at home. R82's friends expressed concerns regarding R82's living conditions. R82 expressed desire to return home with county services. Facility explained if R82 did not admit to assisted living facility (AL) or home with extra services R82 would be considered discharged AMA and facility would not assist with setting up home services. Facility expressed to R82 if stayed in facility while after therapy ended to arrange either an AL or home services R82 may need to privately pay for extra days to enable facility to plan. R82 had expressed continued desire to discharge home. R82 was given a Notice of Medicare Non-Coverage (NOMNC) 1/26/26, at the care conference. Progress note dated 1/21/26, at 2:45 p.m. indicated R82 informed facility staff there were people coming to take him home. Staff explained to R82 if he left AMA they would not be able to set up services or send prescriptions for medications, R82 stated understanding and agreed to stay until 1/28/26 then discharge. Progress note dated 1/28/26, at 12:10 p.m. indicated R82's daughter was notified of R82's decision, R82 discharged from the facility with all personal belongings. R82's electronic medical record (EMR) lacked documentation R82's provider was contacted regarding R82's plan to discharge, in addition R82's EMR lacked documentation facility attempted to facilitate a planned discharge. R82's EMR lacked documentation provider was notified R82 discharged AMA. During interview on 3/26/26, at 10:56 a.m. Social worker (SW)- A stated R82 was educated regarding the risks and benefits of discharge AMA versus discharge to AL or home with services. SW-A stated R82 was adamant was going to discharge to home. When interviewed on 3/26/26, at 11:09 a.m. director of nursing (DON) stated they attempted to convince R82 to remain in facility to allow them to contact the provider regarding desire to discharge to home. DON stated facility goal when a resident expressed they intended to discharge even if AMA was to contact the provider to attempt to facilitate a safe discharge for the resident rather than they discharge AMA with no assistance to obtain services or orders for medications. DON reviewed R82's EMR, DON noted facility was made aware on 1/26/26, R82 intended to discharge, however DON was unable to locate documentation provider had been informed, no attempt had been made to facilitate a safe planned discharge for R82. Facility Discharge and Transfer Rehab/Skilled, Therapy and Rehab policy dated 1/15/26, indicated discharge home facility would obtain an order from the physician for discharge to home with medications, arrange community resources and referrals, and coordinate a discharge plan with interdisciplinary team and resident. In addition, the policy indicated discharge AMA facility was to inform the physician of the situation.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure a discharge summary (recapitulation of stay) was completed for 1 of 1 resident (R80) reviewed for hospitalization who did not return to the facility and for 1 of 1 resident (R82) reviewed for transfer and discharge. Findings include: R80's admission Minimum Data Set (MDS), dated [DATE], identified R80 had intact cognition and required some assistance with activities of daily living (ADLs). R80's diagnoses included other gram-negative sepsis, hypertension, urinary tract infection, diabetes mellitus, non-Alzheimer's dementia, chronic obstructive pulmonary disease (COPD), gross hematuria, benign prostatic hyperplasia with lower urinary tract symptoms, urinary retention, unspecified hydronephrosis, hydrocele, right testicular pain, long-term use of insulin, and a personal history of transient ischemic attack (TIA) and cerebral infarction without residual deficits. Review of R80's progress notes indicated R80 was transferred from the facility to the hospital on 2/12/26, for fluid retention. Further review of the progress notes revealed R80 did not return to the facility following hospitalization and was considered discharged as of 2/13/26, when the family released the bed hold. Review of R80's electronic medical record (EMR) showed no evidence a discharge summary (recapitulation of stay) had been completed, including a summary of the resident's status at discharge or a post-discharge plan of care. During an interview on 3/25/26 at 10:18 a.m., the Director of Nursing (DON) stated the facility normally completed a discharge summary (recapitulation of stay) when a resident was discharged . The DON confirmed a discharge summary had not been completed for R80 and indicated it should have been, as the facility was expected to complete one for all residents upon discharge. The DON explained the discharge summary was important because it outlined the care provided during the resident's stay. She further stated the document was printed and sent to the physician for review and signature, at which time the physician could add additional comments. R82's care plan dated 1/9/26, indicated R82 wished to return home in community pending therapy outcomes. Interventions included facility to make arrangements with required community resources to support independence post-discharge for example home care, physical and/or occupational therapy. R82 required assistance with dressing, transfers, ambulation, bathing and toile use. R82's face sheet undated, indicated R82 had diagnoses which included diabetes, dizziness, anxiety, chronic pain, muscle weakness, falls, abnormal gait and mobility, need for assistance with personal care. Review of R82's progress notes from 1/6/26 to 1/28/26, identified the following: -1/21/26, at 2:45 p.m. indicated R82 informed facility staff there were people coming to take him home. Staff explained to R82 if he left AMA they would not be able to set up services or send prescriptions for medications, R82 stated understanding and agreed to stay until 1/28/26 then (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	discharge -1/26/26, at 11:35 a.m. R82 informed facility during care conference he was going to discharge home on 1/28/26. - 1/28/26, at 12:10 p.m. R82 left the facility home by taxi with all belongings. R82's EMR lacked a discharge summary for R82's stay. During interview on 3/25/26, at 3:04 p.m. Director of nursing (DON) reviewed R82's EMR, indicated was unable to locate a discharge summary for R82. DON was unsure why there was discharge summary. Facility Discharge and Transfer – Rehab/Skilled, Therapy and Rehab policy dated 1/15/26, indicated when a resident discharge from the facility a discharge summary would be completed.

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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 record review and interview, the facility failed to develop and implement a baseline care plan within 48 hours of admission for 2 of 18 residents (R10 and R11) reviewed for care planning.Findings include:R10R10's admission Minimum Data Set (MDS) dated [DATE] identified R10 had intact cognition and required assistance with all activities of daily living (ADLs). R10's diagnoses included encounter for other orthopedic aftercare (follow-up care after bone/joint treatment), GERD (acid reflux), diabetes mellitus (high blood sugar), hyperlipidemia (high cholesterol), arthritis (joint inflammation), osteoporosis (weak/brittle bones), anxiety disorder (excessive worry), depression (persistent sadness), PTSD (post-traumatic stress disorder; stress after trauma), rotator cuff tear/rupture of the right shoulder (tear of shoulder tendons), hereditary ataxia (genetic condition causing poor coordination), demyelinating disease of the central nervous system (damage to nerve covering affecting signals), chondromalacia of the right shoulder (cartilage damage in the shoulder), bicipital tendinitis (inflammation of the biceps tendon), and mild cognitive impairment of unknown etiology (early memory/thinking changes with unclear cause). Review of R10's electronic medical record (EMR) indicated R10 was admitted to the facility on [DATE]. Further review of R10's EMR revealed a baseline care plan had not been initiated or completed within 48 hours of admission. The ADL baseline care plan was first documented on 2/17/26, greater than 48 hours after admission. R11R11's quarterly MDS dated [DATE] identified R11 had intact cognition and required assistance with ADLs. R11's diagnoses included neurocognitive disorder with Lewy bodies (a progressive brain disorder causing changes in thinking, movement, and behavior), non-Alzheimer's dementia (decline in memory and thinking not caused by Alzheimer's disease), and depression (persistent sadness or loss of interest). The MDS indicated R11 received antipsychotic medication. Review of R11's EMR indicated R11 was admitted to the facility on [DATE]. Further review of R11's EMR revealed a baseline care plan had not been initiated or completed within 48 hours of admission. The ADL baseline care plan was first documented on 12/1/25, greater than 48 hours after admission. During interview on 3/25/26 at 3:25 p.m., registered nurse case manager (RN)-B indicated baseline care plans included areas such as transfer status, high-risk (black box) medication warnings, medications, fall risk, behaviors, pain, risk for pressure ulcers, psychotropic medication use, and presence of a feeding tube. RN-B stated baseline care plans should be completed within 24-48 hours of admission. RN-B confirmed R11's ADL interventions were not initiated until 12/1/25. During interview on 3/25/26 at 4:07 p.m., the Director of Nursing (DON) indicated care plans were expected to be initiated upon admission, with assessments set up to automatically populate the care plan. The DON stated the RN manager or herself would follow up or complete the care plan, with an expectation for completion within 48 hours so staff were aware of how to provide care. The DON further stated, at a minimum, fall and ADL interventions should be in place within that timeframe. The DON confirmed R11's ADL interventions were initiated on 12/1/25, which was beyond the required 48-hour timeframe. During interview on 3/26/26 at 11:31 a.m., the DON provided consistent information regarding care plan initiation and expectations for completion within 48 hours of admission, including implementation of fall and ADL interventions. The DON confirmed R10's ADL interventions were initiated on 2/17/26, which was beyond the required 48-hour timeframe. The facility Care Plan policy was requested but was not received

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to revise a comprehensive, person-centered care plan to reflect a change in mobility status for 1 of 1 resident (R25) reviewed for care planning related to wheelchair use.Findings include:R25's admission Minimum Data Set (MDS), dated [DATE], identified R25 had moderate cognitive impairment and required assistance with all activities of daily living (ADLs). R25's diagnoses included non-Alzheimer's dementia (cognitive decline not caused by Alzheimer's disease), muscle weakness (reduced strength), abnormalities of gait and mobility (difficulty walking), hypertension (high blood pressure), arthritis (joint inflammation causing pain), and insomnia (difficulty sleeping). Review of R25's comprehensive care plan, with a print date of 3/26/26, indicated R25 required assistance of one staff with a front wheeled walker for mobility. During the following observations, no use of a front wheeled walker was observed:3/24/26 at 3:26 p.m., R25 was observed sitting outside the elevator in his wheelchair and was self-propelling via wheelchair to and from various locations within the facility.3/24/26 at 6:48 p.m., R25 was observed self-propelling via wheelchair to and from various locations on the second-floor unit.3/25/26 at 8:33 a.m., R25 was observed self-propelling via wheelchair to and from various locations on the second-floor unit.3/25/26 at 3:13 p.m., R25 was observed sitting outside the elevator in his wheelchair and was self-propelling via wheelchair to and from various locations within the facility. Further review of R25's electronic medical record (EMR) lacked evidence the care plan had been revised to reflect R25's current use of a wheelchair for mobility assistance. During interview on 3/25/26 at 3:40 p.m., registered nurse care manager (RN)-B stated the wheelchair use had not been reflected in R25's care plan and should have been revised. During interview on 3/26/26 at 10:46 a.m., the director of nursing (DON) confirmed wheelchair use for R25's mobility had not been revised in the care plan and should have been, to ensure the care plan was clearly identified for staff to provide safe care. A facility care plan policy was requested but was not received.

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Good Samaritan Society - Waconia and Westview Acre	333 Fifth Street West Waconia, MN 55387

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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 shaving was offered or provided for 1 of 1 residents (R15) reviewed for assistance with activities of daily living (ADLs).R15's quarterly Minimum Data Set (MDS) dated [DATE], indicated R15 had severe cognitive impairments and required staff assistance with ADLs. R15's diagnoses included diabetes, Parkinson's disease, dementia, anxiety and chronic pain. R15's care plan revised 3/7/26, indicated R15 had a self-care deficit related to Parkinson's disease with interventions that included resident required assistance from one staff for bathing, dressing and personal hygiene. On 3/23/26, at 11:25 a.m. observed R15 to have gray hairs on chin, above upper lip and below lower lip, about an inch in length. During follow-up observations on 3/24/26, at 12:37 p.m., 3/24/26, at 3:48 p.m., 3/24/26, at 6:55 p.m., 3/25/26, at 8:29 a.m., 3/25/26, at 4:15 p.m. and 3/26/26, at 7:16 a.m. R15 continued to have long gray hair on chin, above upper lip and below lower lip, about an inch in length. During interview on 3/26/26, at 10:18 a.m. family member (FM)-A stated they had asked the facility to shave R15, FM-A further stated R15 would be very bothered if she knew she had long hairs on her face. FM-A stated I don't know why they don't remove the hairs for her, I would think they could easily do that for her, she has a electric razor in her drawer. When interviewed on 3/26/26, at 10:32 a.m. nursing assistant (NA)-A stated R15 did not refuse cares, if a resident was unable to request to be shaved the resident should then be shaved when they start to look scruffy. When interviewed on 3/26/26, at 10:36 a.m. trained medication aide (TMA)-A stated R15 was cooperative with cares, TMA-A stated she had noticed R15 had long hair on her chin but had not shaved her this morning. TMA-A observed R15 with surveyor and stated R15 did look like she should have been shaved before now for R15's dignity When interviewed on 3/26/26, at 11:09 a.m. director of nursing (DON) stated the expectation was both men and women should be shaved when there was hair/whiskers that had grown for their comfort and dignity. Facility Activities of Daily Living - R/S, LTC policy dated 12/10/26, indicated ADLs are those necessary tasks conducted in the normal course of a resident's daily life that included general personal, daily hygiene/grooming: care of hair, hands, face, shaving, applying makeup, skin, nail and oral care.

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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 observation, interview, and record review, the facility failed to ensure care and services were provided in accordance with professional standards of practice by not following provider-ordered edema management interventions, including assistance with application and removal of compression stockings, and by inaccurately documenting care on the Treatment Administration Record (TAR) for 1 of 3 residents (R25) reviewed for edema management.Findings include:R25's admission Minimum Data Set (MDS), dated [DATE], identified R25 had moderate cognitive impairment and required assistance with all activities of daily living (ADLs). R25's diagnoses included non-Alzheimer's dementia (cognitive decline not caused by Alzheimer's disease), muscle weakness (reduced strength), abnormalities of gait and mobility (difficulty walking), hypertension (high blood pressure), arthritis (joint inflammation causing pain), and insomnia (difficulty sleeping). Review of R25's physician orders, dated 3/4/26, indicated an order for staff to apply compression (TEDS) stockings in the morning and remove them in the evening for edema management. Review of the Treatment Administration Record (TAR) from 3/1/26 through 3/26/26 indicated staff documented the application and removal of compression stockings as completed, as ordered. During observation and interview on 3/23/26 at 3:07 p.m., R25 was observed seated in his wheelchair without compression stockings in place. Observation of R25's lower extremities revealed he was wearing regular socks that were causing indentations around his lower extremities. R25 stated staff had not consistently assisted with applying the compression stockings, and he had been wearing regular socks for the past several weeks. During observation on 3/24/26 at 12:59 p.m., R25 was observed seated in his wheelchair in the dining room without compression stockings in place. Observation of his lower extremities revealed he was wearing regular socks that were causing indentations. During observation on 3/25/26 at 8:33 a.m., R25 was observed seated in his wheelchair in the living room area without compression stockings in place. Observation of his lower extremities revealed he was wearing regular socks that were causing indentations. During interview on 3/25/26 at 3:18 p.m., Nursing Assistant (NA)-C stated she was not aware R25 had compression stockings that he should have been wearing during the day. During interview on 3/25/26 at 3:19 p.m., Registered Nurse (RN)-A stated R25 had an order for compression stockings to be applied in the morning and removed at bedtime. RN-A stated R25 did not refuse compression stockings. RN-A confirmed R25 did not have compression stockings on at that time and was wearing regular socks. RN-A confirmed the TAR indicated the compression stockings were applied and removed as ordered and acknowledged the documentation was not accurate when the stockings were not in place. During interview on 3/25/26 at 3:40 p.m., the Registered Nurse Care Manager (RN)-B stated she had not been aware of R25's edema. RN-B reviewed R25's electronic medical record (EMR) and stated R25 had non-pitting edema in the right and left lower extremities and should have been wearing compression stockings. RN-B indicated she would have expected R25 to wear them, as there was an order in place, and stated they were important to help manage his edema. RN-B confirmed staff had been documenting on the TAR that the compression stockings were applied and removed as ordered. During interview on 3/26/26 at 10:46 a.m., the Director of Nursing (DON) stated compression stockings should have had an order to be applied in the morning and removed at night and that this intervention should have been care planned. The DON stated staff were expected to assist R25 with application and removal. The DON further indicated compression stockings were important to help manage edema, promote circulation, and reduce the risk of blood clots. The DON also stated staff were expected not to document care that was not completed, as doing so would be false documentation. A facility policy regarding compression stocking application, documentation, and care planning was requested but was not received.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure ongoing monitoring of pressure ulcers for 2 of 4 residents (R2 and R15) reviewed for pressure ulcers. This had the potential to delay identification of changes in wound status and impact timely interventions to promote healing. F686 Based on observation, interview, and record review the facility failed to ensure ongoing monitoring of pressure ulcers for 3 of 4 residents (R2, R15 and R 72) reviewed for pressure ulcers. This had the potential to delay identification of changes in wound status and impact timely interventions to promote healing. Findings include: The National Pressure Ulcer Advisory Panel (NPUAP) guidelines dated 2016, identified a pressure ulcer as, . localized damage to the skin and underlying soft tissue usually over a bony prominence or related to a medical or other device. These are then staged according to the following criteria: - Stage I Pressure Injury: Non-blanchable erythema (redness) of intact skin. - Stage II Pressure Injury: Partial-thickness skin loss with exposed dermis. - Stage III Pressure Injury: Full-thickness skin loss, Adipose (fat) is visible, and rolled wound edges are often present - Stage IV Pressure Injury: Full-thickness skin and tissue loss, Exposed bone, tendon, ligament, cartilage, or muscle. - Unstageable Pressure Injury: Obscured full-thickness skin and tissue loss. The extent of damage cannot be confirmed because it is covered by slough (contains yellowish or white, soft, stringy dead tissue that acts as a barrier to healing) or eschar (thick, dry black or brown layer of dead tissue). -Deep Tissue Pressure Injury: Intact or non-intact skin with localized area of persistent non-blanchable deep red, maroon, or purple discoloration. R2 R2's quarterly Minimum Data Set (MDS) dated [DATE], indicated R2 was cognitively intact and was dependent on staff for activities of daily living (ADLs). R2's diagnoses included: hemiplegia (weakness, numbness or reduced muscle strength on one side of the body) and hemiparesis (inability to move muscles on one side of the body) following a stroke, pressure ulcers, anemia, muscle weakness and protein-calorie malnutrition. R2's pressure ulcer/injury care area assessment (CAA) dated 11/9/25, indicated R2 was admitted with a stage II pressure ulcer to the coccyx. R2's care plan revised 3/5/26, indicated R2 had actual impairment to skin related to immobility, R2 had an unstageable pressure ulcer to sacral/coccyx/ bilateral intergluteal cleft region with interventions that included: staff to monitor location, size and treatment of skin injury. Report abnormalities, failure to heal, s/s of infection, maceration, etc. to health care provider. Weekly skin observation by licensed nurse. Review of R2's EMR wound documentation identified:On 11/3/25, sacrum wound measured 6.5 centimeters (cm) x 6.5cm x no depth Partial loss of skin, blanchable, 100% granulation tissue, tender to touch, scant bleeding.The next documented measurements was obtained a month later on 12/3/25, indicated sacrum/coccyx recently resolved stage 2 pressure ulcer sacral area is fragile resolved no open area all moisture-associated skin damage (MASD).On 12/13/25, right buttock wound measured 7.5cm x 3.5cm x no depth documented 10% eschar.On 12/18/25, Sacrum/coccyx/bilateral intragluteal cleft suspected deep tissue injury (SDIT) measured 9.0cm x 8.4cm x 0.2cm with 20%on granulation 80% slough worsening with unstageable condition at this time.On 12/23/25, Sacrum/coccyx/bilateral intragluteal cleft SDIT measured 8.4cm x 8.2cm x0.2cm with 20% granulation 80% slough.The next documented measurements were completed 36 days later on 1/28/26, coccyx wound measured 5.6cm x 3.0cm x 0.3cm with 40% granulation 60% slough.On 2/5/26, right intergluteal cleft 7.0cm x 2.2cm x 0.3cm with 80% granulation 20% slough.On 2/18/26, sacrum stage 3 measured 5.5cm x 1.7cm x 0.4cm with 80% granulation 20% slough.On 2/19/26, sacrum 5.0cmx2.5cmx0.3cm with Full thickness skin loss on the buttocks, no drainage, white fat tissue at the base, and non-blanchable.On 2/26/26, sacrum 5.0cm x 1.6cm x 0.4cm with 70% granulation 30% slough minimum serosanguineousOn 3/5/26, unstageable wound pressure ulcer spanning coccyx and bilateral intragluteal cleft (vertical groove between buttocks) 2.7cm x 2.7cm x 0.4cm undermining (tissue under wound edges erode creating a shelf or pocket beneath skin) at 6:00 0.8cm length, 70% granulation 30% slough, surrounding skin (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	macerated (wet, white, waterlogged tissue).On 3/12/26, unstageable wound pressure ulcer spanning coccyx and bilateral intragluteal cleft measured 3.2cmx0.8cmx1.2cm.On 3/20/26, unstageable wound pressure ulcer spanning coccyx and bilateral intragluteal cleft measured 2.5cm x 1.3cm x 0.7cm with 90% granulation 10% slough. Wound edges not attached appear as a cliff, surrounding skin macerated with induration (localized hardening/firming around wound typically caused by inflammation, infection, or chronic cellular immune response). During interview on 3/25/26, at 1:29 p.m. licensed practical nurse (LPN)-A stated R2's wound improved from what it had looked like, had been double the size it currently was and was no longer dark purple in color. When interviewed on 3/26/26, at 11:09 a.m. director of nursing (DON) stated the expectation was all wounds would be measured and documented on weekly. DON stated she expected the nurses/nurse managers to take ownership with their wounds. DON reviewed R2's EMR, stated unable pull data that is not in the chart. R15 R15's quarterly MDS dated [DATE], indicated R15 had severe cognitive impairment and required assistance with ADLSs. R15's diagnoses included: cellulits of right lower limb, pressure ulcer right heels stage 3, pressure ulcer left heel stage 3, diabetes, Parkinson's disease, dementia, hypertension, anxiety and chronic pain. R15's pressure ulcer/injury CAA dated 12/15/25, indicated R15 had pressure ulcers on her right and left heel that she was admitted with hospital documentation listing them as stage 2. Per hospital record Right heel is chronic with poor healing. right heel 1cm x 1.3cm x 0.2cm and Left heel 0.5 0cmx 0.3cm x 0.2cm. R15's care plan revised 3/8/26, indicated R15 had stage 3 pressure ulcer to right and left heels present on admission with interventions that included staff apply foam heel protectors when R15 in bed and assess/record/monitor wound healing. Report improvements and declines to the health care provider. Review of R15's EMR wound documentation identified:On 12/3/25, left heel stag 3 measured 1.5cmx0.4cmx0.2cm with100% slough, right heel stage 3 measured 1.3cmx1.1cmx0.2cm with 90%granulation and 10% slough.On 12/12/25, left heel stage 3, measured 0.9cmx0.4cmx0.2cm with 100% slough. right heel stage 3 measured 1.4cmx0.9cmx0.2cm with 90% granulation and 10% slough.The next documented measurements were completed 47 days later on 1/28/26, right heel stage 3 measured 0.5cmx0.3cmx0.2cm with 100% granulation, left heel stage 3 measured 0.2cmx0.2cmx0.2cm with 100% granulation.On 2/4/26, left heel stage 3 was documented as 0cmx0cmx0cm with100% epithelial. right heel stage 3 measured 0.8cmx0.5cmx0.1cm with 100% epithial wound bed.On 2/12/26, right heel 1cm x 1cm x 0cm scabbed. left heel scabbed 1.5cm x 1.5cm x 0cm.On 2/18/26, right heel 0.1cm x 0.2cm x 0.1cm 100% granulation. left heel 0.9cm x 0.4cm x 0cm 100% slough.The next documented measurements were completed 15 days later on 3/5/26, left heel stage 3 pressure ulcer scab covered measured as 0cmx0cmx0cm. Right heel stage 3 pressure ulcer 1cmx0.5cmx0cm scab covered.On 3/12/26, left heel stage 3 pressure ulcer measured 0.5cmx0.3cmx0.1cm, right heel stage 3 pressure ulcer measured 1cmx0.5cmx0.1cm.On 3/19/26, left heel stage 3 measured 0.5cmx0.3cmx0.1cm, right heel stage 3 measured 1cmx0.5cmx0.1cm. When interviewed on 3/26/26, at 11:09 a.m. director of nursing (DON) stated the expectation was all wounds would be measured and documented on weekly. DON stated she expected the nurses/nurse managers to take ownership with their wounds. DON reviewed R15's EMR, stated unable pull data that is not in the chart. Facility Pressure Ulcer/Wound Care Resource Packet-Rehab/Skilled policy stated 12/8/25, indicated wound RN assessment is required at least every seven days and as needed when skin integrity is impaired or open area is present.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure effective communication of necessary clinical information to the dialysis center for 1 of 1 resident (R88) reviewed for dialysis services.Findings include:R88's admission Minimum Data Set (MDS), dated [DATE], identified R88 had intact cognition and required assistance with activities of daily living (ADLs). R88's diagnoses included dependence on renal dialysis (requires routine dialysis treatment to perform kidney function), chronic kidney disease stage 5 (severe kidney failure where the kidneys no longer function adequately), and presence of other vascular implants and grafts (surgically placed devices or vessels used to support blood flow, often for dialysis access). Review of R88's electronic medical record (EMR) indicated R88 received routine dialysis treatments at an external dialysis center on a scheduled basis (Mondays, Wednesdays, and Fridays). Review of facility documentation, including dialysis communication forms and transfer records from 3/18/26 to 3/25/26, revealed the facility failed to send required clinical information with R88 to the dialysis center. Missing or incomplete information included, but was not limited to, vital signs, current medication list, recent changes in condition, weights, and/or physician orders. During interview on 3/24/26 at 12:13 p.m., R88 stated she went to an offsite dialysis center and reported the facility did not send any paperwork or communication form with her to her dialysis appointments. During interview on 3/25/26 at 3:55 p.m., the Director of Nursing (DON) confirmed the expectation that communication forms should accompany the resident to each dialysis appointment to ensure continuity of care. The DON acknowledged the facility did not consistently ensure this information was provided. A call to the Fresenius Dialysis Center was placed on 3/27/26 at 8:04 a.m.; a message was left, and no return call was received. The facility was requested to provide a policy regarding communication with outside providers, including dialysis centers; however, the facility did not provide the requested policy.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure a trauma-informed care approach was implemented by not completing a trauma assessment upon admission for 1 of 1 resident (R10) reviewed for trauma-informed care.Findings include:R10R10's admission Minimum Data Set (MDS), dated [DATE], identified R10 had intact cognition and required assistance with activities of daily living (ADLs). R10's diagnoses included post-traumatic stress disorder (PTSD) (a mental health condition triggered by experiencing or witnessing a traumatic event), anxiety disorder (excessive worry), and depression (persistent feelings of sadness). Review of R10's electronic medical record (EMR) lacked evidence a trauma assessment was completed upon admission to identify past trauma, triggers, or individualized care needs related to trauma history. Review of R10's comprehensive care plan, print date 3/26/26, did not include trauma-informed interventions, approaches to minimize triggers, or strategies to promote emotional safety. During interview on 3/26/26 at 9:55 a.m., the Director of Nursing (DON) and Social Services Designee (SSD) confirmed R10 had a known history of PTSD; however, no trauma assessment had been completed at the time of admission. The DON and SSD further confirmed trauma-informed interventions had not been developed or implemented for R10. The facility's Trauma-Informed Care policy, dated 12/31/25, indicated the facility would provide trauma-informed care and avoid re-traumatizing residents. The policy further indicated staff would ensure residents who experienced trauma received culturally competent, trauma-informed care in accordance with professional standards of practice, accounting for residents' experiences and preferences to eliminate or mitigate triggers that could cause re-traumatization. The policy indicated a trauma assessment was required within five days of admission for all new residents and as needed. The trauma assessment was to be completed by Social Services while interviewing the resident and/or representative. During the interview, staff were to focus on understanding the resident's experience (what happened to the resident) rather than attempting to correct behaviors. The policy further indicated staff were to document how trauma was currently affecting the resident.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to act upon consultant pharmacist recommendations in a timely manner related to completion of an Abnormal Involuntary Movement Scale (AIMS) assessment for 1 of 3 residents (R11) reviewed for unnecessary medications.Findings include:R11's quarterly Minimum Data Set (MDS), dated [DATE], identified R11 had intact cognition and required assistance with activities of daily living (ADLs). R11's diagnoses included neurocognitive disorder with Lewy bodies (a progressive brain disorder causing changes in thinking, movement, and behavior), non-Alzheimer's dementia (decline in memory and thinking not caused by Alzheimer's disease), and depression (persistent sadness or loss of interest). The MDS indicated R11 received antipsychotic medication. R11's physician order summary report, dated 3/4/26, included an order for Quetiapine (an antipsychotic medication used to treat mood and thought disorders) 25 milligrams (mg) to be administered at bedtime for repeated episodes of anxiety. Review of the consultant pharmacist's monthly medication regimen review (MMR), dated 12/18/25, identified a recommendation for completion of an AIMS assessment to monitor for potential side effects related to antipsychotic medication use. Subsequent MMRs, dated 1/14/26, 2/13/26, and 3/6/26, reiterated the same recommendation. Review of R11's electronic medical record (EMR) revealed no evidence that an AIMS assessment had been completed following the pharmacist's recommendation. Further review showed the recommendation remained unaddressed as of 3/20/26. During an interview on 3/20/26 at 10:15 a.m., the director of nursing (DON) confirmed the consultant pharmacist (CP) recommended completion of an AIMS assessment and acknowledged the facility had not completed the assessment or followed up on the recommendation in a timely manner. During an interview on 3/25/26 at 1:45 p.m., DON stated when MMRs were received, she divided the recommendations between two registered nurse case managers and forwarded provider-related recommendations to the providers. During an interview on 3/25/26 at 3:25 p.m., registered nurse case manager (RN-B) stated the DON printed the pharmacist recommendations and distributed them to the nurse managers, where they were placed in a drawer for follow-up. RN-B stated the nurse manager was responsible for completing the AIMS assessment and that recommendations should be followed up as soon as possible, including consideration of gradual dose reduction (GDR) and monitoring for adverse medication reactions. RN-B confirmed the AIMS assessment had not been completed. During an interview on 3/25/26 at 4:07 p.m., the DON stated MMR recommendations were expected to be completed prior to the next consultant pharmacist visit. The DON stated the recommendation had been assigned to the RN case manager; however, for unknown reasons, it was not completed. The DON further stated the recommendation was important as it related to monitoring the resident's medication and potential adverse effects. During an interview on 3/26/26 at 2:18 p.m., the Consultant Pharmacist (CP) stated the expectation was for facilities to respond to recommendations within the first month and no later than 60 days. The CP stated there had been no response to the recommendation in December, January, or February and reported the lack of follow-up may have been related to turnover in the DON position, resulting in the recommendation not being addressed. Review of the facility policy titled Medication: Drug Regimen Review, dated 12/1/25, indicated drug regimen review included identifying and preventing clinically significant medication issues. The policy further indicated the consultant pharmacist would complete a written report noting any irregularities, which would be provided to the DON, and the facility must ensure recommendations were acted upon and documented within 30 calendar days.

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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 establish and implement an infection prevention and control program to prevent the spread of infection by not initiating Enhanced Barrier Precautions (EBP) per Centers for Disease Control (CDC) guidance. when indicated and failing to ensure staff followed EBP during resident care for 3 of 6 residents reviewed for infection control (R11, R46, and R88).Findings include: Review of CDC guidelines dated 8/12/22, identified EBP are an infection control intervention designed to reduce transmission of resistant organisms that employ targeted gown and glove use during high contact resident care activities. EBP may be indicated (when Contact Precautions do not otherwise apply) for residents with any of the following: Wounds or indwelling medical devices, regardless of MDRO colonization status. CDC guidelines updated 6/28/24 identified examples of indwelling medical devices include, but are not limited to, central vascular catheters (including hemodialysis catheters, peripherally inserted central catheters (PICCs)), indwelling urinary catheters, feeding tubes, and tracheostomy tubes. R11R11's quarterly Minimum Data Set (MDS), dated [DATE], identified R11 had intact cognition and required assistance with activities of daily living (ADLs). R11's diagnoses included neurocognitive disorder with Lewy bodies (a progressive brain disorder causing changes in thinking, movement, and behavior), non-Alzheimer's dementia (decline in memory and thinking not caused by Alzheimer's disease), and depression (persistent sadness or loss of interest). The MDS also identified R11 had a stage 2 pressure ulcer. Review of R11's electronic medical record (EMR) identified the presence of a wound requiring ongoing care. Further review of the comprehensive care plan, with a print date of 3/26/26, and physician orders, dated 3/4/26, indicated an order for EBP precautions and wound orders to cleanse with wound cleanser and apply mepilex every other day to the pressure ulcer, and EBP interventions were included in the care plan. However, there was no evidence of implementation, including no documentation of staff use of gown and gloves for high-contact care and no placement of appropriate signage or personal protective equipment (PPE) outside of R11's room. During observations on 3/24/26 at 4:57 p.m. and 3/25/26 at 8:46 a.m., there was no appropriate signage or PPE placed outside R11's room to indicate the resident was on precautions. During interview on 3/25/26 at 3:07 p.m., Nursing Assistant (NA)-D stated she would know if a resident was on precautions based on signage posted outside the resident's room, stating, I just look before I walk in the room. NA-D confirmed R11 was not on EBP precautions, as there was no signage posted outside the room. During interview on 3/25/26 at 3:25 p.m., the registered nurse case manager (RN-B) stated the facility maintained signage on resident doors and a printed list identifying residents on precautions. RN-B indicated the care plan included an EBP section and confirmed R11 was being followed by the wound nurse practitioner (NP) and that the wound was healing; however, R11 should have been on EBP precautions and was included on the facility's EBP list. RN-B accompanied the surveyor to R11's room and confirmed EBP precautions were not in place. RN-B further stated EBP was important to protect staff and residents from infection. R46R46's admission MDS, dated [DATE], identified R46 had intact cognition and required assistance with all ADLs. R46's diagnoses included sepsis due to E. coli (a serious bloodstream infection caused by bacteria), renal failure (impaired kidney function), obstructive uropathy (blockage of urine flow), urinary tract infections (infection in the urinary system), and presence of urogenital implants (devices placed in the urinary or reproductive system). The MDS also indicated R46 had an indwelling catheter (a tube inserted into the bladder to drain urine). Review of R46's care plan, with a print date of 3/26/26, indicated the resident was on EBP precautions due to the presence of the indwelling catheter, including interventions for staff to use a gown and gloves during high-contact resident care. During observation on 3/23/26 at 3:20 p.m., NA-C and an orientee were observed providing direct care to R46, including assisting with toileting, peri-care, and transferring, without donning a gown and/or gloves in accordance with EBP (continued on next page)

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	03/26/2026

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	requirements. No PPE was observed in use during the care interaction. During interview on 3/23/26 at 3:43 p.m., NA-C stated she was not sure if R46 was on precautions because she did not normally work on that floor. NA-C stated she believed the resident was on EBP precautions due to having a catheter and that staff were to wear gloves and a gown whenever assisting with care. NA-C confirmed she and the orientee did not wear a gown or gloves when assisting R46 and should have. During interview on 3/25/26 at 3:38 p.m., RN-B stated staff were expected to wear a gown and gloves whenever they anticipated coming into contact with the resident. During interview on 3/25/26 at 3:55 p.m., the DON confirmed staff were expected to follow EBP precautions, including use of gown and gloves for high-contact care, and acknowledged the observed care was not provided in accordance with facility policy. R88R88's admission MDS, dated [DATE], identified R88 had intact cognition and required assistance with ADLs. R88's diagnoses included dependence on renal dialysis (requires routine dialysis treatment to perform kidney function), chronic kidney disease stage 5 (severe kidney failure where the kidneys no longer function adequately), and presence of other vascular implants and grafts (surgically placed devices or vessels used to support blood flow, often for dialysis access). Review of R88's EMR identified the presence of a dialysis shunt. Further review of the comprehensive care plan, with a print date of 3/26/26, and physician orders, dated 3/18/26, failed to include initiation of EBP precautions related to the presence of the dialysis shunt. There was no documentation indicating assessment for EBP implementation, use of gown and gloves for high-contact care, or placement of appropriate signage and PPE outside of R88's room. During observations on 3/23/26 at 11:12 a.m., 3/24/26 at 4:59 p.m., and 3/25/26 at 2:53 p.m., there was no appropriate signage or PPE placed outside R88's room to indicate the resident was on precautions. During interview on 3/25/26 at 3:55 p.m., the director of nursing (DON) stated R88 should have been on EBP precautions due to the presence of a tunneled catheter. She indicated there should have been signage outside the door and EBP supplies available in a cupboard outside the room. The DON stated it was important to prevent infection transmission to the resident and to staff and confirmed gloves and a gown should be worn during care. The facility Standard, Enhanced Barrier, and Transmission-Based Precautions policy, dated 7/7/25, indicated Enhanced Barrier Precautions (EBP) were implemented to reduce the transmission of multidrug-resistant organisms (MDROs) for residents who were infected or colonized with a CDC-targeted or epidemiologically significant MDRO, or when additional precautions were warranted. The policy indicated EBP were used for residents with chronic wounds (e.g., pressure ulcers, diabetic foot ulcers, unhealed surgical wounds, venous stasis ulcers) and/or indwelling medical devices (e.g., central lines, hemodialysis catheters, urinary catheters, feeding tubes, tracheostomies), regardless of known MDRO status. The policy indicated staff were to wear a gown and gloves during high-contact resident care activities, including transfers, dressing, bathing, hygiene care, toileting, linen changes, wound care, and care or use of indwelling medical devices. The policy indicated EBP were intended to remain in place for the duration of the resident's stay; however, for residents with a wound or indwelling medical device only, precautions could be discontinued if the wound resolved or the device was removed