STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245252	A. Building B. Wing	04/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Thief River Care Center	2001 Eastwood Drive Thief River Falls, MN 56701

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to ensure medications were coded correctly on the Minimum Data Set (MDS) for 4 of 7 residents (R22, R62, R29, R46) reviewed for MDS discrepancies. Findings include: R22 R22's significant change MDS dated [DATE], identified R22 had a diagnosis of hyperlipidemia. The MDS identified R22 was taking an anticoagulant, antibiotic, diuretic, and hypoglycemic medications. R22's MDS did not identify they received an antiplatelet medication. R22's March 2026, Medication Administration Record (MAR), identified R22 was receiving the following medications: Aspirin (an antiplatelet medication) 81 mg one a day for hyperlipidemia (high cholesterol or triglycerides). R22 was not receiving an anticoagulant medication during this time, as identified on the MDS. R62 R62's quarterly MDS dated [DATE], identified R62 had a diagnosis of hyperlipidemia. The MDS identified R62 was taking an antipsychotic, antidepressant, anticoagulant, and diuretic medications. R62's MDS did not identify they received an antiplatelet medication. R62's December 2025, MAR, identified R62 was receiving Aspirin (an antiplatelet medication) 81 mg one a day for hyperlipidemia. R62 was not receiving an anticoagulant during this time, as identified on the MDS. R29 R29's quarterly Minimum Data Set (MDS) dated [DATE], identified R29 had a diagnoses of a lower extremity artery aneurysm, diabetes type II, depression, hypertension and anxiety. R29 used antipsychotic, antianxiety, antidepressant, anticoagulant, opioid, hypoglycemic, and anticonvulsant medications. R29's March 2026 MAR failed to identify R29 received an anticoagulant medication during the observation period. R29's Medication Review Report dated 4/1/26, identified R29 received aspirin (an antiplatelet medication) (aspirin is used to treat mild to moderate pain, inflammation, and fever, and is frequently (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245252	A. Building B. Wing	04/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Thief River Care Center	2001 Eastwood Drive Thief River Falls, MN 56701

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	used at low doses to prevent heart attacks and strokes) 81 milligrams (mg) by mouth every day for prophylactic. R29 did not have a history of taking an anticoagulant. R46 R46's quarterly Minimum Data Set (MDS) dated [DATE], identified R46 had diagnoses that included Alzheimer's disease and diabetes type II. R46 used antipsychotic, antidepressant, anticoagulant, diuretic, and hypoglycemic medications. R46's March 2026 MAR failed to identify R46 received an anticoagulant medication during the observation period. R46's Medication Review Report dated 4/1/16, identified Aspirin EC Tablet 325 mg by mouth every day for ischemic cardiomyopathy (an issue with damaged heart muscle that can't pump blood well). R46 did not have a history of taking an anticoagulant. During an interview on 4/1/26 at 2:53 p.m., registered nurse (RN)-A stated he was the facility's MDS coordinator. RN-A had always coded aspirin as an anticoagulant medication and had never been told differently. During an interview on 4/1/26 at 3:57 p.m., the director of nursing (DON) stated the resident MDS assessments should be coded accurately to ensure the MDS reflected the resident's care needs. The facility policy MDS 3.0 Assessment reviewed/amended 8/20/24, identified the facility would conduct comprehensive, accurate and standardized assessments known as Minimum Data Set (MDS) for each resident, as specified in the Centers for Medicare and Medicaid and the State of Minnesota Resident Assessment Instrument (RAI) Manual. The Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual dated October 2025, instructed to code all high-risk drug class medication according to their pharmacological classification, not how they were being used: N0415I1. Antiplatelet: Check if an antiplatelet medication (e.g., aspirin/extended release) was taken by the resident at any time during the 7-day observation period (or since admission/entry or reentry if less than 7 days).

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245252	A. Building B. Wing	04/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Thief River Care Center	2001 Eastwood Drive Thief River Falls, MN 56701

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 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 follow the care plan for check and change for 1 of 2 residents (R10) observed for activities of daily living (ADLs).Findings include:R10's annual Minimum Data Set (MDS) dated [DATE], identified R10 had severe cognitive impairment with a diagnosis that included cerebral palsy spastic quadriplegia (the most severe form of spastic cerebral palsy, resulting from brain injury before, during, or shortly after birth). R10 was dependent on staff for all care areas.R10's Urinary Incontinence and Indwelling Catheter Care Area assessment dated [DATE], identified R10 had an indwelling urinary catheter in place for chronic urinary retention secondary to cerebral palsy. R10's catheter remained patent with clear yellow urine noted. No signs of obstruction, leakage, or malfunction observed. R10's peri care provided by protocol. R10 had bowel incontinence and was checked every 2 hours and as needed.R10's care plan revised 3/20/25, identified R10 had an ADL self-care performance deficit r/t cerebral palsy (CP). The care plan directed staff to do the following: TOILET USE: R10 was not toileted due to spastic movements, and it was not safe r/t CP. R10 wore a brief medium size. R10 needed to be checked and changed when R10 was repositioned, and barrier cream was to be applied. R10 was incontinent of bowel related to CP. R10 required check and change with repositioning every 2 hours and as needed. Staff to assist with changing R10's brief and provide peri care after each incontinent episode R10 had.During a continuous observation on 4/1/26 between 7:33 a.m. to 10:06 a.m., R10 was sitting in her wheelchair in the common area. During this time, R10 attended breakfast in the dining room, attended large group activities and returned to the common area to watch television. Staff did not provide incontinence care for R10. At 4/1/26 9:58 a.m., nursing assistant (NA)-A pushed R10's wheelchair to R10's room and stated she was just waiting for NA-D to come with the full body mechanical lift to reposition R10. NA-A and NA-D transferred R10 into bed, however, R10's incontinence brief was clean and dry.During an interview on 4/1/26 at 10:15 a.m., NA-D stated she was only helping NA-A to reposition R10 and did not know the last time R10 had been toileted. During an interview on 4/1/26 at 10:48 a.m., NA-A stated she didn't have a care sheet and was not sure how often R10 needed to be toileted. NA-A went to the nurses' desk and picked up a resident care sheet and stated R10 required toileting every two hours. NA-A stated staff were expected to write down toileting times on the care sheets, but NA-A could not find her care sheet. NA-A replaced the care sheet on the stack at the nurse's desk. NA-A stated she did not know the last time R10 had been toileted that morning because R10 had a bath and the bath aide assisted R10. During an interview on 4/1/26 at 11:14 a.m., NA-F stated R10 was the first resident to have a bath that morning and was done at approximately 6:30 a.m.During an interview on 4/1/26 at 2:29 p.m., licensed practical nurse (LPN)-A stated R10 should be provided toileting every 2 hours to prevent skin breakdown as care planned.During an interview on 4/1/26 at 2:36 p.m., registered nurse (RN)-B stated staff were expected to follow the resident care plans. R10 should be toileted every two hours as care planned to prevent skin breakdown. R10 had no ability to move on her own at all and R10 was at risk for skin breakdown due to moisture and pressure. That's a huge concern. During an interview on 4/1/26 at 3:58 p.m., the director of nursing (DON) stated staff were expected to follow the resident care plan because the care plan reflected the resident's needs as well as the assessed needs to prevent complications. The facility policy Urinary Incontinence Program revised 4/16/15, identified each resident who is incontinent will be identified, assessed, and provided appropriate care and services to achieve or maintain their greatest level of continence. Each resident will receive the appropriate care and services to prevent incontinence related complications to the extent possible. An indwelling catheter will not be used unless there is valid medical justification for use, and if there is no indication for use, it will be discontinued as soon as clinically warranted.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245252	A. Building B. Wing	04/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Thief River Care Center	2001 Eastwood Drive Thief River Falls, MN 56701

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 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 turning and repositioning was timely for 1 of 1 resident (R10) reviewed who was at risk for the development of pressure ulcers.Findings include:R10's annual Minimum Data Set (MDS) dated [DATE], identified R10 had severe cognitive impairment and included a diagnosis of cerebral palsy spastic quadriplegia (the most severe form of spastic cerebral palsy, resulting from brain injury before, during, or shortly after birth). R10 was dependent on staff in all care areas.R10's Pressure Ulcer/Injury Care Area Assessment (CAA) dated 3/3/26, identified R10 was unable to reliably express needs or discomfort. Braden score indicated moderate risk for skin breakdown. R10's head of bed was typically elevated approximately 30 degrees for positioning and comfort. R10 required pressure-reducing devices for bed and chair and followed a turning/repositioning program. Foot deformity present. R10 had a history of recurrent redness under bilateral breasts and lateral trunk folds consistent with moisture/friction areas; No open areas noted at this time. Peripheral vascular disease/peripheral artery disease (poor circulation) symptoms, venous stasis signs, or neuropathy symptoms noted at this time. R10's skin remains intact. Ongoing monitoring and preventative interventions were in place to reduce risk of pressure injury and moisture associated skin disorder (MASD).R10's Comprehensive Skin Risk dated 2/24/26, identified R10 was at moderate risk for pressure ulcer/injury.R10's care plan revised 3/20/26, identified R10 had a potential/actual impairment to skin integrity related to fragile skin. Staff were directed that R10 was to be turned and repositioned every two hours to help prevent skin breakdown.During a continuous observation on 4/1/26 between 7:33 a.m. to 10:06 a.m., R10 attended breakfast in the dining room, attended large group activities and returned to the common area to watch television. Staff did not reposition R10. At 4/1/26 9:58 a.m., nursing assistant (NA)-A and NA-D assisted R10 to lie down in bed using the full body mechanical lift. R10 did not have any pressure ulcers.During an interview on 4/1/26 at 10:15 a.m., NA-D stated she was only helping NA-A to reposition R10 and did not know the last time R10 had been repositioned. During an interview on 4/1/26 at 10:48 a.m., NA-A stated she didn't have a care sheet and was not sure how often R10 needed to be repositioned. NA-A went to the nurses' desk and picked up a resident care sheet and stated R10 required repositioning every two hours. NA-A stated staff were expected to write down repositioning times on the care sheets, but NA-A could not find her care sheet. NA-A placed the care sheet on the stack at the nurse's desk. NA-A stated she did not know the last time R10 had been repositioned that morning because R10 had a bath and the bath aide assisted R10. During an interview on 4/1/26 at 11:14 a.m., NA-F stated R10 was the first resident to have a bath that morning and was done at approximately 6:30 a.m.During an interview on 4/1/26 at 2:29 p.m., licensed practical nurse (LPN)-A stated R10 should be provided repositioning every two hours to prevent skin breakdown as care planned.During an interview on 4/1/26 at 2:36 p.m., registered nurse (RN)-B stated staff were expected to follow the resident care plans. R10 should be repositioned every two hours to prevent skin breakdown as care planned. R10 had no ability to move on her own at all and R10 was at risk for skin breakdown due to moisture and pressure. That's a huge concern. During an interview on 4/1/26 at 3:58 p.m., the director of nursing (DON) stated staff were expected to follow the resident care plan because the care plan reflected the resident's needs as well as the assessed needs to prevent complications such as pressure ulcer/injury. A turning and repositioning policy was requested but not received.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245252	A. Building B. Wing	04/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Thief River Care Center	2001 Eastwood Drive Thief River Falls, MN 56701

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 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 interview and document review, the facility failed to ensure staff were comprehensively assessing falls and implementing appropriate interventions for 1 of 3 (R50) residents reviewed for falls.Findings include:R50's quarterly Minimum Data Set (MDS) dated [DATE], identified R50 was cognitively intact and was dependent on two staff for activities of daily living (ADL's) including toileting and transfers in/out of wheelchair and on/off the toilet. R50 was non-ambulatory and had contractures of both lower extremities. R50's diagnoses included cerebral palsy, epilepsy, schizophrenia and mild intellectual disability.R50's care plan dated 11/25/24, identified R50 was totally dependent on two staff and required a total mechanical lift (hoyer) for transfers to/from the bed/wheelchair/toilet. R50 was at risk for seizures related to epilepsy. Interventions included monitoring for seizure activity and staying with and ensuring the resident was safe during a seizure. R50 was at risk for falls related to impaired mobility and psychoactive medication use. Interventions included ensuring resident's call light was within.R50's fall risk assessment dated [DATE], identified R50 was alert and oriented, chairbound, incontinent of bowel and bladder, and was at risk for falls. The facility incident investigation report dated 7/18/25, identified R50 was being transferred from toilet to the wheelchair with the hoyer lift and staff were following the resident's care plan. The top strap on the hoyer sling on the right side came off and R50 was lowered to the floor with the hoyer. R50 reported she didn't know what happened and had not touched the strap. Immediate interventions included the hoyer strap was rehooked and R50 was lifted from the floor to her wheelchair. Staff were educated to ensure a double check was performed on all straps before lifting residents. R50 was educated on the importance of not touching the straps. The staff present at the time of incident identified the straps were hooked when R50 was lifted from the wheelchair to the toilet. The investigation failed to identify if the resident could be left unattended with the hoyer in the bathroom and if the straps were double checked prior to transferring R50 from the toilet to the wheelchair.R50's progress note dated 7/18/26 at 9:49 a.m., identified R50 had a fall in R50's bathroom on 7/18/25. the root cause analysis identified it appears that resident had been messing with hoyer straps. The interventions identified staff were educated to ensure they double check all straps before lifting the resident. R50 was educated on the importance of not touching the straps. R50 preferred staff to stand outside of bathroom and be left alone for privacy. During observation on 3/31/26 at 9:57 a.m., NA-A and NA-B were assisting R50 onto the toilet using the hoyer lift. The NA's left the sling attached to the hoyer. NA-A secured the hoyer brakes and both NA's left R50 unattended in the bathroom.During interview on 3/30/26 at 3:51 p.m., R50 stated she fell out of the hoyer lift previously, the staff came and helped. R50 was unable to provide further details of when or how the fall happened.During interview on 3/31/26 at 10:00 a.m., NA-A stated staff usually left R50 unattended in the bathroom with the hoyer brakes locked, the lift sheet under her and fastened to the hoyer lift.During interview on 3/31/26 at 10:10 a.m., NA-B stated after R50 was transferred onto the toilet with the hoyer, staff would leave the lift sheet under the resident with the straps fastened to the lift. The hoyer locked in place in front of the resident and exited the bathroom to provide privacy.During interview on 4/1/26 at 2:30 p.m., registered nurse (RN)-C stated it was a safety concern and staff were not to leave a resident unattended in the bathroom with the hoyer lift sheet under them and fastened to the lift. Residents could potentially fall from the toilet and injure themselves.During interview on 4/1/26 at 4:24 p.m., the director of nursing (DON) stated staff were instructed and shown proper use of the hoyer lift upon hire. The DON stated a resident should not be left unattended in the bathroom while seated on the toilet with the lift sheet under them and attached to the hoyer lift. It was a safety concern because the residents could potentially use the remote control and end up dangling or falling from the lift.The facilities Mechanical Lift policy reviewed 5/28/25, identified care center staff were to use appropriate techniques and (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245252	A. Building B. Wing	04/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Thief River Care Center	2001 Eastwood Drive Thief River Falls, MN 56701

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	processes when utilizing mechanical lift devices to lift and move residents, to protect the safety and well-being of staff and residents, to promote quality care, and to follow applicable laws regarding use of power-driven mechanical lifts.The Volaro Series 4 Lift operator's manual dated 3/2019, identified staff were to ensure all four loops from the sling were properly nested in the bottom of the hooks before lifting or transferring a patient or resident, as well as ensuring all four retainer springs were functioning correctly.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245252	A. Building B. Wing	04/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Thief River Care Center	2001 Eastwood Drive Thief River Falls, MN 56701

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 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review the facility failed to ensure staff maintained the proper positioning for gastrostomy tube care for 1 of 1 resident (R10) reviewed for tube feedings.Findings include: R10's annual Minimum Data Set (MDS) dated [DATE], identified R10 had severe cognitive impairment and included a diagnosis of cerebral palsy spastic quadriplegia (the most severe form of spastic cerebral palsy, resulting from brain injury before, during, or shortly after birth). R10 had an enteral feeding tube (delivers nutrition directly to the stomach or small intestine for individuals unable to take in adequate calories by mouth) and was dependent on staff for all care areas.R10's care plan revised 3/20/26, identified R10 had an ADL self-care performance deficit related to CP. Staff were directed to ensure R10's head of bed was elevated above 30 degrees when R10 was hooked up to her feeding. However, the care plan failed to identify to pause the feeding during turning and repositioning.R10's undated care sheet, directed staff that during transfers R10 needed nursing staff to stop R10's tube feeding before the transfer and restart it after transfer was complete. If nursing assistants were assisting with R10's transfer, they must notify a nurse to manage R10's feeding.During an observation on 4/1/26 at 9:58 a.m., nursing assistant (NA)-A and NA-D assisted R10 into bed using a fully body mechanical lift and performed turning and repositioning for R10. When R10 initially laid down, R10's head of bed was flat, and NA-A raised the bed to approximately 20 degrees. NA-A and NA-D rolled R10 left and right while R10's feeding continued running. A bright pink sign hung on the wall at the head of R10's bed stating Reminder: have nurses pause feeding when lying lower than 30 degrees during repositioning, transfers, or cares. Restart by nurse when above 30 degrees. At 10:05 a.m., NA-A raised R10's head of bed to 45 degrees.During an interview on 4/1/26 at 10:08 a.m., NA-A stated the nurses using came and took care of R10's feeding and stuff. However, neither NA-A or NA-D had asked the nurse to come and pause R10's feeding before laying R10 down. NA-A stated R10 was lying flat but NA-A had raised the head of the bed but could not say if it was greater than 30 degrees. NA-A then stated she did not know if the feeding needed to be paused if it was a split second thing. I'll have to get that clarified. During an interview on 4/1/26 at 10:15 a.m., NA-D stated she was only helping NA-A to lay R10 down and didn't think of the feeding at all. NA-D stated they should have asked the nurse to pause R10's feeding because R10 could have vomited. During an interview on 4/1/26 at 2:29 p.m., licensed practical nurse (LPN)-A stated whenever the aides were going to lie R10 down they were supposed to ask a nurse to come and pause the feeding, then when they're done, they're supposed to call the nurse to turn it back on. That is supposed to happen every time. During an interview on 4/1/26 at 2:36 p.m., registered nurse (RN)-B stated the nursing assistants were expected to ask nursing to pause R10's feeding before transfers and to restart once the transfers/cares were done. This was required every time to prevent complications such as vomiting and aspiration. During an interview on 4/1/26 at 3:58 p.m., the director of nursing (DON) stated R10 had been assessed for possible aspiration but lung sounds were clear and R10 had no signs or symptoms of distress. The DON stated staff were expected to follow R10's care plan and request to have R10's feeding paused prior to transfers because the care plan reflected the R10's needs as well as the assessed needs to prevent complications. The DON stated R10 had been assessed for possible aspiration but lung sounds were clear and R10 had no signs or symptoms of distress. The facility policy Enteral Feeding Tube Usage revised 4/1/19, identified the facility provided enteral feeding tube care and services. However, the policy failed to direct staff how to care for the feeding during turning and repositioning.Nursing Skills textbook ISBN-13: 9781734914122 (ebook) dated 2021, identified the head of the bed (HOB) should be elevated to a 30 to 45-degree angle (semi-Fowler's position) during enteral feeding and for at least 30-60 minutes afterward to prevent aspiration. This positioning is crucial for all patients receiving tube feeds to reduce the risk of formula entering the lungs.