

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

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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245235	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/16/2026
NAME OF PROVIDER OR SUPPLIER Woodbury Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 7012 Lake Road Woodbury, MN 55125	
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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to ensure food was served in a timely manner and at palatable temperatures for 1 of 1 residents (R102) who expressed concerns about food temperatures and palatability. Findings include: R102's quarterly Minimum Data Set (MDS) dated [DATE], indicated R102 was cognitively intact, had diagnoses of malnutrition and heart failure, and required set-up or clean-up assistance with eating. R102's room was on the second floor of the building. During interview on 7/13/26 at 3:08 p.m., R102 stated she received cold scrambled eggs the previous day. R102's family member who was present also indicated they were ice cold. During interview on 7/14/26 at 2:49 p.m., R102 stated again that the food was cold, and the lasagna served the previous evening was cold and she could not eat it. During observation on 7/15/2026 at 11:03 a.m., three containers of sliced carrots and one large container of stuffing were open, uncovered on the steam table in the main kitchen. One large container of turkey was also present and covered with clear plastic. Additional covered containers of each food item were sitting on top of unheated metal three-tiered carts for transport to other floors for serving. During observation on 7/15/2026 from 11:30 a.m. through 11:47 a.m., kitchen staff plated and delivered meals for the first-floor residents. During observation in the second-floor dining area on 7/15/26 at 12:08 p.m., uncovered metal containers of food were sitting on top of a flat surface on a serving cart. Staff reviewed resident menu forms and dished out one plate at a time, placing the plates on top of a three-tiered cart. Once three plates were completed, the food sat on top of the cart until a staff person arrived to take the cart and deliver the meals to the appropriate residents. Another empty cart was brought to the area, and three more plates were dished and left on top until staff returned to distribute them. During interview on 7/15/26 at 12:08 p.m., KPM stated staff completed three meals at a time and then needed to find an aide to take them to the residents, and that's why the food got cold. At 12:15 p.m., KPM stated two hallways were completed and there was still one left. During observation on 7/15/26 at 12:28 p.m., KPM used a thermometer to take the temperature of the food on the last (test) tray, plated nearly 90 minutes after the food was brought to the floor from the kitchen. Results were as follows in degrees F: Carrots - 125.5, Stuffing - 139.6, Turkey 113.6, Gravy 105.0. During interview on 7/15/26 at 12:30 p.m., KPM stated the hot items should be at 135 degrees F or higher and cold items should be at 40 degrees F or lower to prevent foodborne illness. During interview on 7/16/26 at 12:03 p.m., dietary district manager (DDM) stated all hot foods should be above 140 degrees F and can be held at 120 degrees, and all cold items should be at 40 degrees or below. She stated meat needed to be higher than 110 degrees F to keep bacteria from growing and for palatability. The facility Food Temperature Control Policy dated 1/1/26, indicated hot foods shall be maintained at 135 degrees F or above during holding and service.		

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and document review, the facility failed to ensure food items were labeled, dated when opened, and stored at the proper temperatures to prevent foodborne illness. In addition, the facility failed to ensure dishware was cleaned and sanitized and failed to ensure cups and pans were dry prior to stacking and storage. This had the potential to affect all residents who consumed food from the main production kitchen. Furthermore, the facility failed to ensure nursing and dietary staff followed appropriate infection control practices while handling plate covers during 1 of 1 meal service. This had the potential to affect residents residing on the second floor who received room tray. Findings include: Food Storage and Labeling During the initial tour of the kitchen on 7/13/26 at 10:44 a.m., an undated bag of red grapes was in the refrigerator portion of a refrigerator/freezer unit in a small storeroom. The temperature gauge read 45 degrees Fahrenheit (F). The lower freezer portion of the unit contained four containers of sherbet and did not appear to have a working temperature gauge. A sign on the door indicated Do not leave sherbet or ice cream in here. The food service director (FSD) joined the tour and stated during interview the sign was there because items melted in that freezer, and nobody likes melted ice cream. He indicated the grapes had not yet been washed and was not sure how long they had been in the refrigerator. Upon review of the sandwich bar refrigeration unit, an undated metal container of egg salad approximately 2/3 full was seated in a refrigeration well. The top was dry and congealed, with a watery liquid approximately 1/2 inch deep around the edges. FSD stated lunch had already been served, verified it was undated, and stated, that looks pretty gross, it's going in the garbage. A large metal pan of sliced ham was also undated. The lower refrigerator compartment of the sandwich bar area contained two metal cubical containers on the far-left side in the back of the unit, one full of applesauce and another approximately 30% full of a white yogurt-like substance, both covered in plastic and undated. A large undated metal container of cut mixed fruit covered in plastic wrap with watery juices at the bottom and another undated container of grapes were also in the unit. FSD confirmed all items were undated, and he unsure how long they had been there, although suspected they were placed there sometime over the weekend. During a subsequent interview and tour of the kitchen with FSD on 7/15/2026 at 10:38 a.m., a large rack containing two large trays of gelatin cups was stored in the walk-in cooler and covered with a semi-transparent plastic garbage bag with a label indicating they were made on 7/14 for dinner on 7/15. The inside of the bag was dripping wet with moisture. FSD stated it was from the steam from the hot gelatin and staff probably did not let it cool down before covering which was not a good thing. During interview on 7/16/26 at 12:03 p.m., dietary district manager (DDM) stated refrigerator temperatures should be under 41 degrees F and freezer temperatures should be under -10 degrees F. DDM stated the facility put sherbet in the one freezer, but things disappeared once they had been placed there. DDM stated most items should be dated upon opening, and the items in the deli cooler all (continued on next page)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	should have a label and date. The facility New Horizon Foods Skilled Nursing Facility Food and Beverage Policy dated 1/1/26, indicated all items related to food and drink must be labeled in a way that supports safety and quality standards. Labels should be clear and include basic identifying information. Items should generally include what the item is, when it was prepared or opened, and when it should be used or discarded (if need be). The facility Refrigerator and Freezer Temperature Monitoring Policy dated 1/1/26, indicated refrigerators shall be maintained at 41 degrees F or below. Freezers shall be maintained at 0 degrees F or below. Each unit shall have an accurate, easily visible thermometer or continuous temperature monitoring device. Dish storageDuring observation of the clean dish storage area on 7/13/26 at 11:01 a.m., a group of metal shelving units contained a stack of food service trays, the top tray being soiled with an egg-like drippy substance and a one-inch by one-inch large piece of solid crusty dessert-like food. The shelves also contained a beverage pitcher with a light brown film and dark brown pepper-like specks inside. Thirty-three plastic cups were stacked upside down on another tray, each with droplets of water on top and between each cup. During observation and interview on 7/13/26 at 11:03 a.m., dietary aide (DA)-B was washing pans using the dish machine. He took large metal serving pan from exit area of dishwasher, looked inside the pan, and stacked it in storage area upside down on top of five other pans while still wet. DA-B stated he looked at the pan for anything the dish machine may have missed so it could be re-washed if needed and then put them on the shelf, but every now and then they were damp. He observed the cups on the shelf, verified they were wet, and stated he usually let them sit out and air dry before stacking them, because if they were put away wet it could cause mold and stuff. During observation and interview on 7/13/26 at 11:08 a.m., FSD stated staff should wait for dishes to dry before putting them away. He observed and confirmed the wet pan and the wet stacked cups, stating they shouldn't be that way, bacteria builds up, and brought them back to be re-washed. FSD also verified the pitcher was not clean and returned it to be re-washed. During a subsequent tour of the kitchen on 7/15/26 at 11:09 a.m., Six plastic beverage pitchers were upside down on the metal dish storage racks, each covered with a light brown film and dark brown specks on the inside. During interview on 7/15/2026 at 11:17 a.m., kitchen production manager (KPM) viewed the six pitchers, confirmed they appeared soiled, and indicated they looked like there was coffee or juice splashed up in them. During interview on 7/16/26 at 11:47 a.m., registered dietician (RD) stated she did not know anything about stacking wet dishes or opening and dating packages of food and referred to the FSM. During interview on 7/16/2026 at 12:03 p.m., DDM stated dishes should be air dried before they were put away to prevent bacterial growth. Regarding the pitchers, DDM stated she thought it was residue (continued on next page)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	from cranberry juice and staff needed to do a better job soaking them before washing. Meal Service During observation on 7/15/26 at 7:43 a.m., breakfast was being served on the second floor. At this time, there were 10 residents in the dining room. After the residents in the dining room received their meals, the dietary aid started to plate meals for residents in their rooms. All the plates were covered with a plastic cover. At 7:53 a.m., the plates were put on a metal cart, and a nursing assistant (NA)-A took 5 meals to the residents' rooms. At 8:09 a.m., NA-A returned to the dining room with the plastic plate covers down, one cover on top of the other. NA-A took the covers and with her fingers touched the inside part of the covers and placed them one by one on top of clean plate covers. At 8:11 a.m., another nursing assistant took plates served with breakfast items and grabbed the used covers and placed over the food. At the same time, another NA returned with an empty cart and plate covers. The NA placed the used plate covers on back on top of the same stack of plate covers. During interview at 8:13 a.m., NA-A stated they always re-used the plate covers. NA-A stated they knocked on the residents' door, opened the door and brought the covered meals to the residents' rooms. CN-A stated some residents needed assistance to set up their meals. The plate covers were removed from the rooms and placed on the food cart. During interview on 7/15/26 at 8:15 a.m., food service manager (FSM) stated reusing the plate covers was concerning due to the risk of cross contamination. FSM stated the plate covers shouldn't be re-used. During interview on 7/16/26 at 2:10 p.m., director of nursing (DON) stated reusing plate covers was an infection control issue, due to potential cross contamination and foodborne illnesses. The facility Dishwashing and Clean Dish Storage Policy dated 1/1/26, indicated all dishes, utensils, trays, cookware, and food-contact equipment shall be cleaned and sanitized after each use. All items shall be allowed to air dry completely before storage. Clean items shall not be stacked while still wet as moisture could prevent proper drying. If this is observed, these items need to be immediately removed and rewashed. All dishware should be properly inspected before use. If wet or soiled. Itemed need to immediately be brought back to the dishwasher along with items it had been in contact with. Facility's policy titled Food Handling and Food Safety Policy dated 1/1/26, indicated the policy's purpose was to ensure all food served to residents, patients, visitors, and staff was received, stored, prepared, transported, served, and discarded in a manner that prevents foodborne illness and maintains food quality.		

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F 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Inform resident or representatives choice to enter into binding arbitration agreement and right to refuse. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to ensure binding arbitration agreements for 3 of 3 residents (R63, R5, R120) were clearly explained in a form and manner that they understood prior to entering into the binding arbitration agreements. Findings include: R63's comprehensive Minimum Data Set (MDS) dated [DATE], identified R63 was admitted to facility on 6/30/26 and had intact cognition. R63 signed [NAME] Senior Living Arbitration Agreement on 7/1/26. During interview on 7/16/26 at 12:40 p.m., R63 stated he knew what an arbitration agreement was, but he was unable to remember signing an arbitration agreement with the facility. R63 said he didn't remember talking about it when he signed a bunch of admission documents. R5's comprehensive MDS dated [DATE], identified R5 was admitted to the facility on [DATE] and had intact short- and long-term memory. R4 signed [NAME] Senior Living Arbitration Agreement on 6/30/26. During interview on 7/16/26 at 12:45 p.m., R5 stated she didn't remember signing an arbitration agreement. R5's husband was present when she signed the admission papers, and he was present during this interview. R5 and her husband stated that they didn't know what an arbitration agreement meant. R120's comprehensive MDS dated [DATE], identified R120 was admitted to the facility on [DATE] and had intact cognition. R120 signed [NAME] Senior Living Arbitration Agreement on 6/30/26. During interview on 7/16/26 at 12:55 p.m., R120 stated she didn't remember what documents she signed on admission. R120 stated she was heavily medicated and believed legal documents should not been signed when somebody was heavily medicated with pain medications. During interview on 7/15/26 at 1:51 p.m., social service designee (SS)-A stated she presented and reviewed all the admission papers with new residents, including the arbitration agreement. SS-A stated some residents asked questions and others did not. SS-A stated she explained the arbitration agreement as follows, If they [new resident] felt there was a concern with the facility and was not resolved, arbitration was a step forward if they choose to sign the agreement. SS-A stated nobody had asked questions about what a concern referred to. SS-A added if a new resident asked, she would explain it meant meeting with a third party instead of using a lawyer. During interview on 7/15/26 at 2:03 p.m., director of social services/licensed social worker (SS)-C stated the new residents should understand what an arbitration agreement meant before they sign one on admission. SS-C stated it needed to be explained in a way they understand they are waiving the right to hire a lawyer and instead they choose to use an arbitrator to act as a mediator between the facility and themselves. Requested the policy regarding the facility's arbitration agreement but it was not provided.		

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F 0559 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to share a room with spouse or roommate of choice and receive written notice before a change is made. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to provide in writing a transfer of room notice. This effected 2 of 2 residents (R1, R102) reviewed for room change. Findings Include: R1's admission Minimum Data Set (MDS) dated [DATE], indicated R1 was cognitively intact. Diagnoses included heart failure, post-traumatic stress disorder (PTSD), depression, and anxiety disorder. R1 was admitted on [DATE], to a transitional care unit (TCU) bed. R1's census report undated indicated R1 move to a long-term care (LTC), semiprivate bed on 5/5/26. R1's Transfer, Discharge, Bed Hold Notification form dated 5/5/26 at 3:38 p.m., indicated R1 was transferred from TCU to LTC on 5/5/26, because TCU was for rehabilitation and R1 was staying long term. The form lacked a signature or indication R1 refused to sign. R1's medical record lacked evidence of a signed copy of the Room Transfer Form with explanation for transfer. On 7/15/26 at 10:38 a.m., R1 was called but no answer. No voicemail available. An email correspondence received 7/15/26 at 1:04 p.m., family member (FM)-C indicated R1 had been told during the care conference on 4/22/26, R1 might need to move to a room on the LTC unit. R1 did not really want to move and did vocalize not wanting a roommate. Staff reported at that time, more conversations would come. On 5/5/26 R1 was moved to the second floor. there was no paperwork given to R1 that explained the reasons for the move or for her to sign related to the move. R102's admission MDS dated [DATE], indicated R102 was admitted to the facility 2/26/26 into a TCU room, and had intact cognition. R102's census list printed 7/16/26, identified R102 moved to a long-term care room on 3/14/26. R102's electronic medical record (EMR) lacked evidence of a room transfer notice. R102's progress notes dated 2/27/26 through 6/17/26, lacked evidence of any discussion or notice of room change with R102 or R102's family. During interview on 7/14/26 at 2:49 p.m., family member (FM)-A stated no one provided a room transfer notice. FM-A stated all of a sudden, they were moving R102 and did not provide anything in writing. During interview on 7/14/26 at 2:55 p.m., R102 stated did not feel like she was not informed of what was going on and did not receive anything in writing regarding room transfer. During interview on 7/14/26 at 3:18 p.m., (FM)-B stated R102 was abruptly moved to the LTC room without any (continued on next page)		

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F 0559 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	advanced written notice. During an interview on 7/16/26 at 9:51 a.m., licensed social worker (LSW)-B stated all residents who would be transferred from the TCU to the LTC units would be given the Room Transfer Form 7 days prior to the actual change of rooms. The form explains why the room change was occurring and when the change would occur. LSW-B could not remember if R1 was given a Room Transfer Form prior to the transfer of rooms. During an interview on 7/16/26 at 10:07a.m., licensed social worker (LSW)-C confirmed all residents were to be given the Room Transfer Form at least 7 days prior to transfer. The 7 days allowed the resident to ask questions related to the move, see the new room, and meet the possible roommate. LSW-C reviewed R1 medical record and confirmed there was no Room Transfer Form in the chart. During an interview on 7/16/26 at 12:26 p.m., the administrator stated all residents should be given the Room Transfer Form, which explains why the move occurs and the timeframe for the move, at least 7 days prior to the move. The room change policy was not received.		

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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 residents had the appropriate indications for use for 1 of 1 resident (R11) who was receiving antipsychotic medications. Findings include: R11's annual Minimum Data Set (MDS) dated [DATE], indicated severely impaired cognition and diagnoses of dementia and Schizophrenia (severe mental illness that often leads to hallucinations and delusions). It further indicated R11 received an antipsychotic medication (medication to treat Schizophrenia) on a routine basis. Furthermore, a gradual dose reduction (GDR) for the antipsychotic medication was attempted on 10/24/24, and the physician documented GDR as clinically contraindicated on 11/24/25. R11's physician's orders dated 3/27/25, indicated Zyprexa (Olanzapine) oral tablet 2.5 milligrams (an antipsychotic medication). Give 1 tablet by mouth once a day related to Schizophrenia. R11's pharmacist recommendations for 8/28/25 and 10/6/25, indicated R11 had been taking the following antipsychotic medication: Olanzapine tab 2.5 mg. Take 1 tablet by mouth daily for dementia related agitation. According to 8/28/25, psych meeting, R11 was not a candidate for a gradual dose reduction. When she was off this medication, she yelled and cursed having an increase in behaviors. It further indicated the following recommendation to update diagnosis to schizophrenia and add it to her medical diagnosis list. R11's care planned dated 6/10/26, lacked documentation R11 had a diagnosis of Schizophrenia. R11's nursing progress notes dated October of 2025 to 7/15/26, lacked documentation R11 had been diagnosed with Schizophrenia. During interview on 7/16/26 at 9:08 a.m., registered nurse (RN)-A stated a diagnosis of Schizophrenia was added to R11's medical chart due to a pharmacy recommendation dated 8/28/25, which indicated to update diagnosis to Schizophrenia. During interview on 7/16/26 at 12:23 p.m., the pharmacist stated they had interdisciplinary team (IDT) meetings on a regular basis to discuss residents on antipsychotics to discuss resident GDR. The IDT meetings included the medical director, director of nursing (DON), assistant director of nursing (ADON), nurse managers, nursing staff, and the administrator. The pharmacist further stated it was decided at one of those meetings (on 8/8/25) to add Schizophrenia to R11's diagnosis list. The pharmacist further stated the former medical director (MD)-A was the one who made that determination. During interview on 7/16/26 at 1:17 p.m., the director of nursing (DON) stated she didn't know the basis for R16's Schizophrenia diagnosis and didn't remember having a conversation about it. During interview on 7/16/26 at 1:50 p.m., MD-A verified they were the medical director for the facility at the time R11's diagnoses of Schizophrenia was added to her medical record (on 10/6/25). MD-A further stated they were not aware the diagnosis had been added and they never gave the okay to add it. The reason R11 was being prescribed Zyprexa (Olanzapine) was for vascular dementia stating R11 does not have Schizophrenia. A facility policy regarding psychotropic medications was requested and received but did not address the indications for use.		

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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 report an allegation of physical abuse to the state agency (SA) for 1 of 1 residents (R1) reviewed for abuse. Findings Include R1's admission Minimum Data Set, dated [DATE], indicated R1 was cognitively intact. Diagnoses included heart failure, post-traumatic stress disorder (PTSD), depression, and anxiety disorder. R1's care plan dated 4/20/26, indicated R1 was a vulnerable adult and interventions included investigating any suspicions of abuse and report as necessary. R1's care plan dated 5/14/26, also indicated R1 had a history of experienced trauma and PTSD. R1's Trauma Informed Care Screening dated 6/6/26, indicated R1 had a history or experienced trauma with a goal to feel secure in the environment. In email correspondence received 7/15/26 at 1:04 p.m. family member (FM)-C indicated R1 had complained about abuse from staff on two different occasions. The first one involved a staff member shaking R1. The second incident involved a staff member physically threatened R1 by raising a fist to R1 as if the staff member was going to hit R1. FM-C indicated the director of nursing and registered nurse (RN)-B had been notified of the abuse concerns by email shortly after the occurrences. In email correspondence received 7/15/26 at 4:10 p.m., FM-C forwarded the email that was sent to the DON on 6/30/26 at 3:12 British standard time (BST). In the email FM-C reported a formal complaint of abuse against R1. A staff member who worked on the transitional care unit raised their arm and hand at R1 and threatened to hit R1. FM-C indicated R1 had been afraid of the staff member after that occurrence. In email correspondence received 7/15/26 at 4:24 p.m., FM-C forwarded the email that was sent to the RN-B on 6/26/26 at 12:54 a.m., BST. The email indicated FM-C reported to the RN-B on Wednesday night R1 reported to FM-C a nurse aide had physically shook R1. During an interview on 7/16/26 at 9:33 a.m., RN-B stated FM-C had sent an email to her that reported a concern of abuse between a staff member that had allegedly shook R1. As soon as the email was read, the email was forwarded to the DON and confirmed the DON had received the forwarded email. RN-B stated she was not sure how much investigating had been done or if a report was filed with the SA because the DON and/or administrator took care of those steps. During an interview on 7/16/26 at 10:53 a.m., the DON stated she had received a copy of both emails sent by FM-C and both emails had concerns of abuse. R1 was talked with and there were no concerns of abuse, so they were not reported to the SA. Facility policy Abuse, Neglect and Exploitation dated 25, indicated an alleged violation related to abuse or serious bodily injury would be reported to the SA immediately, but no later than 2 hours after the allegation is made.		

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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 an allegation of abuse for 1 of 1 residents (R1) reviewed for physical and mental abuse. Findings Include R1's admission Minimum Data Set, dated [DATE], indicated R1 was cognitively intact. Diagnoses included heart failure, post-traumatic stress disorder (PTSD), depression, and anxiety disorder. R1's care plan dated 4/20/26, indicated R1 was a vulnerable adult and interventions included investigating any suspicions of abuse and report as necessary. R1's care plan dated 5/14/26, also indicated R1 had a history of experienced trauma and PTSD. R1's Trauma Informed Care Screening dated 6/6/26, indicated R1 had a history or experienced trauma with a goal to feel secure in the environment. In email correspondence received 7/15/26 at 1:04 p.m. family member (FM)-C indicated R1 had complained about abuse from staff on two different occasions. The first one involved a staff member shaking R1. The second incident involved a staff member physically threatened R1 by raising a fist to R1 as if the staff member was going to hit R1. FM-C indicated the director of nursing and registered nurse (RN)-B had been notified of the abuse concerns by email shortly after the occurrences. In email correspondence received 7/15/26 at 4:10 p.m., FM-C forwarded the email that was sent to the DON on 6/30/26 at 3:12 British standard time (BST). In the email FM-C reported a formal complaint of abuse against R1. A staff member who worked on the transitional care unit raised their arm and hand at R1 and threatened to hit R1. FM-C indicated R1 had been afraid of the staff member after that occurrence. In email correspondence received 7/15/26 at 4:24 p.m., FM-C forwarded the email that was sent to the RN-B on 6/26/26 at 12:54 a.m., BST. The email indicated FM-C reported to the RN-B on Wednesday night R1 reported to FM-C a nurse aide had physically shook R1. During an interview on 7/16/26 at 9:33 a.m., RN-B stated FM-C had sent an email to her that reported a concern of abuse between a staff member that had allegedly shook R1. As soon as the email was read, the email was forwarded to the DON and confirmed the DON had received the forwarded email. RN-B stated she was not sure how much investigating had been done or if a report was filed with the SA because the DON and/or administrator took care of those steps. During an interview on 7/16/26 at 10:53 a.m., the DON stated she had received a copy of both emails sent by FM-C and both emails had concerns of abuse. R1 was talked with during the first allegation of abuse. R1 and the alleged perpetrator were talked with related to the accusation. Nobody in the facility talked with anybody else, staff or resident, related to the concerns and accusations made about the staff member. The staff member was removed from R1's care but was allowed to provide care for all the other residents in the facility. Facility policy Abuse, Neglect and Exploitation dated 25, indicated the facility would make efforts to ensure all residents were protected from physical and psychosocial harm, as well as additional abuse, during and after the investigation.		

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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 interview and document review, the facility failed to ensure written bed hold/transfer notices were give upon transfer to the hospital for 2 of 2 residents (R32, R9) reviewed for hospitalization. Findings include: R32 R32's admission Minimum Data Set (MDS) dated [DATE], indicated R32 was cognitively intact, had diagnoses of anemia, irregular heartbeat, high blood pressure, liver disease, kidney failure, and diabetes. R32 was non-ambulatory, used a wheelchair, and was dependent on staff for toileting, transfers, and showering. R32's profile reviewed 7/16/26, indicated R32 was her own responsible party and did not have a guardian or power of attorney (POA). R32's progress note dated 6/30/26 at 12:04 p.m., indicated R32 was sent to the hospital for altered mental status at 10:50 a.m. and R32's emergency contact was informed. R32's progress note dated 6/30/26 at 2:48 p.m., indicated bed hold was given via telephone to resident representative/POA. The note included Bed Hold determination by resident and/or resident representative/POA is Yes, I want my bed held and agree to pay privately. R32's Transfer, Discharge, Bed Hold Notification -V3 dated 6/30/26, indicated R32's emergency contact person was reached via phone and chose to hold the bed and pay privately. A field labeled A written copy of the bed hold was provided (explain if faxed, mailed, in person, etc.) was blank. R32's progress note 7/1/26 at 8:00 p.m., indicated R32 was admitted with right internal carotid artery (ICA) narrowing. R32's Interagency Transfer Form & Physician Orders signed by the provider on 7/4/26 at 10:28 a.m., indicated R32 was being discharged from the hospital. R32's progress notes lacked indication R32 transferred back to the facility. R32's progress note dated 7/4/26 at 4:19 p.m., indicated R32 had a nosebleed at 2:50 p.m. which could not be controlled. Provider was called and R32 was sent to the hospital at 3:53 p.m. for evaluation and treatment. The note indicated R32's friend was updated. Bed hold information was identified in the note. R32's progress note dated 7/7/26 at 2:43 p.m., indicated R32 was sent to hospital for evaluation of continued vaginal bleeding, lethargy, and weakness. (continued on next page)		

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R32's medical record lacked evidence that a bed hold and/or transfer notice was given to R32 for hospital transfers on 7/4/26 and 7/7/26. During interview on 7/13/26 at 3:11 p.m., R32 stated she had to go to the hospital twice recently, back-to-back, for bleeding. She did not recall receiving information regarding bed hold. R9 R9's admission MDS dated [DATE], identified R9 was cognitively intact. R9's diagnoses included diabetes, neurogenic bladder (condition affecting the nerves between bladder and brain causing under or over-active bladder), and kidney disease. R9's census list printed 7/16/26, indicated R9 transferred out of the facility to the hospital on 7/11/26. R9's electronic medical record (EMR) lacked evidence of a bed hold. R9's progress noted dated 7/11/26 at 11:19 a.m., indicated (R9) complained of lower abdominal pain and thought she could be passing a kidney stone. The on-call provider was notified and order given to send (R9) to the hospital. R9's progress notes 7/11/26 through 7/16/26, lacked evidence of discussion or written notice provided regarding bed hold. During interview on 7/16/26 at 11:49 a.m., R9 stated she went to the hospital with symptoms of kidney stones and that it was not under emergent conditions. R9 remembered having a conversation regarding a bed hold but was not provided anything in writing. During interview on 7/16/26 at 10:27 p.m., licensed practical nurse (LPN)-A stated when she sent a resident to the hospital, she contacted the provider, prepared paperwork including a face sheet, medication list, and code status forms. Depending on the resident's level of orientation, she contacted the family listed in the medical record. LPN-A indicated for each transfer to the hospital, she verbally explained what a bed hold was and completed a transfer/bed hold assessment form on the computer, however, they did not usually print one out to give to the resident or family. During interview on 7/16/2026 at 10:54 a.m., social services designee (SSD)-A stated when a resident was sent to the hospital the nurse was responsible for completing the bed hold assessment in the computer, however, did not think it was needed if the resident was not gone overnight. She stated if it was not completed, she would address it the next day. When asked how the resident and/or family would receive the information regarding their bed hold rights, she stated she would print it out and they could receive it when they returned. She indicated it was important for residents to know they have a right to come back to the same room and indicated they could have it as long as they wanted it and could cancel any time. During interview on 7/16/26 at 10:59 a.m., registered nurse (RN)-B who was also the nurse manager (continued on next page)		

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stated the facility bed hold process changed a few months prior. She stated nursing used to complete a paper bed hold/transfer notice form and staff would try to get a signature from the resident before they left for the hospital and give a copy to the resident. RN-B stated social services recently took ownership of the process, and now the resident or POA would be called and the assessment form would be completed afterward. Regarding R32, RN-B indicated she called her emergency contact to ask him if he wanted to hold the bed, although she was unsure if he could make decisions regarding her care since she was her own responsible party. During interview on 7/16/2026 at 1:05 p.m., director of nursing (DON) stated she expected staff to get a bed hold upon transfer of the resident, or as soon as possible if the resident needed to be sent to the hospital urgently. She indicated there was a form in the electronic record to fill out and it should be printed and given to the resident so they have the information. The facility Bedhold Notice Policy dated 7/21/25, indicated: 1. As part of the admission packet and at the time of a transfer to the hospital or therapeutic leave, the facility will provide the resident and/or the resident representative written information that specifies: The duration of the State bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; The reserve bed payment policy in the state plan policy, if any. The facility policies regarding bed-hold periods include allowing a resident to return to the next available bed. Conditions upon which the resident would return to the facility: The resident requires the services which the facility provides; The resident is eligible for Medicare skilled nursing facility services or Medicaid nursing facility services. In the event of an emergency transfer of a resident, the facility will provide written notice of the facility's bed-hold policies to the resident and/or the resident representative within 24 hours. The facility will document multiple attempts to reach the resident's representative in cases where the facility was unable to notify the representative. The facility will keep a signed and dated copy of the bed-hold notice information given to the resident and/or resident representative in the resident's file and/or medical record.		

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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 document review the facility failed to ensure pressure ulcer interventions were implemented for 1 of 1 resident (R16) reviewed for pressure ulcers. R16's quarterly Minimum Data Set (MDS) dated [DATE], indicated severely impaired cognition and diagnoses of chronic kidney disease, congestive heart failure (CHF), and diabetes. It further indicated R16 was dependent on staff for most activities of daily living (ADL) and mobility, was at risk for and had (1) unstageable facility acquired pressure ulcer and moisture associated skin damage (MASD). R16's physicians orders dated 6/10/26, indicated R16 required pressure reducing boots on at all times, every shift for deep tissue injury (DTI) to left heel. R16's care plan dated 6/8/26, indicated R16 had potential/actual impairment to skin integrity related to MASD, current lower extremity venous wound, unstageable pressure injury (blood blister) on toe, and a history of removing dressing despite education not to do so. R16's care plan indicated the following interventions: -Attempt to reposition off area and/or not position on area when possible -Educate, cue and assist with repositioning -Elevate lower extremities if resident is wanting to be up in her wheelchair without rest periods with repositioning. -Encourage good nutrition and hydration to promote healthier skin-Float/off load heels -Keep linens dry, wrinkle free-Keep skin clean and dry. Apply lotion to dry skin during cares. Do not apply lotion between toes or to open areas or rashes. -Mattress replacement system: Air mattress -Observe skin during cares. Report any changes to nurse -Observe/document location, size and treatment of skin injury. Report abnormalities, failure to heal, signs/symptoms of infection, maceration, etc. to medical practitioner-Position body with pillows/supportive devices, protect bony prominences -Pressure relieving support surfaces in bed and chair: Standard reduction necessary to reduce pressure and to improve comfort level in relation to positioning/repositioning in bed and chair.-Reposition/position changes every 2-3 hours -See skin/wound tab for current skin measurements and interventions-Treatment as ordered. Notify medical practitioner if skin alteration worsening, shows signs of infection or no improvement x 14 days-Treatment to venous ulcer on LLE as ordered-Weekly skin inspection and prnR16's care plan lacked documentation of a DTI to her left heel or the intervention to wear pressure reducing boots at all times. R16's treatment administration record (TAR) dated 7/2026, indicated the nurse documented R16 was wearing her pressure reducing boots. No refusals were documented. R16's nursing progress note dated 6/10/26 indicated a new area of skin impairment noted to left heel when resident complained of pain in that area during weekly wound rounds. The wound nurse was present and gave a diagnosis of DTI with orders for skin prep twice a day and to wear pressure reducing boots at all times. During observation on 7/14/26 at 2:25 p.m., R16 was sitting in her wheelchair in her room. She was not wearing pressure reducing boots. R16's pressure reducing boots were sitting at the end of her bed. During interview on 7/14/26 at 2:53 p.m., registered nurse (RN)-A verified R16 wasn't wearing her heel protectors but should be at all times. If R16 refused to wear them, it should be documented. During observation on 7/16/26 at 7:53 a.m., R16 was in bed sleeping without the pressure reducing boots in place. R16's pressure reducing boots were on a card table in front of the window. During interview on 7/16/26 at 7:48 a.m., licensed practical nurse (LPN)-B stated nursing assistants (NA) were primarily responsible for putting on resident's pressure reducing boots and the nurses were responsible for charting it. LPN-B further stated the NAs should report resident refusals to the nurse, and it should be documented. During interview on 7/16/26 at 1:17 p.m., the director of nursing (DON) stated she expected nursing staff to be following doctor's orders for pressure reducing boots and if a resident refused care, they should be documenting (continued on next page)		

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	refusals. A facility policy regarding pressure ulcer prevention dated April of 2026, directed staff to prevent the formation of avoidable pressure injuries and to promote the healing of existing pressure injuries, it is the policy of this facility to implement evidence-based interventions for all residents who are assessed at risk or who have a pressure injury present.		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review the facility failed to ensure perimeter mattress were assessed for safety for 2 of 2 residents (R11, R16) reviewed for falls. Findings include: R11's annual Minimum Data Set (MDS) dated [DATE], indicated severely impaired cognition and diagnoses of dementia, muscle weakness, and failure to thrive. It further indicated R11 was dependent on staff for all activities of daily living (ADL) and mobility. R11's physician's orders lacked orders for a perimeter mattress. R11's care plan dated 6/10/26, indicated R11 was at risk for falls related to poor safety judgment, non-ambulatory at this time, overestimates own abilities, was not aware of her own limitations, and had a history of a fall with left hip fracture. It further indicated the following interventions:-Bed adjusted to appropriate height -Call light and personal belongings within reach -Contour/defined perimeter mattress. -Coordinate with appropriate staff to ensure a safe environment: floors even and free from spills or clutter, adequate, glare-free light, call light, bed at appropriate height, grab bar/U-bar as ordered, handrails on walls, personal items within reach.-Get up into chair as soon as she is dressed in the morning.-Gripper stockings or shoes at all times -Place in commons area for observation when unsteady/unsafe or involve in structured activity of her choice-Removed foot pedals from wheelchair to prevent from tripping over if she attempts to stand. R11's progress notes indicated the following:- On 6/13/2026, R11's roommate went to the nurse's station to report that R11 was on the floor. R11 was on the floor, on her back, next to her bed.-On 6/15/2026, interdisciplinary team (IDT) met to review R11's fall. Incident was from bed and a perimeter mattress had been placed for edge of bed awareness. R11's medical record lacked evidence a physical device safety assessment was completed when R11 had a perimeter mattress placed. During observation on 7/13/26 at 3:51 p.m., R11 was in bed sleeping. R11's bed had a perimeter mattress in place. During observation on 7/14/2026 at 1:42 p.m., R11 was in bed sleeping. R11's bed had a perimeter mattress in place. R16's quarterly MDS dated [DATE], indicated severely impaired cognition and diagnoses of chronic kidney disease, congestive heart failure (CHF), and diabetes. It further indicated R16 was dependent on staff for most ADL's and mobility. R16's physician's orders lacked an order for a perimeter mattress. R16's care plan dated 6/8/26, indicated R16 was at risk for falls and included the following interventions:-Bed adjusted to appropriate height -Call light and personal belongings within reach-Gripper stockings or shoes at all times -Monitor for mattress overlays and remove as needed (PRN).-Offer to get up for the day before 10:00 am per preference. -Provide reacher in room if requesting it -Touch pad call light R16's care plan lacked indication R16 required a perimeter mattress. R16's physical device assessment dated [DATE], lacked documentation of an assessment for a perimeter mattress. During observation on 7/15/26 at 8:15 a.m., R16 was in bed, awake, and had a perimeter mattress. During interview on 7/16/26 at 9:08 a.m. registered nurse (RN)-A verified R11 and R16 had perimeter mattresses but didn't know who was responsible for assessing them. RN-A also verified R11 and R16 did not have an assessment for a perimeter mattress. During interview on 7/16/26 at 7:48 a.m., licensed practical nurse (LPN)-B stated residents who have a perimeter mattress need to be assessed for safety and therapy was responsible for assessing them. During interview on 7/16/26 at 8:13 a.m., RN-E stated residents who have a perimeter mattress need to be assessed for safety and the nurses were responsible for assessing them. During interview on 7/16/26 at 1:17 p.m., the director of nursing (DON) stated they talk about interventions such as perimeter mattresses at IDT meetings. Their goal was to make sure they aren't (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	inhibiting the residents from getting up. They only used the perimeter mattress as an intervention for awareness of the edge of the bed because the beds were so small. The DON further stated the residents were required to have an assessment in order to have a perimeter mattress, and the assessments didn't reflect that very well. There was not a spot to assess it (perimeter mattress), therefore there was no documentation that those residents were being assessed. A facility policy regarding physical device assessments was requested but not received.		

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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 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, quality laboratory services/tests to meet the needs of residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to ensure orders were carried out for a urinary analysis and urine culture (UA/UC) in a timely manner for 1 of 1 resident (R76) reviewed for urinary tract infection (UTI). Findings include: R76's quarterly Minimum Data Set (MDS) dated [DATE], indicated R76 had moderate cognitive impairment, was always incontinent of urine, and needed maximal assistance with toileting hygiene. Further, the MDS indicated R76 did not have a current or previous UTI within the last 30 days. R76's care plan dated 7/16/26, indicated R76 was incontinent of bladder, required assistance with toileting hygiene, and directed staff to monitor and report to the medical practitioner any signs and symptoms of UTI including urinary frequency, burning, foul smelling urine, cloudy urine, hematuria, fever, chills, and altered mental status. R76's progress note dated 7/12/16 at 10:13 p.m., indicated UA/UC one time only for 2 days, discontinue when done. Progress note indicated a straight catheterization was attempted and was able to get a little urine, but not enough. R76's treatment administration record (TAR) for the month of July 2026, identified a UA/UC order to straight catheterization one time for 2 days and discontinue when done. The TAR order directed staff to collect a sample on 7/12, 7/13, and 7/14. The TAR only included the failed attempt to obtain the urine sample on 7/12/26. Nothing was documented on 7/13/26 or 7/14/2026. R76's medical record lacked documentation of UA/UC laboratory results and/or updates to primary provider from 7/12/26 through 7/15/26. During observation and interview on 7/14/26 at 8:54 a.m., R76 was awake in bed but kept her eyes closed for most of the interview. R76 stated she was tired, didn't feel well and was not going to eat breakfast because after she drank cranberry juice and she felt nauseous. R76 stated the staff thought she had a UTI. During observation on 7/15/26 at 10:03 a.m., R76 was in bed, she didn't open her eyes or answer any questions. During interview on 7/15/26 at 11:43 a.m., registered nurse (RN)- C stated R76 was very weak, she refused breakfast and wanted to be left alone. RN-C verified a urine sample was not collected. RN-C stated when a nurse was unable to obtain a urine sample during their shift it was reported to the next shift, and so on. RN-C stated the provider needed to be updated if the nurses were unable to collect a sample. RN-C stated the previous nurse did not report anything about it. RN-C added he needed to update the provider and obtain new orders. RN-C added, I am concerned the sample was not collected. During interview on 7/16/26 at 11:43 a.m., nurse manager/registered nurse (RN)-D stated he was not aware of R76's orders for an UA/UC. RN-D stated two days ago he was informed R76 was not eating well. RN-D stated he expected the nurses to collect a sample according to the doctor's order. RN-D expected the nurses to report to next shifts, and he added the order is open until the sample was collected. RN-D verified R76's medical record lacked documentation why the sample was not collected. During interview on 7/16/26 at 2:10 p.m., director of nursing (DON) stated the provider needed to be updated if the staff was unable to obtain a sample. DON stated if R76 had an UTI, it needed to be treated without delay. A policy regarding following doctors' order was requested but not received.		