STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245271	A. Building B. Wing	05/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Providence Place	3720 23rd Avenue South Minneapolis, MN 55407

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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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review, the facility failed to take appropriate steps to ensure raw meat items were stored and discarded in a timely manner to reduce the risk of cross contamination and potential food born illness in 1 of 1 walk- in refrigerators used in the main production kitchen. In addition, the facility failed to ensure frozen food items were stored in a clean area and in a manner to reduce the risk of cross contamination and potential foodborne illness in 1 of 1 walk-in freezers in the main production kitchen. This had the potential to affect all residents who consumed food from the kitchen. Furthermore, the facility failed to ensure the unit refrigerator on 1 of 6 units was kept clean to reduce the risk of cross contamination and potential food born illness. Findings include: On 5/11/26 at 10:26 a.m., an initial kitchen [NAME] was completed with dietary manager (MGR)-D. A single walk-in refrigerator was in use, opened and inspected. The unit contained metal shelving racks which had 4 shelves. On the second shelf from the bottom was a large metal tray that contained 6 undated and unlabeled packages of meat which appeared to be in the original packing. On the same tray was a package of raw meat wrapped in clear plastic dated 4/2/26 which had a brown colored liquid substance coming from the bottom of the clear plastic that was touching the undated/unlabeled sealed packages of meat. Upon inspection, MGD-D stated the raw meat in clear plastic dated 4/2/26 should be thrown away. MGR-D dated the 6 undated/unlabeled packages of meat, and indicated it was hamburger that had come in last week on delivery. The shelf above (second shelf down from the top) contained a chunk of turkey that was wrapped in a clear plastic sitting directly on the metal shelving rack. It had a sticker dated 4/16 and use by 4/21. MGR-D stated this was left over from when the turkey was cooked and was going to be sliced and served. MGR-D stated the date must be wrong and planned on using it. MGR-D stated that once a week, on Monday mornings, she went through the fridges to ensure there was no expired food in the fridges and stated she must have missed the items above. Continuing the initial kitchen tour, a single walk-in freezer was in use, opened and inspected. The unit contained metal shelving with a prepackaged wild brown rice and chicken soup. Upon inspection, the soup was noted to have visible ice on the top of the soup. MGR-D stated the facility would use the soup but since surveyor was asking about it, was going to throw it out. MGR-D stated air must have gotten into the prepackaged container. Another shelf contained an opened carboard box that had a plastic bag labeled personal belongings sitting on top. Inside the plastic bag was a gray plastic tub with 2 packages of brats. Neither the bag nor the packages of brats were labeled with a name. The cardboard box contained 4 bags of unopened egg noodles. The eggs noodles appeared to have ice buildup and frost inside the packaging. MGR-D stated the brats inside the personal belongings bag must be staff food that was put in the freezer. MGR-D stated staff was able to store food in the freezer as long as it was labeled and stated since the food wasn't labeled it shouldn't be in the freezer. MGR-D stated air must have gotten inside the egg noodle bags at some point and stated it appeared as though the egg noodles have frost on them. Under the shelves in the freezer appeared to have food build up. MGR-D stated the freezer should be cleaned daily which would include underneath the shelving units. During an observation and interview on (continued on next page)

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	5/11/26 at 5:14 p.m., nursing assistant (NA)-I stated the unit fridge was for resident food. During inspection of the unit fridge, an open, labeled and uncovered can of monster (energy drink) was noted. NA-I stated the can should be covered. There were two undated pitchers of juices on the bottom shelf of the fridge which NA-A stated were just put in the fridge for supper. NA-I stated it was kitchen staff's responsibility to clean the unit fridges. NA-I verified the drawers at the bottom of the fridge and the bottom of the fridge itself had a red colored liquid substance in them. During an interview on 5/14/26 at 1:22 p.m., MGR-D stated it was dietary staff's responsibility to inspect and clean the unit refrigerators daily on the floors. A facility policy titled Food Safety Requirements, dated 4/1/26, was provided. The document included the following: Food will also be stored, prepared, distributed and served in accordance with professional standards for food service safety, and storage of food in a manner that helps prevent deterioration or contamination of the food, including from growth of microorganisms. Additionally, Refrigerated storage - foods that require refrigeration shall be refrigerated immediately upon receipt or placed in freezer, whichever is applicable. Practices to maintain safe refrigerated storage include:Monitoring food temperatures and functioning of the refrigeration equipment daily and at routine intervals during all hours of operation;Placing hot food in containers (e.g., shallow pans) that permit the food to cool rapidly;Separating raw foods (e.g., beef, fish, lamb, pork, and poultry) from each other and storing raw meats on shelves below fruits, vegetables or other ready-to-eat foods so that meat juices do not drip onto these foods; Labeling, dating, and monitoring refrigerated food, including, but not limited to leftovers, so it is used by its use-by date, or frozen (where applicable)/discarded; andKeeping foods covered or in tight containers.

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F 0576 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure residents have reasonable access to and privacy in their use of communication methods. Based on interview and document review, the facility failed to ensure resident mail was delivered to residents on Saturdays for 4 of 4 residents (R65, R82, R51, R128) who voiced concerns with mail delivery during Resident Council. This had the potential to affect all residents residing in the facility.Findings include:On 5/13/26 at 10:59 a.m., a Resident Council meeting was held with four residents from varied areas of the facility. R82, and R51 stated mail was not delivered to residents on Saturdays. This was confirmed by R128, and R65. R65 indicated mail delivered by the post office on Saturdays was not delivered by any staff until Monday.During interview on 5/13/26 at 2:01 p.m., director of nursing (DON) stated the mail was sorted when it came into the building and should be delivered on the same day by facility staff. DON stated it was the responsibility of all staff to ensure residents received their mail and stated it was a resident right to have their mail delivered in a timely manner. DON stated her expectation was for mail to be delivered to residents on the same day it arrived at the facility. DON could not identify a specific staff member to oversee mail delivery.During interview on 5/13/26 at 2:37 p.m., Administrator (Admin) stated it was the responsibility of all staff working in the building to deliver mail to residents, including mail delivery on the weekends. Admin stated the facility received a high volume of resident mail throughout the week and it was his expectation mail would be delivered to the residents the same day it was delivered to the facility.A policy was requested but not provided.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident?s drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and document review, the facility failed to ensure non-pharmacological interventions were attempted and recorded prior to the administration of as-needed (PRN) narcotic/opioid and non-narcotic medication to help facilitate person-centered care planning and reduce the risk of complication (i.e., constipation, sedation) for 4 of 4 residents (R2, R15, R23, R155) reviewed for pain. In addition, the facility failed to ensure a scheduled antifungal medication was, as applicable, evaluated for the appropriateness of its continued use and stopped per the provider order for 1 of 5 residents (R118) reviewed for unnecessary medications. Findings include: R2 R2's admission Minimum Data Set (MDS) assessment dated [DATE], identified R2 had intact cognition without hallucinations or delusions present and no behaviors, or rejection of care. In addition, the MDS outlined R2 received both scheduled and PRN pain medications during the review and did receive any non-medication intervention for pain. Further, R2 indicated they had occasional pain which they rated at six (6) out of 10 (10 being the worst possible). R2's care plan, printed 5/13/26, identified R2 had chronic pain with need for medication management with a list goal of will voice/display level of comfort acceptable to the resident through the review date. The care plan listed interventions to help R2 meet this goal which included, opioid side effect monitoring: Monitor resident for any of the following: Tolerance level (is med still effective in managing pain?), is resident displaying signs of physical dependence that may cause symptoms of withdrawal when the med is stopped, held, or missed? Increased sensitivity to pain, constipation, nausea, vomiting, dry mouth, Sleepiness, dizziness, and/or confusion, depression, Itching and sweating. Document any positive indications or areas of concern and update MD, and Observe/document verbal and non-verbal s/sx of pain: Resident reports pain, Weight changes, protective behavior, guarding behavior, facial mask, irritability, self-focusing, restlessness, depression, Atrophy of involved muscle group, Changes in sleep pattern, Fatigue, Fear of re-injury, Reduced interaction with people, Altered ability to continue previous activities, Sympathetic mediated responses (e.g., temperature, cold, changes of body position, hypersensitivity), Anorexia. The care plan lacked evidence of identifying resident-specific non-pharmacological interventions that had been attempted, what interventions were effective, should be offered, or which interventions were ineffective for R2's pain management. On 5/11/26 at 2:42 p.m., R2 was observed seated in her wheelchair. R2 stated she had left shoulder pain for which she took Tylenol (acetaminophen). R2 stated staff did not offer any non-pharmacological interventions (i.e., ice, heat or massage) and stated it would be nice if they did as it would be helpful. R2's May Medication and Treatment Administration Record (MAR/TAR) for 5/1/26 to 5/13/26 was reviewed and identified the following relevant information: - acetaminophen 325 milligram (mg) tablet – give 3 tablets (975 mg) by mouth as needed 4 times a day for mild pain. Do Not Exceed 4,000 mg in 24 Hours with a start date of 2/17/26 which had (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	been administered twice. Both administrations were marked with U which indicated 'unknown' effectiveness. All administrations were documented with a pain scale. There was no documentation with administration of a nonpharmacological intervention being offered prior to administration. The MAR/TAR lacked any orders or documentation for nonpharmacological interventions offered or attempted prior to administration of PRN medication administrated for pain. R2's progress notes, dated 5/1/26 to 5/13/26, were reviewed. Progress notes lacked evidence of nonpharmacological interventions being offered or attempted prior to administration of PRN pain medication. R2's medical record was reviewed and lacked evidence of what, if any, non-pharmacological interventions were offered or attempted prior to the administration of the PRN pain medication all the administered doses from 5/1/26 to 5/13/26. R15 R15's quarterly Minimum Data Set (MDS) assessment dated [DATE], identified R15's short term or long-term memory were both marked as memory ok after staff assessment of mental status was completed. In addition, the MDS outlined R15 received both scheduled and non-medication interventions for pain during the review; however, did not receive any PRN pain medication. Further, R15 indicated they had frequent pain which they rated at 4 out of 10. R15's care plan, printed 5/13/26, identified R15 had actual/potential for acute and chronic pain with need for medication management related to fibromyalgia, PCV, osteoarthritis, gout, plantar fascial, fibromatosis, RLS with a list goal of will not have an interruption in normal activities due to pain through the review date. The care plan listed interventions to help R15 meet this goal which included, notify medical practitioner if interventions are unsuccessful or if current compliant is a significant change from past experience of pain, and provide analgesia as ordered, observe/document for side effects and effectiveness. Additionally, the care plan identified R15 had a terminal prognosis requiring hospice involvement/palliative care for cancer/end stage disease process with a list goal of comfort will be maintained through the review date. Listed interventions included: Observe closely for non-verbal indicators of pain. Administer analgesics as ordered. Monitor for side effects of medication and breakthrough pain. Notify medical practitioner if side effects of pain management pain ineffective, and offer comfort alternatives such as music of choice, aroma therapy, soft lighting, other. On 5/11/26 at 12:47 p.m., R15 was observed lying in bed and stated she couldn't talk due to being in so much pain. On 5/12/26 at 10:21 a.m., R15 was observed lying in bed moaning. R15's May Medication and Treatment Administration Record (MAR/TAR) for 5/1/26 to 5/13/26 was reviewed and identified the following relevant information: -oxycodone (opioid pain medication) 10 mg- give 10 mg by mouth every 4 hours as needed for pain and shortness of breath with a start date of 4/28/26 which had been administered 14 times. Three administrations were marked with an I which indicated ineffective and 5 with an U which indicated unknown per follow-up code guide. 6 administrations were documented with an e indicated effective. All administrations were documented with pain scale. There was no documentation with (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	administration of a nonpharmacological intervention being offered prior to administration. The MAR/TAR lacked any orders or documentation for nonpharmacological interventions offered or attempted prior to administration of PRN medication administrated for pain. R15's progress notes, dated 5/1/26 to 5/13/26, were reviewed. Progress notes lacked evidence of nonpharmacological interventions being offered or attempted prior to administration of PRN pain medication. R15's medical record was reviewed and lacked evidence of what, if any, non-pharmacological interventions were offered or attempted prior to the administration of the PRN pain medication all the administered doses from 5/1/26 to 5/13/26. On 5/11/26 at 12:52 p.m., trained medication aid (TMA)-A stated that R15 was in constant pain and was going to visit with R15. R23 R23's admission MDS assessment dated [DATE], identified R23 had intact cognition with no hallucinations, delusions, verbal or physical behaviors. In addition, the MDS outlined R23 received both scheduled and PRN pain medications during the review; however, did not receive any non-medication intervention for pain. Further, R23 indicated they had almost constant pain which they rated at 10 out of 10. R23's care plan, printed 5/13/26, identified R23 had actual chronic and acute pain with needs for medication management related to chronic lower extremity pain and acute pain due to wounds with a list goal of will voice/display a level of comfort acceptable to the resident through the review date. The care plan listed interventions to help R23 meet this goal which included: observe for potential side effects and report to medical practitioner; opioid side effect monitoring: tolerance level, physical dependence, increased sensitivity to pain, document any positive indications and update MD; Observe/document pain characteristics PRN: Quality (e.g., sharp, burning), Severity (1 to 10 scale), Anatomical location, Onset, Duration (e.g., continuous, intermittent), Aggravating factors, Relieving factors; observe/document verbal and non-verbal signs and symptoms of pain; notify medical practitioner if interventions are unsuccessful of if current complain is a significant change from past experience of pain; and provide analgesia as ordered. The care plan lacked evidence of identifying resident-specific non-pharmacological interventions that had been attempted, what interventions were effective, should be offered, or what interventions were ineffective for R23's pain management. On 5/11/26 at 3:17 p.m., R23 stated she has chronic pain which she felt had not been managed well by the facility as she stated they made changes to her pain medication without talking with her. R23 stated they had not offered any sort of non-pharmacological interventions to help manage her pain, which might be helpful at times. During an observation and interview on 5/11/26 at 5:25 p.m., R23 was in the dining room telling staff that she was in pain and stated staff weren't doing anything about it. R23's May Medication and Treatment Administration Record (MAR/TAR) for 5/1/26 to 5/12/26 was (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	reviewed and identified the following relevant information: -acetaminophen 500 mg tablet – give 1000 mg by mouth every 6 hours as needed for mild-moderate pain with max dose of 4000g in 24 hours with a start date of 4/11/26 and end date of 5/11/26 and restarted 5/11/26 which had been administered one time. The administration was marked with e indicating effective and was documented with a pain scale. There was no documentation with administration of a nonpharmacological intervention being offered prior to administration. -hydromorphone (opioid pain medication) 2 mg tablet – give 2 mg by mouth as needed for severe chronic pain as needed three times a day with a start date of 4/29/26 ending 5/11/26 which had been administered 18 times. Two administrations were marked with an I which indicated ineffective and four with an U which indicated unknown per follow-up code guide. The remaining 12 administrations were documented with an e indicated effective. All administrations were documented with pain scale. There was no documentation with administration of a nonpharmacological intervention being offered prior to administration. -hydromorphone 2 mg table – give 2 mg by mouth as needed for severe breakthrough pain max 3 times a day, at least 4 hours between doses, consider giving a doze 30-40 minutes prior to dressing change. Hold for RR (respiration rate) less than 10, sedation, confusion with a start date of 5/11/26 which had been administered 4 times. All administrations had a pain scale. There was no documentation with administration of a nonpharmacological intervention being offered prior to administration. The MAR/TAR lacked orders or documentation for nonpharmacological interventions offered or attempted prior to administration of PRN medication administrated for pain. R23's progress notes, dated 5/1/26 to 5/12/26, were reviewed. Progress notes lacked evidence of nonpharmacological interventions being offered or attempted prior to administration of PRN pain medication. R23's medical record was reviewed and lacked evidence of what, if any, non-pharmacological interventions were offered or attempted prior to the administration of the PRN pain medication all the administered doses from 5/1/26 to 5/12/26. R155 R155's quarterly Minimum Data Set (MDS) assessment dated [DATE], identified R155 had moderately impaired cognition, no hallucinations, delusions, behaviors or rejection of care. In addition, the MDS outlined R155 received both scheduled pain medications during the review; however, did not receive any PRN pain medication or non-medication interventions for pain. R155's care plan, printed 5/13/26, identified R155 had actual chronic pain with need for medication management with a list goal of will voice/display a level of comfort acceptable to the resident through the review date. The care plan listed interventions to help R155 meet this goal which included, Offer non-pharmacological interventions for pain relief such as music, repositioning, massage, integrative therapies and observe for effectiveness, and provide analgesia as ordered. Observe/document for side effects and effectiveness. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 5/11/26 at 12:30 p.m., R155 was observed laying in bed. R155 stated it was not a good day but did not elaborate. R155 was observed attempting to feed himself lunch. R155's May Medication and Treatment Administration Record (MAR/TAR) for 5/1/26 to 5/14/26 was reviewed and identified the following relevant information: -hydromorphone 2 mg tablet – give 2 mg by mouth every 4 hours as needed for pain with a start date of 11/26/25 which had been administered 2 times. Both administrations were marked with an e indicating effective. Both administrations were documented with a pain scale. There was no documentation with administration of a nonpharmacological intervention being offered prior to administration. The MAR/TAR lacked any orders or documentation for nonpharmacological interventions offered or attempted prior to administration of PRN medication administrated for pain. R155's progress notes, dated 5/1/26 to 5/14/26, were reviewed. Progress notes lacked evidence of nonpharmacological interventions being offered or attempted prior to administration of PRN pain medication. R155's medical record was reviewed and lacked evidence of what, if any, non-pharmacological interventions were offered or attempted prior to the administration of the PRN narcotic medication all the administered doses from 5/1/26 to 5/14/26. On 5/13/26 at 9:57 a.m., nursing assistant (NA)-H stated if a resident complained of pain, they notified the nurse or TMA (trained medication aid) right away. NA-H stated they did not offer any interventions. On 5/13/26 at 12:03 p.m., trained medication aid (TMA)-A stated if a resident reported pain, they notified the nurse and administered a PRN medication. TMA-A stated if a resident asked for an ice pack or other nonpharmacological interventions then they would provide it but did not offer them unless requested. On 5/13/26 at 12:21 p.m., licensed practical nurse (LPN)-B stated they should be offering and documenting non-pharmacological interventions prior to administering PRN pain medications. LPN-B stated if any non-pharmacological interventions were offered, they would be in the progress notes. On 5/14/26 at 10:07 a.m., assistant director of nursing (ADON)-A stated the expectation was that non-pharmacological interventions would be offered prior to any PRN medication administration and documented in the progress notes as the medication notes are linked to the progress notes. ADON-A stated it was important to offer non-pharmacological interventions prior to PRN administration as want to reduce medications whenever able. On 5/14/26 at 11:37 a.m., ADON-A stated she had reviewed R2, R15, R23 and R155's electronic medication records and paper records. ADON-A verified the PRN administered above for R2, R15, R23 and R155 and verified there were no documented non-pharmacological interventions offered with PRN pain medication administrations. On 5/14/26 at 12:56 p.m., director of nursing (DON) stated it would be on a case-by-case basis whether a resident would be offered non-pharmacological interventions prior to PRN pain medications (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	as it was a resident's choice. DON stated (R2), (R23) and (R155) don't like non-pharmacological interventions and (R15) was on hospice. DON stated she would follow up. No additional information was provided. A facility policy titled PRN medications, dated 4/1/26, was provided. The policy does not specifically address non-pharmacological interventions and PRN pain medications. R118 R118's quarterly Minimum Data Set (MDS) dated [DATE], indicated R118 had intact cognition and was diagnosed with respiratory failure and debility. The MDS indicated R118 was independent with most activities of daily living (ADLs). R118's Physician's order form dated 3/9/26, indicated R118 was to use Nystatin powder to the groin daily for a duration of 14 days. R118's order summary dated 3/10/26, included an order dated 3/10/26 for Nystatin Powder applied topically to the groin in the morning and did not include an end date. R118's medication administration record (MAR) dated 5/1/26 to 5/12/26, indicated the Nystatin powder to the groin was administered every day during the period. R8's progress note dated: -4/24/26 to 5/8/26 were reviewed and did not indicate R118 had skin alteration to her groin. -4/24/26 at 1:48 p.m., indicated no skin issues were identified. -5/1/26 at 2:05 p.m., indicated no skin issues were identified. -5/8/26 at 1:31 p.m., indicated no skin issues were identified. -5/8/26 at 3:59 p.m., indicated no skin issues were identified. R118's pharmacist review dated 3/30/26, indicated R118 had an order for nystatin powder to the groin in the morning for redness. The review indicated antifungals should be discontinued when healing was complete, as prolonged, unnecessary use can cause drug-resistant fungal infections. The review indicated Candida [yeast] rashes typically take one to two weeks to resolve with treatment, so the pharmacist recommended the nystatin powder be discontinued. During an interview on 5/13/26 at 10:18 a.m., R118 stated she used the nystatin powder in her groin every day. R118 stated she did not currently have any redness or open areas in her groin. During an interview on 5/13/26 at 10:20 a.m., registered nurse (RN)-H stated R118 did not have any skin alterations at this time. RN-H stated at one point, R118 did have redness in her groin but was unsure when this resolved. During an interview on 5/14/26 at 2:26 p.m. with the director of nursing (DON) and assistant director of nursing (ADON)-B, the DON stated it depended on how the order was written when the nystatin (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based interview and record review, the facility failed to ensure accurate and complete clinical records for 3 of 5 residents reviewed for immunizations (R7, R59, and R130) by incorrectly documenting COVID-19 vaccinations as influenza vaccinations in the electronic medical record (EMR). This had the potential to result in inaccurate medical records, confusion regarding residents' immunization status, inappropriate clinical decision-making, and the transmission of inaccurate health information during transfers, hospitalizations, or discharge to another provider. Findings include: R7R7's quarterly Minimum Data Set (MDS) assessment, dated 2/10/26, indicated R7 was admitted to the facility on [DATE].R7's immunization record revealed an influenza vaccination was documented as administered on 9/26/25. The immunization record further revealed a second influenza vaccination was documented as administered on 4/15/26, during the same influenza season.R59R59's quarterly MDS assessment, dated 4/17/26, indicated R59 was admitted to the facility on [DATE].R59's immunization record revealed an influenza vaccination was documented as administered on 9/26/25. The immunization record further revealed a second influenza vaccination was documented as administered on 4/15/26, during the same influenza season.R130R130's quarterly MDS assessment, dated 2/24/26, indicated R130 was admitted to the facility on [DATE].R130's immunization record revealed an influenza vaccination was documented as administered on 9/26/25. The immunization record further revealed a second influenza vaccination was documented as administered on 4/15/26, during the same influenza season.During an interview on 5/14/26 at approximately 11:15 a.m., the Director of Nursing (DON), who also served as the facility's Infection Preventionist (IP), stated the influenza vaccinations documented in the EMR were entered incorrectly. The DON stated the vaccination clinic conducted in April 2026 was a COVID-19 vaccination clinic and not an influenza vaccination clinic.During a follow-up interview on 5/14/26 at 2:56 p.m., the DON stated staff would use the Minnesota Immunization Information Connection (MIIC) to verify which vaccine a resident actually received. The DON acknowledged it was best practice for residents' medical records to be accurate. A facility policy regarding accurate medical records was requested, however the facility was unable to provide a policy that addressed the requirement for maintaining accurate and complete medical records.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to ensure the need for enhanced barrier precautions (EBP) was identified and implemented for 4 of 4 residents reviewed for transmission-based precautions, three of whom (R2, R10, R135) received dialysis via dialysis access sites located on the right upper chest (a central venous catheter (CVC)), and one (R60) who had an open wound. The facility further failed to implement infection prevention and control practices related to oxygen equipment storage, handling, and use for 1 of 1 resident (R51) reviewed for oxygen therapy by failing to ensure oxygen tubing and nasal cannula equipment remained off the floor and failed to prevent potentially contaminated oxygen equipment from being reapplied to the resident without cleaning or replacement. Findings include: R2 R2's admission Minimum Data Set (MDS) assessment dated [DATE], identified R2 had intact cognition without hallucinations or delusions present with no behaviors, or rejection of care present. In addition, the MDS outline R2 received dialysis while a resident at the facility. During an interview and observation on 5/11/26 at 2:51 p.m., R2 stated she received dialysis via a port on her right upper chest. R2 stated staff did not wear gowns when they assisted her. There was no EBP sign on R2 door, plastic bin outside the door containing proper personal professional equipment (PPE) or bin for disposal of PPE by R2's door During a follow up observation on 5/13/26 at 8:24 a.m., there continued to be no EBP signage on R2's door. R2's care plan, printed 5/13/26, identified R2 required dialysis with potential for CVC malfunction related to renal failure. The care plan lacked identification of need for enhanced barrier precautions. R2's Treatment Details Report, dated 5/1/26, identified R2 had a tunneled Central Venous Catheter (CVC) on her right chest for dialysis access site which was used. R10 R10's significant change in status MDS assessment dated [DATE], identified R10 had severe cognitive impairment with physical behavioral symptoms presenting 1 to 3 days during the look back period, verbal behaviors, and other behavioral symptoms not directed towards others occurring daily which significantly interfere with resident's care. In addition, the MDS outlined R10 received dialysis while a resident at the facility. During an observation on 5/11/26 at 5:38 p.m., there was no EBP signage on R10's door. Furthermore, there was no bin containing PPE outside R10's room or bin for disposal for PPE by R10's door. During a follow up observation on 5/13/26 at 8:25 a.m., there continued to be no EBP signage on R10's door. R10's care plan, printed 5/13/26, identified R10 required dialysis with potential for fistula/graft malfunction related to end stage renal failure. The care plan lacked evidence of the need for enhanced (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	barrier precautions. R10's Treatment Details Report, dated 5/1/26, identified R10 had a tunneled Central Venous Catheter (CVC) on her right chest for dialysis access site which was used. R135 R135's admission MDS assessment dated [DATE], identified R135 had intact cognition without delusions and no behaviors, or rejection of care present. In addition, the MDS outline R135 received dialysis while a resident at the facility. R135's care plan, printed 5/13/26, identified R135 required dialysis with potential for CVC malfunction related to renal failure. The care plan lacked identification of need for enhanced barrier precautions. R135's Treatment Details Report, dated 5/1/26, identified R135 had a tunneled Central Venous Catheter (CVC) on his left chest for dialysis access site which was used. During an interview and observation on 5/11/26 at 12:22 p.m., R135 stated he received dialysis through a dialysis port on his right upper chest. R135 stated staff did not wear gowns when assisting him. There was no EBP sign on the R135's door, plastic bin outside the door containing PPE or garbage bin for disposal of PPE by R135's door. During a follow up observation on 5/13/26 at 8:24 a.m., there continued to be no EBP signage on R135's door. During an interview on 5/13/26 at 12:06 p.m., trained medication aid (TMA)-A stated if a resident was on any sort of precautions (EBP, contact, etc), there would be a sign on the resident door indicating what type of precautions they were on along with a PPE bin outside the door. During an interview on 5/13/26 at 9:54 a.m., nursing assistant (NA)-H stated they were familiar with R2, R10 and R135. NA-H stated R2 was on fall precautions but not on EBP precautions. NA-H stated R10 and R135 were not on EBP either. NA-H verified R2, R10 and R135 did not have EBP signage on their doors or PPE bins outside their rooms. During an interview on 5/13/26 at 12:30 p.m., licensed practical nurse (LPN)-B stated R2, R10 or R135 were not on EBP precautions. After reviewing R2, R10 and R135's medical records, LPN-B verified R2, R10 and R135 have tunneled CVC dialysis access sites. During an interview on 5/14/26 at 10:10 a.m., assistant director of nursing (ADON)-A stated it was not the facility practice for residents on dialysis with tunneled CVC access sites to be on EBP precautions. ADON-A stated a resident may be on EBP for another reason, but the facility did not put residents on EBP for a dialysis site alone. ADON-A reviewed R2, R10 and R135's medical records, verified R2, R10 and R135 had tunneled CVC dialysis access sites and verified R2, R10 and R135 were not on EBP precautions. ADON-A reviewed the precautions list kept in the nursing office and verified no residents listed were on EBP for dialysis. On 5/14/26 at 1:03 p.m., director of nursing (DON) stated she would have to look at the policy regarding wearing PPE and dialysis. DON added, if we touch the fistula, then we would have to wear PPE, but we don't touch the fistula, so we don't have to wear PPE. No additional information was (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	provided. A facility policy titled Hemodialysis, dated 4/1/26, identified the following: 14. The nurse will ensure that the dialysis access site (e.g. AV shunt or graft) is checked before and after dialysis treatments and every shift for patency by auscultating for a bruit and palpating for a thrill. If absent, the nurse will immediately notify the attending physician, dialysis facility and/or nephrologist, 16. Residents with external dialysis catheters will be assessed every shift to ensure that the catheter dressing is intact and not soiled. Change dressing to site only per the dialysis facility's direction, and 17. The staff will ensure that appropriate PPE is worn and follow current infection control practices when assessing dialysis access sites. R60 R60's quarterly Minimum Data Set (MDS) dated [DATE], indicated R60 had severely impaired cognition, was dependent on staff for personal hygiene, and was at risk for developing pressure ulcers/injuries. R60's diagnoses included Alzheimer's disease, dementia, bipolar, and overactive bladder. R60's care plan dated 4/23/26, indicated R60 had actual skin impairment and required wound care of a gluteal fold (area between the buttocks and the upper thigh) wound, and instructed, Treatment as ordered and Daily wound monitoring in place. R60's care plan lacked evidence EPB was required. R60's provider orders dated 5/7/26, indicated, Right gluteus wound cleanse with wound cleanser, pat dry. Apply foam QD [every day] and PRN [as needed]. Until healed. Additionally, Left gluteus wound cleanse with wound cleanser, pat dry. Apply Medi honey [medical grade honey product used to promote wound healing, prevent infection, and support skin repair] and foam QD and PRN. R60's provider orders lacked evidence of EBP. R60's progress note (PN) dated 4/22/26, indicated Skin has open area on L gluteal fold. R60's PN dated 5/6/26 at 3:57 p.m., indicated, Left Gluteal Fold. Issue type: Pressure ulcer/injury.Stage 2 Pressure ulcer/injury – partial thickness skin loss with exposed dermis. In addition, New skin issue.Right Gluteal Fold.Stage 3 Pressure ulcer/injury – full thickness skin loss.mixture of serous and sanguineous fluid. During observation on 5/11/26 at 6:30 p.m., R60's doorway lacked signage for EBP and there was no isolation cart anywhere in R60's hallway. During observation on 5/12/26 at 12:47 p.m., nursing assistant (NA)-G wheeled R60 into her room to offer toilet, check and change, and lay down. NA-F also into room to assist. Both NA's donned gloves, and neither NA donned a gown. NA-G placed a transfer belt around R60 and both NAs assisted her to a standing position by the toilet. R60's brief was removed and she was transferred to toilet. R60 was able to pass some urine and small bowel movement. NA-G and NA-F assisted with peri care. Dressing dated 5/11/26 was covering the left gluteal fold and an undressed open wound was observed on the right gluteal fold. A new brief was placed, pants pulled up and R60 was assisted into bed. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During interview on 5/12/26 at 12:59 p.m., NA-F stated was not sure how long R60 had the two wounds on her bottom, but it was the NA's responsibility to notify the nurse of new skin concerns. NA-F further stated would notify the nurse that the one dressing was missing, and needed to be replaced. During observation on 5/12/26 at 1:02 p.m., registered nurse (RN)-D and nursing assistant (NA)-G went into R60's room to complete wound care. RN-D and NA-G both donned gloves and neither donned a gown. RN-D prepared two new dressings by writing the date on each one. R60's pants and brief were pulled down and the old dressing removed. The left gluteal wound appeared closed and nearly healed, while the right gluteal wound was approximately 4 cm and open and reddened with some oozing of clear drainage. RN-D used wound cleanser on the right wound, patted dry, and placed a foam adhesive dressing over it. RN-D then cleansed the left wound, patted it dry and placed a foam adhesive dressing over it. During interview on 5/12/26 at 1:14 p.m., NA-G stated R60 had one wound for quite a while and another one just recently developed. NA-G stated could not remember R60 ever being on EBP and thought gloves were the only requirement when completing any cares for R60. During interview on 5/12/26 at 1:22 p.m., RN-D stated R60 had wounds for a couple months and could not recall that she was ever on EBP. RN-D stated EBP should be used when there was an open wound, and that he probably should have worn a gown during wound care earlier. During observation on 5/13/26 at 7:24 a.m., R60's door had EBP signage and an isolation cart in the hallway outside her room. During interview on 5/13/26 at 11:58 a.m., licensed practical nurse (LPN)-A stated she had been working at the facility for about three months and had been completing wound care on R60 since then. LPN-A stated EBP was initiated this morning and confirmed EBP had not been used previously during wound care on R60. During interview on 5/13/26 at 2:17 p.m., RN-E stated she completed wound rounds on R60 that morning and felt that the left gluteal wound appeared healed and the right wound was open and stable when compared to the previous week. RN-E stated EBP should have been initiated last week when the right gluteal wound was discovered as a new open wound. RN-E could not explain why EBP had not been initiated until today. During interview on 5/14/26 11:19 a.m., director of nursing (DON), who was also the infection preventionist (IP), stated EBP should be initiated as soon as an open wound was identified. DON could not explain why EBP were not initiated for R60 until today. Facility policy Enhanced Barrier Precautions dated 4/1/26, indicated, EBP was an infection control intervention utilizing gown and gloves during high contact resident care to reduce transmission of multidrug-resistant organisms (MDRO). The policy further indicated and order would be obtained and EBP initiated for residents with wounds (e.g., chronic wounds such as pressure ulcers, diabetic foot ulcers, unhealed surgical wounds, and chronic venous stasis ulcers) and/or indwelling medical devices (e.g., central lines, urinary catheters, feeding tubes, tracheostomy/ventilator tubes, hemodialysis catheters, PICC lines, midline catheters) even if the resident is not known to be infected or colonized with a MDRO. (Peripheral IVs, continuous glucose monitors, insulin pumps, or ostomies without an associated indwelling medical device are not an indication for EBP.) The policy indicated (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	gowns and gloves would be readily available outside the resident room and would be used during all high contact resident care including wound care: any skin opening requiring a dressing. R51 R51's quarterly Minimum Data Set (MDS), dated [DATE], identified R51 received oxygen therapy and used a noninvasive mechanical ventilator. The MDS further identified R51 required substantial to maximal assistance with most activities of daily living and was cognitively intact. R51's physician orders identified prior orders for continuous oxygen at 4 liters per minute (LPM) via nasal cannula or mask to maintain oxygen saturations at or above 90%, oxygen at 2 LPM via nasal cannula while sleeping until CPAP supplies arrived, and CPAP/BIPAP settings of CPAP 16/EPAP 8 with 3 LPM oxygen. Those orders discontinued on 4/24/26 following hospitalization and return to the facility on 4/25/26. R51's care plan, dated 4/29/26, identified R51 had altered respiratory status and required oxygen therapy, including interventions to provide oxygen as ordered and observe pulse oximetry readings. During interview and observation on 5/13/26 at 7:33 a.m., R51 stated the night nurse applied oxygen at 2 LPM overnight and licensed practical nurse (LPN)-F removed it that morning. Observation revealed the oxygen tubing and nasal cannula lying on the floor while the oxygen tank remained turned on. During interview and observation on 5/13/26 at 9:07 a.m., LPN-E stated staff completed daily vital signs for R51 and R51's oxygen saturation levels should remain above 90%, with oxygen applied at 2 LPM as needed to maintain those levels. LPN-E picked up the oxygen tubing and nasal cannula from the floor, reconnected the tubing to the oxygen source, and immediately reapplied the nasal cannula to R51 without cleaning or replacing the equipment. LPN-E stated he was unsure when the oxygen tubing had last been changed. During interview on 5/14/26 at 10:00 a.m., the director of nursing (DON), who also served as the facility's infection preventionist (IP), was asked about concerns related to oxygen tubing and nasal cannulas being left on the floor and not routinely changed. The DON/IP stated, I would have to find out a little bit more about why and she (R51) gets angry a lot. The DON/IP further stated R51 was very particular, liked certain people only, and will fixate on people and if they do the slightest thing. When asked about the infection risk associated with oxygen tubing and a nasal cannula being picked up from the floor and placed directly back into a resident's nose without cleaning or replacement, the DON/IP refused to comment on the infection risk.

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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 document review, the facility failed to ensure resident's dignity was maintained for 2 of 2 residents (R60,R51) observed during personal cares. In addition, the facility failed to ensure dignity was maintained for 2 of 2 residents (R47, R134) who experienced uncontrolled loss of bladder and bowel function waiting for staff to answer their call lights. Findings include: R60's quarterly Minimum Data Set (MDS) dated [DATE], indicated R60 had severely impaired cognition, was dependent on staff for personal hygiene, and was frequently incontinent of bowel and bladder. R60's diagnoses included Alzheimer's disease, dementia, bipolar, and overactive bladder. R60's care plan dated 4/23/26, indicated R60 had actual skin impairment and required wound care of a gluteal fold (area between the buttocks and the upper thigh) wound, was incontinent of bowel and bladder and required perineal care after each incontinent episode, had a communication problem and had difficulty expressing wants due to impaired cognition, and had an ADL (activities of daily living) self-care deficit and required substantial to maximal assistance with personal cares. During observation on 5/12/26 at 1:02 p.m., registered nurse (RN)-D and nursing assistant (NA)-G into R60's room to complete wound care and perform incontinent care. R60's door was left ajar approximately 18 inches on the right side of the doorway. R60 was lying in bed. There was no privacy curtain and R60's bed was to the left and in view from the doorway. R60's pants pulled down to her ankles and incontinent brief removed. R60 was positioned on her left side with her exposed bottom to the center of the room. At 1:10 PM housekeeper (H)-A knocked on R60's door and announced self as laundry. Neither RN-D nor NA-G said anything to stop H-A from entering. H-A entered R60's room and placed clean clothes in her closet and left the room. During interview on 5/12/26 at 1:14 p.m., NA-G stated the resident's room should be closed during incontinent cares to provide privacy and maintain dignity. NA-G stated someone should have spoken up and stopped H-A from entering R60's room while she was exposed. NA-G stated staff should knock and wait for a response prior to entering a resident's room. During interview on 5/12/26 at 1:22 p.m., RN-D stated R60's door should have been closed during incontinent and wound care, and that H-A should have waited for a response before entering her room. RN-D further stated he or NA-G should have said something when H-A knocked to stop him from entering. RN-D stated it was important to protect the resident's privacy and dignity during cares. During interview on 5/12/26 at 1:35 p.m., H-A stated he knocked and announced himself when he delivered clothing to R60's room and did not hear anyone tell him not to enter. H-A further stated the door was partially open which he thought indicated it would be okay to enter. H-A stated he could see that R60 was exposed, and he should not have been allowed to enter when personal cares were being completed. During interview on 5/13/26 at 2:17 p.m., RN-E stated they would expect staff to pull privacy curtains and close the resident's door during cares. They would also expect staff to knock prior to entering a resident room and for staff inside to respond whether they could enter or not, and for the staff at the (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	door wait for that answer. RN-E stated it was usually not appropriate for non-nursing staff to enter a resident's room while personal cares were being performed. During interview on 5/14/26 at 11:19 a.m., director of nursing (DON) stated would expect the door to be closed during cares and staff would not enter without permission. DON further stated the staff performing personal cares should respond and inform the person knocking not to enter when it was not appropriate to do so. R51 R51's quarterly Minimum Data Set (MDS), dated [DATE], indicated R51 was admitted to the care facility on 2/5/2020 and was cognitively intake. The MDS further indicated R51 required substantial to maximum assistance with most activities of daily living (ADLs). R51's care plan, dated 2/5/2020, indicated R51 had an ADL self-care performance deficit related to chronic cellulitis, morbid obesity, osteoarthritis, cancer and chronic pain and required substantial assistance of one staff for personal hygiene and assistance of 2 staff for transfers via a mechanical lift. During observation and interview on 05/13/2026 at 9:18 a.m., Nursing Assistant (NA)-E provided incontinent care to R51 in bed. NA-E gathered supplies, removed the resident's oxygen and turned the oxygen concentrator off, removed the resident's blanket, and provided perineal and skin care while the resident remained exposed in bed. NA-E discussed the resident's skin condition and treatments with the resident while applying barrier cream to the groin and buttocks areas and assisting the resident with dressing and repositioning. During the care, multiple staff entered the resident's room without waiting for permission to enter. At 9:40 a.m., the Administrator knocked and immediately entered the room while the resident remained uncovered from the waist up and wearing only a brief. R51 stated, big ole negative on that one, that [administrator], shame on him, he just walked right in. The administrator stated he heard voices and thought someone said, come in. At 9:41 a.m., Licensed Practical Nurse (LPN)-D knocked and entered the room without waiting for a response while the resident continued receiving care in bed. At 10:02 a.m., Registered Nurse (RN)-G knocked once and immediately walked into the room with morning medications while care continued. Facility policy Promoting/Maintaining Resident Dignity dated 4/1/26, indicated, All staff members are involved in providing care to residents to promote and maintain resident dignity and respect resident rights. The policy further instructed, Maintain resident privacy. R47 R47's admissions Minimum Data Set (MDS) dated [DATE] identified R47 with intact cognition, used a walker or wheelchair for mobility and required set up or cleanup for toileting hygiene. In addition, R47 had diagnoses of anxiety, chronic obstructive pulmonary disease, respiratory failure, fibromyalgia, opioid abuse, pulmonary fibrosis and dependence on supplemental oxygen. During interview with R47 on 5/11/26 at 11:55 a.m., R47 stated on 5/10/26 during the day shift she had the urge to have a bowel movement so she pressed her call light on and could not wait so she stood up and walked to the bathroom using her wheeled walker and wearing her oxygen tubing. During the walk, she had an accident on the floor before getting to the toilet. R47 said she had waited as long as she could for help, but staff did not arrive in time. I felt so bad. I kept saying I was sorry because I (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	felt really bad, but I could not hold it. Review of call light logs for 5/10/26 identified a wait of 38 minutes and 53 minutes at 1:06 p.m. R134 R134's admissions MDS dated [DATE] identified R134 with intact cognition, did not reject cares, required substantial to maximal assist with dressing, hygiene and bed mobility. In addition, R134 had frequent incontinence of urine and stool, and an unhealed pressure ulcer. Also, R134 had diagnoses of Multiple Sclerosis (MS), heart failure, diabetes, obesity and a stroke leading to partial paralysis of lower limbs. During observation and interview with R134 on 5/11/26 at 11:36 a.m., R134 stated he had an experience in April [2026], I pooped in my brief and had to sit in it.before they came. R134 stated he had pressed his call light for assistance and the staff ignored him. R134 stated he was very upset and angry about experiencing the episode. Review of facility call light log for R134 on date of April 19, 2026, identified a call light wait of 58 minutes and 15 seconds. During interview with registered nurse (RN)-A on 5/13/26 at 8:21 a.m., RN-A stated, usually 10 minutes is max for waiting for someone to answer [the call light]. RN-A stated a delay in answering a call light could result, in a medical emergency including falling, having a urine or bowel accident and the effects of waiting, affects their mental health and dignity. During interview with nursing assistant (NA)-A on 5/13/26 at 8:31 a.m., NA-A stated expectation of answering a call light as 5 to 6 minutes. NA-A stated there was a risk of residents being impatient, at increased risk for falls and, feel upset if they have an accident before staff can help them. During interview with RN-B on 5/13/26 at 9:12 a.m., RN-B stated she was the nurse manager on the unit including R47 and R134. RN-B stated expectation of staff to answer call lights in under 10 minutes. RN-B stated risk of long call lights included residents attempting to transfer themselves without assistance, and emotional distress. RN-B stated, it is emotional if someone has an accident waiting for help. I would feel bad if it happened to me. And angry. RN-B reviewed call light logs for R47 and R134 and stated the wait times were too long and not acceptable. During interview with director of nursing on 5/13/26 at 1:05 p.m., DON stated expectation of staff to answer call lights within 15 minutes. DON reviewed call light logs for R47 and R134 and stated, that is not ok. Facility policy titled Notification of Changes, effective 04/2025 state, All staff members who see or hear an activated call light are responsible for responding.

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	245271	A. Building B. Wing	05/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Providence Place	3720 23rd Avenue South Minneapolis, MN 55407

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to honor 1 of 1 residents (R61) request for larger than the regular/standard portion sizes, reviewed for food choices who had complained of hunger between meals when receiving the facility's standard portion size of protein. Findings include:R61's quarterly Minimum Data Set (MDS) dated [DATE], indicated R61 had intact cognition and was diagnosed with diabetes and depression, and malnutrition. The MDS indicated R61 had no weight gain or loss of five percent or greater in the last month or 10 percent or greater in the last six months.R61's diet order dated 11/20/25, indicated R61 was to receive a CSC regular texture diet. The diet order did not include a reference to large portions.R61's dietary progress note dated 2/25/26 at 12:01 p.m., indicated R61 had complained of increased hunger for meals, and the dietician had added for the resident to receive larger protein portions at all meals to his meal ticket.R61's care plan dated 5/14/26, indicated R61 had potential for a nutrition problem related to a diagnosis of diabetes, a history of a heart attack and a stroke, a therapeutic diet related to diabetes, reduced mobility with need for staff assistance, and recurrent depression. The care plan indicated that R61 was to receive double protein portions, and staff were to provide and serve the diet as ordered.During an observation on 5/12/26 at 11:36 a.m., R61 was observed sitting at a dining table with three other residents. R61's meal ticket indicated he was to get larger protein/main dish portions. R61 was given one piece of what appeared to be chicken (a light colored meat) that was about 75% of the size of a deck of cards, about 1/2 to 3/4 cups mixed vegetables, and three small potatoes. When R61's given portion of chicken was compared to multiple other residents' in the dining room whose tickets did not indicate larger portions, R61's portion was noticeably smaller.During an interview on 5/12/26 at 11:36 a.m., R61 stated he was supposed to get larger portions of his main meal because he gets hungry, but they never give it to him, and confirmed he did not feel that he had gotten large protein servings since he had asked for the increase.During an interview on 5/12/26 at 11:39 a.m., registered nurse (RN)-E was asked about the portion sizes of R61's meal and stated that, after looking at R61's meal, his protein serving did not look like a large serving or larger than other residents' servings.During an interview on 5/14/26 at 2:12 p.m., the dietary manager (D-MGR) stated that when a resident needs large portions, this was communicated to staff on the resident's meal ticket. The D-MGR stated that if a resident was supposed to get double portions, staff should give six ounces instead of three ounces of meat. The D-MGR stated that the chicken pieces came pre-proportioned, so she will have to look into their size. The D-MGR stated she would expect staff to find a resident a larger piece of chicken if they were supposed to have larger protein portions. At 2:48 p.m., the D-MGR brought a document indicating the facility bought bone-in 4.5-ounce pieces of chicken that included an assortment of wings, drumsticks, breasts, and thighs. The D-MGR stated that they were only required to give the residents three ounces of protein, so they had been giving everyone larger portions, including R61. When asked how long they had been serving this size of chicken pieces, D-MGR was not able to give a date, but stated this was the standard size of chicken portions they had been giving all residents on a regular portioned diet and a larger protein portioned diet. During an interview on 5/14/26 at 2:19 p.m., dietary aide (DA)-A confirmed that she helped to plate and serve food. DA-A stated that if a ticket said larger protein, they were supposed to give two pieces of meat instead of one.A policy regarding diet choices was requested but not received.

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to provide the Skilled Nursing Facility Advanced Beneficiary Notice (SNFABN) to 1 of 2 residents (R6) reviewed, whose Medicare Part A coverage ended and remained in the facility. Findings include:R6's quarterly Minimum Data Set (MDS) dated [DATE], indicated R6's most recent Medicare-covered stay was from 1/1/26 to 1/12/26.R6's Notice of Medicare Non-Coverage (CMS-10123) dated 1/12/26, indicated R6's last covered day of Medicare A would be 1/12/26 and indicated the resident representative was notified on 1/9/26.R6's SNF Beneficiary Protection Notification Review form dated 1/12/26, indicated R6 had not been provided a SNFABN as R6 was dropped to a non-skilled level.R6's Census list dated 4/19/26, indicated R6 remained at the facility after 1/12/26 (Medicare Part A discharge date).During an interview on 5/13/26 at 9:08 a.m., the assistant administrator confirmed he had reviewed R6's medical record and stated that R6 had remained in the facility after Medicare Part A discharge in January. The assistant administrator stated he would have expected a SNFABN to be completed, but it didn't look like it had been.The facility's Advanced Beneficiary Notices policy dated 4/1/26, indicated the facility shall inform Medicare beneficiaries of his or her potential liability for payment. The policy directed when Part A services are used, the facility shall use the [SNFABN].

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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 ensure the comprehensive care plan was accurate and updated to reflect the resident's current transfer, mobility, ambulation, and toileting needs. The care plan contained conflicting and inconsistent interventions and functional status information, which had the potential to result in staff confusion and inconsistent care delivery for 1 of 1 resident (R128) reviewed for care planning. In addition, the facility failed to ensure two care conferences were done to correspond with the Minimum Data Set (MDS) cycle for 1 of 1 resident (R11) reviewed for care conferences. Findings include: R128's quarterly Minimum Data Set (MDS), dated [DATE], indicated R128 was independent with toileting, always continent of bladder, however frequently incontinent of bladder. R128's Continence Evaluation, dated 4/29/26, indicated R128 had functional incontinence of bladder and occasional incontinence of bowel indicating a check and change toileting schedule per resident request. A check and change toileting program is a scheduled approach used for residents who experience urinary and/or bowel incontinence. Under this program, staff routinely check the resident at designated intervals for incontinence, provide incontinence care as needed, and change briefs or clothing to maintain cleanliness, comfort, and skin integrity. R128's care plan identified multiple conflicting entries related to R128's toileting, transfers, and mobility status. The care plan dated 9/3/25 identified R128 as independent with toileting, while a separate intervention dated 12/31/25 indicated toilet transfers were NA because the resident wore pull-up briefs and required barrier cream after incontinent episodes. Additional interventions directed staff to encourage toileting during rounds dated 5/13/24, listed toileting schedule as independent dated 2/3/26, and identified toilet hygiene required set-up/clean-up assistance of one staff person dated 2/3/26. The care plan also contained conflicting transfer information, including supervision assist of 1 with transfers dated 12/31/25 and chair to bed transfer - independent dated 4/29/26. Additional care plan documentation indicated R128 had bladder incontinence related to functional loss and diuretic use but remained continent of bowel at all times dated 5/13/24. R128's care plan further identified inconsistent mobility interventions. One care plan intervention dated 3/26/25 identified R128 as requiring a wheelchair with foot pedal for mobility, while another intervention dated 3/26/25 indicated the resident used a four-wheeled walker for ambulation with supervision of one staff person. During interview on 5/13/26 at 10:47 a.m., licensed practical nurse (LPN)-E stated R128 had returned from the hospital and was no longer ambulating upon return. LPN-E stated prior to hospitalization, R128 required standby assistance with transfers, but now required staff assistance. LPN-E stated R128 was mostly continent but was sometimes incontinent of bladder. LPN-E further stated R128's condition had changed significantly since hospitalization and had recently started to improve again. During interview on 5/13/26 at 12:50 p.m., the Director of Rehabilitation (DOR) stated therapy had initially treated R128 as a full body mechanical lift following return from the hospital. The DOR stated R128 had progressed to stand pivot transfers with staff assistance as of that morning and had begun ambulating with a walker during therapy sessions only. The DOR stated R128 knew when toileting was needed but could not independently get to the bathroom. The DOR stated therapy discussed (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	additional toileting interventions with occupational therapy, including use of a bedside commode; however, R128 declined use of a bedside commode in the resident room. The DOR confirmed R128 was only to ambulate with therapy staff at this time. During interview on 5/14/26 at 9:07 a.m., nurse manager and LPN-F stated it was expected to update the care plan and Nurse Aide Reference (NAR) guide when a resident's condition changed. LPN-F stated R128's condition had fluctuated significantly following hospitalization, explaining that one day R128 believed she was paralyzed and the next day ambulated with therapy. LPN-F stated prior to hospitalization, R128 had been independent with many tasks. LPN-F stated R128 currently required assistance of one staff person with pivot transfers into the wheelchair. LPN-F further stated R128 had walked to the bathroom with staff the previous day and confirmed R128 was expected to ambulate with staff assistance. A facility policy on Comprehensive Care Plans was requested and not received. R11 R11's significant change (SCSA) Minimum Data Set (MDS) dated [DATE] identified R11 had intact cognition, required assistance with hygiene, did not reject care, and had diagnoses of paralysis on dominant side of body from a stroke, diabetes, and depression. During interview with R11 on 5/11/26 at 3:14 p.m., R11 stated she did not recall having a care conference since she was admitted in October of 2025. R11 stated she was interested in discussing a discharge or transfer and did not know how long she was to stay in the facility. On 5/12/26 at 3:02 p.m., the facility administrator emailed State Agency Surveyor (SA) and stated there was no documentation to support a care conference that was conducted for R11 for her quarterly and SCSA MDS cycle. During interview with social worker (SS)-A on 5/13/26 at 8:40 a.m., SS-A stated expectation of care conference timing to correspond with each MDS cycle and as needed, if there were changes. During interview with registered nurse (RN)-B on 5/13/26 at 9:11 a.m., RN-B stated expectation of care conference timing to correspond with each MDS cycle and as needed. RN-B viewed R11's electronic medical record (EMR) and verified one care conference was conducted at admission on [DATE]. RN-B verified R11's medical record failed to show a care conference to correspond with the quarterly MDS dated [DATE] and the SCSA MDS dated [DATE]. During interview with SS-B on 5/13/26 at 10:50 a.m., SS-B stated she was filling in for the transitional care unit social work position and had worked at facility for a month. SS-B stated expectation of care conferences to be done on admission, quarterly, SCSA and as requested to correspond with the MDS cycle. SS-B reviewed R11's medical record and stated, [R11's] care conferences were missed. Facility policy titled Care Planning- Resident Participation effective 4/1/26 indicated, The facility will discuss the plan of care with the resident and/or representative at regularly scheduled care plan conferences, and allow them to see the care plan, initially, at routine intervals, and after significant changes. The facility will make an effort to schedule the conference at the best time of the day for the resident/resident's representative. The facility will obtain a signature from the resident and/or resident representative after discussion or viewing of the care plan.

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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 routine personal hygiene (i.e., nail care) was completed for 1 of 1 residents (R155) reviewed for activities of daily (ADLs) and who were dependent on staff for their care.Findings include:R155's quarterly Minimum Data Set (MDS) assessment dated [DATE], identified R155 had moderately impaired cognition, no hallucinations, delusions, behaviors or rejection of care. R155 was dependent on staff assistance for dressing, oral hygiene, toileting, mobility, and showering. Furthermore, R155 received hospice services.R155's diagnosis report, printed 5/14/26, included the following relevant diagnoses: vascular dementia without behavioral disturbances (cognitive decline from restrictive brain blood flow without exhibited behaviors such as aggrieve, anxious, psychoses or mood-altering symptoms), glaucoma-severe stage (advanced irreversible optic nerve damage where person experiences severe tunnel visions, compromised daily function and significant difficulty navigating spaces), need for assistance with personal care, and hemiplegia and hemiparesis following cerebral infarction affecting right dominant side (weakness and paralysis of dominant side following a stroke).R155's care plan, printed 5/13/26, identified R155 had an ADL self-care performance deficient related to cognitive impairment, impaired balance, chronic pain which included the following interventions:- Check nails length and trim and clean on bath day and as necessary. Report any changes to the nurse.- Bathing: totally dependent on staff for bathing- Bathing: assist of 1 with shower/occasional bath and skin condition. Nurse nails.- personal hygiene: is dependent on assistance of 1 staff to completeThe care plan lacked evidence of R155 having a history or refusing staff assistance with ADLs (specifically nail care) or preference for longer fingernails.R155's care sheet, printed 5/14/26, identified R155 required assistance of 1 staff as needed with dressing, was independent with grooming and assistance of 1 staff with showers.R155's May 2026 Treatment Administration Record (TAR) was reviewed for 5/1/26 to 5/13/26 and included bath/shower documentation, and whether fingernails and toenails were intact or trimmed/filed. The TAR specified:Nail care answers if No or NA further information MUST BE documented in progress note to explain. Refused shower MUST BE documented in progress note details on reapproaches. every evening shift every Wed. Refused shower MUST BE documented in progress note details on reapproaches. With a start date of 4/22/26.-5/6/26: was blank-5/13/26: indicated R155 received a bed bath, and fingernails were intact and were not trimmed or filed. The TAR lacked evidence nail care had been provided in May. R155's progress notes, dated 4/1/26 to 5/13/26, were reviewed. Progress notes lacked evidence of R155 being offered nail care or refusing nail care.During an observation on 5/11/26 at 12:32 p.m., R155 was observed to have fingernails ranging in length from approximately 1/8 to 1/4 inch in length, jagged with dark colored debris underneath. R155 didn't answer when asked about his nails. R155 did nod his head yes when asked if staff assist him with trimming and cleaning his fingernails.On 5/12/26 at 10:19 a.m., R155 was observed sleeping in bed. R155's fingernails were observed to continue to be approximately 1/8 to 1/4 inches in length, some with jagged tips with dark colored debris underneath. At 1:52 p.m., R155 was observed awake in bed with a hospice volunteer by his bedside.On 5/13/26 at 7:55 a.m., R155 was observed sleeping in bed. R155's fingernails continued to have dark colored debris underneath, jagged edges on multiple nails and nail lengths ranging from 1/8 to 1/4 inch in length. At 8:26 a.m., it was observed staff was assisting R155 with breakfast.During an interview on 5/13/26 at 9:55 a.m., nursing assistant (NA)-H stated R155 required extensive assistance. NA-H stated R155 did not refuse staff assistance with any ADLs, but staff must give R155 enough time when assisting him. During an interview on 5/13/26 at 12:16 p.m., licensed practical nurse (LPN)-B stated R155 was used to a routine. LPN-B stated she thought if you missed a step in R155's routine, he might refuse but would be accepting upon reapproach. LPN-B stated if R155 or any resident refused assistance it would be documented in a progress note.During an observation and interview on 5/13/26 at 2:26 p.m., (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	registered nurse (RN)-F stated they were familiar with R155. RN-F observed R155 fingernails and stated there were long with sharp edges, should be cut, and had stuff underneath them. RN-F stated it should be a collaboration between hospice and the facility to ensure R155's needs were being met which would include nail care. RN-F stated they hoped R155 was being provided hand hygiene prior to meals as he ate with his hands.During an interview on 5/14/26 at 9:58 a.m., assistant director of nursing (ADON)-A stated the expectation for nail care was that it be offered on shower days and as needed. ADON-A stated the importance of appropriate nail care was for hygiene purposes, helping stop the spread of bacteria, overall cleanliness, and to help decrease the risk of a resident scratching themselves causing a skin tear or wound. ADON-A stated hospice had been providing bed baths recently due to R155's decline and nail care may have not been getting done. ADON-A stated it should be a collaboration between hospice and the facility, and if R155 was refusing nail care with hospice they should be informing the facility and this would be documented in the progress notes. ADON-A stated she was going to review R155's medical record along with hospice charting. No additional information was provided for refusals of nail care.During an interview on 5/14/26 at 12:59 p.m., director of nursing (DON) stated the minimal standard would be offering nail care on shower days. DON stated the biggest part of nail care was resident choice. During a follow up interview on 5/14/26 at 3:54 p.m., DON stated nail care was offered on shower days and R155's nail care was done yesterday. DON stated she will follow up about any refusals of nail care prior to survey entrance. No additional information was provided.A facility titled policy Activities of Daily Living, dated 4/1/26, identified Care and services will be provided for the following activities of daily living:Bathing, dressing, grooming and oral care;Transfer and ambulation;Toileting;Eating to include meals and snacks; andUsing speech, language or other functional communication systems.

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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 document review, the facility failed to ensure insulin was administered as ordered for 1 of 2 residents (R2) reviewed for insulin administration and wound care was provided as ordered for 1 of 1 resident (R60) reviewed for pressure ulcers.Findings include: R2 - not following provider orders R2's admission Minimum Data Set (MDS) assessment dated [DATE], identified R2 had intact cognition without hallucinations or delusions present with no behaviors, or rejection of care present. Diagnoses included diabetes. Furthermore, Section N: Medication identified R2 received insulin injections 4 days out of 7 days. During an interview on 5/11/26 at 2:34 p.m., R2 stated she received insulin injections for her diabetes. R2's care plan, printed 5/13/26, included the following: -has diabetes mellitus with a goal of will be free from any s/sx [signs/symptoms] of hypoglycemia through the review date with the following interventions: Dietary consult for nutritional regimen and ongoing monitoring. Observe for compliance with diet and document any problems. Observe/document/report to medical practitioner PRN s/sx of hypoglycemia: Sweating, Tremor, Increased heart rate (Tachycardia), Pallor, Nervousness, Confusion, slurred speech, lack of coordination, Staggering gait. Observe/document/report to medical practitioner PRN for s/sx of hyperglycemia: increased thirst and appetite, frequent urination, weight loss, fatigue, dry skin, poor wound healing, muscle cramps, abdominal pain, Kussmaul breathing, acetone breath (smells fruity), stupor, coma. Observe/document/report to medical practitioner PRN for s/sx of infection to any open areas: Redness, Pain, Heat, swelling or pus formation. R2's May Medication Administration Record (MAR/TAR) from 5/1/26 – 5/13/26 included the following: -Aspart Insulin injection (fast acting insulin) - inject 6 units subcutaneously with meals related to type 2 diabetes mellitus with unspecified complications. Hold BG [blood glucose] less than 130 with a (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	start date of 4/29/26 with administration times of 8 a.m., 12 p.m., and 5 p.m. The record indicated it was administered as ordered except for the following: -5/1/26 at 12 p.m., coded with a 2 -5/4/26 at 8 a.m., coded with a 13 and 12 p.m., coded with a 2 -5/5/26 at 8 a.m., coded with a 13 -5/6/26 at 8 a.m., coded with a 13 and 12 p.m., coded with a 2 -5/7/26 at 8 a.m., coded with a 13 -5/8/26 at 8 a.m., coded with a 13 and 12 p.m., coded with a 2 -5/11/26 at 8 a.m., coded with a 13 -5/13/26 at 12 p.m., coded with a 9 *Per chart code: 2 indicates out of facility without meds, 13 indicated no insulin required and 9 indicated a progress note. -Aspart Insulin Flex Pen 100 units/milliliter(mL) – inject as per sliding scale: If 130-150=0 units; 151-200=0 units; 201-250=1 units; 251 - 300 = 2 Units; 301 - 350 = 3 Units; 351 - 400 = 4 Units; 401 - 500 = 5 Units; 501 + = 6 Units, subcutaneously before meals and at bedtime for Type 2 Diabetes with a start date of 2/17/16. The record indicated this order was administered as ordered. The administration record included blood sugar readings. R2's Blood Sugar (BS) Summary, printed 5/14/26, identified the following relevant information (blood sugar readings are milligrams/deciliter (mg/dL)): -5/2/26 at 7:14 a.m., BS 101 -5/3/26 at 8:11 a.m., BS 111 -5/4/26 at 7:29 a.m., BS 86 -5/5/26 at 7:16 a.m., BS 101 -5/6/26 at 7:29 a.m., BS 91 -5/7/26 at 7:37 a.m., BS 90 -5/8/26 at 10:53 a.m., BS 91 -5/9/26 at 8:53 a.m., BS 106 -5/10/26 at 8:04 a.m., BS 120 (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-5/11/26 at 8:47 a.m., BS102 -5/12/26 at 7: 11 a.m., BS 93 -5/12/26 at 8:07 a.m., BS 93 -5/12/26 at 10:33 a.m., BS 127 -5/13/26 at 7:36 a.m., BS 94 -5/14/26 at 7:13 a.m., BS 97 R2's progress notes for 5/1/2 to 5/14/26 were reviewed and identified the following: -5/13/26 at 12:05 p.m.: noted resident out for dialysis Progress notes lacked evidence of holding insulin per order when blood glucose/sugar was below 130. On 5/14/26 at 8:17 a.m., licensed practical nurse (LPN)-C stated if a resident had a low blood sugar, the expectation would be the provider was notified. LPN-C stated if a resident had orders to hold insulin if a blood sugar was a certain level, it would be expected to follow that order and to notify the provider when it was held. During an interview on 5/14/26 at 9:40 a.m., assistant director of nursing (ADON)-A stated it was expected that physician orders were being followed. ADON-A stated it was important that if there were parameters to hold insulin if a blood sugar was low that the insulin was held as this had the potential to have negative effects all the way around. ADON-A stated the resident would likely become hypoglycemic. ADON-A reviewed R2's medical record. ADON-A verified R2 should not have received, and did receive, the scheduled morning dose of aspart insulin as R2's blood sugars were below 130 on 5/2/26, 5/3/26, 5/9/26, 5/10/26, 5/12/26, and 5/13/26. ADON-A stated the orders were clearly not being followed. ADON-A stated the 6 units of Aspart should not have been given those mornings per the orders. On 5/14/26 at 10:37 a.m., nurse practitioner (NP)-A stated they reviewed R2's blood sugars and were aware of R2's blood sugar trends. NP-A stated R2 was a brittle diabetic, and they had made changes to better manage her diabetes. NP-A stated the staff should be following the orders as giving insulin to someone with a low blood sugar could result in the person becoming hypoglycemic. NP-A stated he was going to review the orders as the order may be too stringent for R2 as her noon blood sugars tended to be higher. On 5/14/26 at 1:00 p.m., director of nursing (DON) stated the staff should follow a provider order and then added, a resident can choose to get the insulin even if low and go against provider orders as they have a choice. DON was going to follow up. No additional information was provided. A facility policy regarding following provider orders was requested but not received as facility indicated this was a procedural standard. R60 (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R60's quarterly Minimum Data Set (MDS) dated [DATE], indicated R60 had severely impaired cognition, was dependent on staff for personal hygiene, and was at risk for developing pressure ulcers/injuries. R60's diagnoses included Alzheimer's disease, dementia, bipolar, and overactive bladder. R60's care plan dated 4/23/26, indicated R60 had actual skin impairment and required wound care of a gluteal fold (area between the buttocks and the upper thigh) wound, and instructed, Treatment as ordered and Daily wound monitoring in place. R60's provider orders dated 5/7/26, indicated, Right gluteus wound cleanse with wound cleanser, pat dry. Apply foam QD [every day] and PRN [as needed]. Until healed. Additionally, Left gluteus wound cleanse with wound cleanser, pat dry. Apply Medi honey [medical grade honey product used to promote wound healing, prevent infection, and support skin repair] and foam QD and PRN. When reviewed on 5/12/26 at 12:43 p.m., R60's May 2026, treatment administration record (TAR) indicated left and right gluteus wound care to be completed daily with a start date of 5/8/2026. The right and left gluteus wound care was not documented as completed on 5/8/26, and 5/9/26. The wound care was documented as completed on 5/10/26, 5/11/26, by registered nurse (RN)-C. The wound care was documented as completed on 5/12/26, by RN-D. During observation on 5/12/26 at 12:47 p.m., nursing assistant (NA)-G wheeled R60 into her room to offer toilet, check and change, and lay down. NA-F also into room to assist. R60 was assisted to a standing position, brief removed and transferred to toilet. R60 was able to pass some urine and small bowel movement. NA-G and NA-F assisted with peri care. Dressing dated 5/11/26 was covering the left gluteal fold and an undressed open wound was observed on the right gluteal fold. A new brief was placed, pants pulled up and R60 was assisted into bed. During interview on 5/12/26 at 12:59 p.m., NA-F stated was not sure how long R60 had the two wounds on her bottom, but it was the NA's responsibility to notify the nurse of new skin concerns. NA-F further stated would notify the nurse that the one dressing was missing and needed to be replaced. During observation on 5/12/26 at 1:02 p.m., registered nurse (RN)-D and nursing assistant (NA)-G went into R60's room to complete wound care. RN-D prepared two new dressings by writing the date on each one. R60's pants and brief pulled down and the old dressing removed. RN-D confirmed the dressing had yesterday's date (5/11/26) indicating last time it was changed. RN-D used wound cleanser on the right wound, patted dry, and placed a foam adhesive dressing over it. RN-D then cleansed the left wound, patted it dry and placed a foam adhesive dressing over it. Medi honey was not used on either wound. During interview on 5/12/26 at1:22 p.m., RN-D stated he completed the wound care on R60 today only since the NA had reported the missing dressing and that R60's wound care was only scheduled three days a week on Monday, Wednesday, and Friday. RN-D stated he normally only worked on Tuesday's therefore, only treated R60's wounds as needed. When asked, RN-D stated he signed off R60's TAR as wound care being completed, even though he had not completed wound care at that time and had not planned on doing any wound care on R60 today. RN-D further stated was not aware the order had changed to complete wound care daily. RN-D confirmed did not use any Medi honey and could not say where the Medi honey was even stored. RN-D stated he should have read the order to realize it had been changed to daily wound care and for Medi honey to be used. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 5/13/26 at 2:17 p.m., RN-E stated R60's wound care was changed from three days a week to daily on 5/7/26, and would expect wound care to be completed daily starting on 5/8/26. In addition, RN-E stated if the provider order was for Medi honey to be used, she would staff to be using Medi honey during wound care. RN-E stated would expect nurses to read and review resident orders, since they can change at any time. During interview on 5/14/26 at 11:19 a.m., director of nursing (DON) stated would expect provider orders to be completed as ordered. Facility policy for following provider orders was requested but not provided.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure orders included resident-specific settings for the use and management of non-invasive ventilation machines for 2 of 2 residents (R15, R23) reviewed for the use of CPAP/BiPAP machines. In addition, the facility failed to ensure oxygen-related orders were reinstated after hospitalizations and readmission to the facility for 1 of 1 resident (R51) who used oxygen. Findings include: R15 R15's quarterly Minimum Data Set (MDS) assessment dated [DATE], identified R15's short term or long-term memory were both marked as memory ok after staff assessment of mental status was completed. In Section O- Special Treatment, Procedures and Programs, in section G1 Non-invasive mechanical ventilator was marked with a check mark to indicate R15 uses a non-invasive mechanical ventilator. During an observation on 5/11/26 at 12:47 p.m., a non-invasive ventilation machine (CPAP/BiPAP machine) on the bedside table. The mask for the machine was observed laying on the table next to the machine. No dates on the tubing or mask were observed. R15 declined to answer any questions. R15's care plan, printed 5/13/26, identified R15 had an altered respiratory status due related to OSA (obstructive sleep apnea) with an intervention to assist to elevate head of bed to no greater than 30 degrees. R15's care plan lacked evidence R15 required or used a CPAP or BiPAP machine. R15's May Medication and Treatment Administration Record (MAR/TAR), printed 5/13/26, included the following orders: -CPAP/BiPAP – on at bedtime, off in the morning. At bedtime at 9 p.m. with a start date of 3/17/26. Record indicated from 5/1/26 to 5/13/26, R26 wore the CPAP/BIPAP 4 times which was marked with a y indicating yes, 6 times did not wear have the CPABIPAP as it was marked with a n indicating no, and 2 times was marked with a 3 with the chart code indicating refused. -CPAP/BiPAP – on at bedtime, off in the morning. In the morning at 9 a.m. with a start date of 3/18/26. Record indicated from 5/1/26 to 5/13/26, all days were marked with off. The MAR lacked evidence of resident specific settings for the CPAP or BiPAP machine. Furthermore, lacked evidence of cleaning of mask, tubing or filters. R15's Task Log reviewed and lacked evidence of staff cleaning mask or tubing. R15's progress notes for 4/1/26 to 5/14/26 were reviewed. Progress notes lacked evidence of specific settings for R15's non-invasive ventilation machine which would determine whether R15 was using the machine as a CPAP (continuous positive airway pressure) or BiPAP (bilevel -two distinct pressures-positive airway pressure). During an interview on 5/13/26 at 9:57 a.m., nursing assistant (NA)-H stated they were familiar with R15. NA-H stated R15 wore a CPAP at night. NA-H stated they had not helped R15 put the mask on but had turned the CPAP machine on for R15. NA-H stated the nurses helped with putting masks on if a (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident needed assistance and when tubing needed to be changed. During an interview on 5/13/26 at 12:25 p.m., licensed practical nurse (LPN)-B stated R15 had a CPAP machine that nursing assisted with by putting mask on and off and turning machine on and off. LPN-B stated R15 refused to wear her CPAP machine sometimes. LPN-B reviewed R15's orders and verified the orders to did have specific resident pressure settings. R23 R23's admission MDS assessment dated [DATE], identified R23 had intact cognition and used a non-invasive mechanical ventilator. During an observation and interview on 5/11/26 at 3:23 p.m., R23 stated she had been on the portable ventilator since admission. R23 stated she returned from the hospital a little while ago. R23's care plan, printed 5/13/26, identified R23 had an altered respiratory status with an inability to lie flat with the following interventions: -administer medications/inhalers/nebulizer treatments as orders. -elevate head of bed, observe and document any shortness of breath when lying flat and with activities due to shortness of breath. -Observe/document and report to nurse/medical practitioner any s/sx [signs/symptoms] of respiratory distress; increased respirations, decreased pulse oximetry, increased heart rate, restlessness, diaphoresis, headaches, lethargy, confusion, hemoptysis, cough, pleuritic pain, accessory muscle use, skin color changes to blue/gray -Head of bed to be elevated (semi-Fowlers to fowlers) or out of bed upright in a chair during episodes of difficulty breathing (Dyspnea). The care plan lacked evidence of any resident specific settings for R23's CPAP machine. R23's May MAR/TAR included the following orders: - CPAP/BIPAP - filter maintenance: Wash reusable filters monthly by hand in warm soapy water (antibacterial), rinse well and let air dry. If filters are disposable, change monthly every day shift every 30 day(s) with a start date of 5/12/26. The record indicated it was completed on 5/12/26. - CPAP/BIPAP - Fill reservoir with distilled water at bedtime at 9 p.m. with a start date of 4/17/26 and end of 5/11/26 with a new order starting 5/11/26. From 5/1/26 to 5/11/26, all were marked with a check mark to indicate as completed except for 3 days (5/8/26-5/10/26) which were coded with a 6 indicating hospitalized . -CPAP/BiPAP – ON at bedtime, Off in the morning at 9 p.m. with a start date of 4/18/26 and end date of 5/11/26 with a new order starting 5/11/26. Of 11 opportunities (from 5/1/26-5/11/26), the record indicated 6/11 times it was marked as self, 2/11 times as on and 3/11 with a 6 which (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	indicated hospitalized . -CPAP/BiPAP – ON at bedtime, Off in the morning at 9 a.m. with a start date of 4/18/26 and end date of 5/11/26 with a new order starting 5/12/26. Of 12 opportunities (from 5/1/26-5/12/26), the record indicated it was completed all days except for 3 which were documented with a 6. -CPAP/BIPAP - Wash face mask/nasal pillow and water chamber/reservoir by hand with warm soapy water (cannot contain antibacterial soap), rinse well and let air dry every day shift with a start date of 4/18/26 and end date of 5/11/26 with a new order starting 5/12/26. The record indicated this was completed all days (5/1/26-5/12/26) except for 3 days which were marked with 6. R23's progress notes for 4/1/26 to 5/14/26 were reviewed. Progress notes lacked evidence of specific settings for R23's non-invasive ventilation machine. During an interview on 5/13/26 at 9:56 a.m., NA-H stated they had not assisted R23 with the CPAP machine. NA-H stated they had seen R23 wear the CPAP mask when sleeping. During an interview on 5/13/26 at 12:02 p.m., trained medication aid (TMA)-A stated nurses were responsible for CPAP machines, and anything related to CPAP machines. During an interview on 5/13/26 at 12:21 p.m., LPN-B stated it was the nurse's responsibility to ensure R23's CPAP was working correctly, and the nurses would assist R23 with turning the machine on and off. LPN-B stated she had assisted R23 with shutting the machine off previously. LPN-B went and looked at R23's CPAP machine and confirmed it was the CPAP machine that R23 had since admission. LPN-B reviewed R23's orders and verified the orders did not have any settings. During an interview on 5/14/26 at 10:02 a.m., assistant director of nursing (ADON)-A stated the expectation would be if a resident had CPAP/BiPAP machine, staff would be ensuring the machines were being cleaned appropriately (i.e., masks wiped down, tubing changed, etc), which would be documented on the MAR/TAR. ADON-A stated the orders should include settings. ADON-A stated if the settings didn't come with the admission orders, they could be difficult to obtain but the facility did need to get the correct orders. ADON-A reviewed R15 and R23's electronic medical records. ADON-A verified the facility did not have orders for the setting for either R15 or R23. ADON-A stated the orders should contain the settings and if something happened to the machine or the resident was transferred, the settings need to be known. During an interview on 5/14/26 at 12:55 p.m., director of nursing (DON) stated the orders for CPAP and BiPAP machines should be followed. DON stated she would have to look at the facility policy to answer whether or not the settings for a CPAP or BiPAP needed to be included in the orders. No follow up was provided. A facility policy titled Noninvasive Ventilation, dated 4/1/26, indicated The facility will obtain an order for the use of a CPAP, BiPAP, AVAPS or Trilogy™ device and settings from the practitioner. R51 (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R51's quarterly Minimum Data Set (MDS), dated [DATE], identified R51 received oxygen therapy and used a noninvasive mechanical ventilator. The MDS further identified R51 required substantial to maximal assistance with most activities of daily living and was cognitively intact. R51's physician orders identified prior orders for continuous oxygen at 4 liters per minute (LPM) via nasal cannula or mask to maintain oxygen saturations at or above 90%, oxygen at 2 LPM via nasal cannula while sleeping until CPAP supplies arrived, and CPAP/BIPAP settings of CPAP 16/EPAP 8 with 3 LPM oxygen. Those orders discontinued on 4/24/26 following hospitalization and return to the facility on 4/25/26. R51's May 2026 Medication/Treatment Administration Records (MAR/TAR) identified no active orders for oxygen therapy, CPAP/BIPAP use, oxygen saturation monitoring, or oxygen tubing changes. Review of the April 2026 MAR/TAR identified oxygen tubing and humidifier bottle changes last occurred on 4/19/26 and the treatment discontinued on 4/24/26. R51's care plan, dated 4/29/26, identified R51 had altered respiratory status and required oxygen therapy, including interventions to provide oxygen as ordered and observe pulse oximetry readings. During interview on 5/12/26 at 10:00 a.m., R51 stated when admitted to the facility she used a CPAP with a face mask, but experienced leaking issues and was awaiting a replacement mask and currently used oxygen at night while waiting for CPAP supplies. R51 further stated she did not like when the oxygen tubing fell on the floor and staff did not pick it up, stating they should be providing her with new tubing weekly but that was not happening. During interview and observation on 5/13/26 at 7:33 a.m., R51 stated the night nurse applied oxygen at 2 LPM overnight and licensed practical nurse (LPN)-F removed it that morning. The oxygen tubing, and nasal cannula, was observed lying on the floor while the oxygen tank remained turned on. During interview and observation on 5/13/26 at 9:07 a.m., LPN-E, stated staff completed vital signs daily for R51 and R51's oxygen saturation levels should remain above 90% and R51 should be placed on oxygen at 2 LPM to keep oxygen saturations above 90%. LPN-E picked up R51's oxygen tubing and nasal cannula from the floor, reconnected it to the machine, and placed it directly back on R51. LPN-E was not sure when R51's oxygen tubing was changed. During interview on 5/14/26 at 9:07 a.m., nurse manager and LPN-F, stated staff expectations for residents receiving oxygen included monitoring oxygen saturation levels, verifying oxygen settings, and changing tubing periodically, but could not specify specifically how often. LPN-F reviewed R51's electronic medical record and stated, It is not in here, when unable to locate orders for oxygen flow rate, changing oxygen tubing, or when and how often to use oxygen. LPN-F further stated R51 previously had oxygen orders from 3/10/26 through 4/24/26 because R51 was not wearing the CPAP at night, but she was unsure what happened to the orders after hospitalization and return to the facility. During interview on 5/14/26 at 10:00 a.m., the director of nursing (DON), who also served as the facility's infection preventionist (IP), stated the standard practice was to change nasal cannulas once weekly. A facility policy titled Oxygen Safety, dated 4/1/26, directed staff is how to safely use and store oxygen but did not address the necessity for oxygen orders or the facility policy on how often oxygen tubing should be changed.

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide necessary behavioral health services, trauma-informed care planning, and coordinated mental health support for 1 of 1 resident (R130) reviewed for behavioral health services. The facility failed to implement interventions to address ongoing sanitation and environmental concerns in the resident's room, failed to develop and implement interventions to address R130's identified trauma triggers and feelings related to loss of control over her surroundings, and failed to revise or implement new behavioral health interventions after 10/24/25 despite continued concerns which had the potential to result in unmet psychosocial needs and unsafe living conditions. Findings include:R130's quarterly Minimum Data Set (MDS), dated [DATE], identified R130 was admitted to the facility on [DATE], was cognitively intact with a Brief Interview for Mental Status (BIMS) score of 15, and was independent with most activities of daily living.R130's diagnoses, dated 8/13/25, included bipolar II disorder, post-traumatic stress disorder (PTSD), depression, and anxiety.R130's trauma-informed care screening, dated 8/19/25, identified R130 disclosed she had experienced something traumatic in the past but did not disclose the specifics of the event. The section addressing, what are some things that you do now to help manage consequences of going through difficult/tough times was left blank R130's care plan, dated 8/20/25, identified R130 had post-traumatic stress disorder (PTSD) and trauma but would not discuss specifics and triggers could include a sense that things were outside of her control. The care plan included interventions for staff to assist with calming approaches, including encouraging reading books, validating R130's feelings, and using a professional approach due to R130's perceived ideas that men have often tried to hit on her. However, the care plan lacked specific trauma-informed interventions to guide staff on how to support R130's need to feel in control of her surroundings while simultaneously addressing ongoing sanitation, clutter, food tray, and environmental concerns within the room. Additional care plan interventions, dated 10/24/25, identified R130 was not organizing her room and may benefit from staff support to set up her room and initiate functioning more within a normal range, and questioned whether R130 would benefit from a behavioral contract to assist with cleaning her room if it became problematic. The care plan lacked evidence a behavioral contract or other structured behavioral interventions were implemented to assist with R130 keeping her room clean and organized. Review of R130's care plan lacked evidence the facility updated, revised, or implemented additional interventions related to R130's trauma history, behavioral health needs, refusal of assistance, sanitation concerns, or ongoing room conditions after 10/24/25, despite continued concerns observed throughout the survey.R130's Associated Clinic of Psychology (ACP) notes, dated 8/20/25, identified R130 had a history of sexual abuse by her father and emotional abuse by her husband. Additional ACP notes, dated 10/24/25, identified R130 had multiple outpatient mental health supports. The ACP notes lacked any documentation of a completed behavioral contract regarding R130 keeping her room clean and organized. R130's progress notes identified the last documented social work intervention related to assisting R130 with room organization prior to survey occurred on 10/16/25, when the licensed social worker (LSW) attempted to assist R130 in cleaning her room but R130 appeared asleep and did not wake when prompted. Additional progress notes, dated 10/3/25, identified R130 provided verbal consent for the LSW to enter her room while hospitalized to move items and reduce tripping hazards but did not want assistance organizing or cleaning her room. R130's electronic medical record (EMR) lacked evidence the facility coordinated care, communicated recommendations, or implemented ongoing collaborative interventions with R130's outside mental health providers related to her PTSD, trauma history, room conditions, behavioral concerns, or identified psychosocial needs.During observation on 5/11/26 at 5:05 p.m., R130's room was observed extremely cluttered with a strong urine odor. The floor was not visible due to the number of (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	belongings and clutter throughout the room. Old food trays, cups containing red liquid, milk cartons, and food debris were observed throughout the room. The facility also had concerns related to mice in the building.During observation on 5/13/26 at 7:45 a.m., R130's room contained both lunch and dinner trays from 5/12/26. The lunch tray appeared untouched and contained chicken, vegetables, and a baked potato. The dinner tray contained leftover food.During observation on 5/13/26 at 9:07 a.m., two unnamed housekeeping staff were observed cleaning R130's room while R130 remained present in the room and did not object to the cleaning. The floor contained multiple rusty-red colored stains and the room continued to have a noticeable odor of urine and old food.During interview on 5/13/26 at 10:47 a.m., licensed practical nurse (LPN)-E stated staff attempted to work with R130 regarding the condition of her room and social work was also involved. LPN-E stated R130 wanted to keep her belongings in the room and staff encouraged her to remove food trays when finished eating. LPN-E stated if staff attempted to remove items while R130 was not present, R130 instructed staff not to touch her belongings. LPN-E stated staff often left trays in the room because R130 slept in the mornings and ate later when awake and would eat the food on her trays at her leisure. LPN-E further stated he had no knowledge of R130's trauma history or past abuse and had not received guidance regarding trauma-informed approaches for R130 or other residents. During interview on 5/13/26 at 12:58 p.m., social services designee (SSD)-C stated the facility coordinated with Associated Clinic of Psychology (ACP) providers through referrals, faxes, emails, and weekly meetings and reviewed recommendations to determine whether care plans required updates. SSD-C stated R130 had multiple outside providers and that ACP had been assisting with concerns related to R130's room. SSD-C stated she continued to offer assistance with room organization, including offering boxes and garbage bags, and documented those offers in progress notes, acknowledging the last attempted was documented in October of 2025. SSD-C stated R130 could be resistant to housekeeping and cleaning and staff used repeated approaches as the only intervention. SSD-C further stated she was unsure whether a behavioral contract or risk versus benefit approach had ever been implemented for R130 and stated, maybe ACP did. SSD-C stated R130 made many of her own appointments and often did not involve the facility so there was no coordination with her outside mental health providers. SSD-C further stated she would need to review the record to determine whether R130 had trauma or PTSD and stated she had no knowledge of R130's past trauma history despite those diagnoses and abuse history being documented in the record and ACP notes. During interview on 5/14/26 at 9:07 a.m., third floor nurse manager and licensed practical nurse (LPN)-F stated R130 had a lot of trauma but she did not know the specifics. LPN-F stated R130's prior apartment had also been cluttered and contained roaches and many of R130's belongings were damaged prior to admission. LPN-F stated she did not know whether a behavioral contract or structured intervention existed for R130 and stated the facility had been in between social workers. LPN-F stated nursing assistants reported that is how she likes it regarding the condition of the room. LPN-F further stated she instructed staff to remove food trays or place items in the refrigerator but acknowledged those interventions were not care planned and there was no behavior monitoring in place related to food trays remaining in the room, room cleanliness, odors, or refusal of housekeeping services. LPN-F stated R130 received services from outside mental health providers and medication changes were expected to be faxed to the facility and uploaded into the medical record.During a follow interview on 5/13/26 at 2:41 p.m., SSD-C stated R130 was seen by an outside provider for medication management.During interview on 5/14/26 at 10:00 a.m., the director of nursing (DON) stated concerns related to food trays remaining in R130's room, odors, clutter, and the condition of the floor needed to be balanced with resident rights. The DON stated staff could not just take things out of her room without her permission and stated R130 had the right to keep old food trays and clutter in her room. The DON further stated removing items from the room could trigger her and staff attempted to balance infection control concerns with R130's rights. The DON did not identify specific trauma-informed interventions, behavioral supports, or staff approaches to minimize triggering R130 while addressing the sanitation and environmental concerns in the room.A (continued on next page)

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	245271	A. Building B. Wing	05/14/2026

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	facility policy titled Behavioral Health Services, dated 4/1/26, indicated it was the policy of the facility to, ensure all residents receive necessary behavioral health services to assist them in reaching and maintaining their highest level of mental and psychosocial functioning and well-being.

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide medically-related social services to help each resident achieve the highest possible quality of life. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to ensure medically related social services were provided for 1 of 1 residents (R61) observed who wore mismatched shoes which caused discomfort, despite staff knowledge of the lack of matching shoes.Findings include:R61's quarterly Minimum Data Set (MDS) dated [DATE], indicated R61 had intact cognition and was diagnosed with diabetes, depression, and an amputation. The MDS indicated R61 had no hallucinations, delusions, behavioral symptoms directed towards others, or rejection of care behaviors.R61's care plan dated 5/26/26 indicated R61 had a self-care performance deficit related to a right below-the-knee amputation. The care plan indicated R61 preferred to choose his own clothing and what to wear. The care plan indicated he required moderate assistance with tub/shower transfers, showering/bathing, and lower body dressing.R61's medical record was reviewed, and did not indicate that prior to survey entrance, staff had attempted to assist R61 with finding matching shoes.During an interview and observation on 5/11/26 at 12:04 p.m., R61 was observed sitting in his wheelchair, a black shoe with a thick sole observed on his right leg prosthetic, and a grey shoe on his left foot with a noticeably shorter sole. R61 stated that he didn't have any money, so he was unable to buy matching shoes. R61 stated he had only had the left leg without the right prosthetic for a while, so he had only needed the left shoe. R61 stated he had gotten a prosthetic about a month ago and didn't have a shoe for it, so the prosthetic company had provided one for the prosthetic, but not for his other foot. R61 stated that he wished he had matching shoes to wear, but he didn't. On observation, without opening drawers or doors, no additional shoes of R61's were present. R61 stated that because his shoes were different heights, his legs were different heights, and this caused him hip pain. R61 stated he had talked with staff about not having matching shoes and was sure the social worker knew about it, but no one had done anything to help.During an interview on 5/12/26 at 2:00 p.m., nursing assistant (NA)-J stated he had worked with R61 frequently in the past. NA-J stated that R61 needed a variable amount of help with activities of daily living (ADLs), so sometimes needed help with things like dressing, and sometimes was independent. NA-J stated that when assisting him, he had noticed that R61 did not own matching shoes. NA-J stated that he had assumed the prosthetic needed a special shoe and didn't know if the shoes needed to match or not, so he was unsure if anyone had tried to help him get matching ones.During an interview on 5/13/26 at 12:27 p.m., medical coordinator (MC)-A, from the prosthetic company, stated that it was not their usual practice to provide patients with shoes, but when R61 came in, he didn't have a shoe for his prosthetic, so they provided one solely for the prosthetic. MC-A stated it was better if the patient wore matching shoes and had expected R61 or the facility to obtain them.During an interview on 5/13/26 at 2:23 p.m., registered nurse (RN)-H stated that she had noticed that R61 did not have matching shoes since he came back with his prosthetic about a month ago but did not know if anyone had offered to help him get new ones.During an interview on 5/14/26 at 1:48 p.m., social services designee (SSD)-C confirmed she was R61's social worker and stated she had helped him with things in the past, such as getting new clothing. SSD-C stated that she had noticed that R61 did not have matching shoes. SSD-C stated she was unsure if anyone had offered to help him obtain new shoes before the survey start and confirmed she had not.During an interview on 5/14/26 at 2:57 p.m., with the assistant administrator and the director of nursing (DON), the DON stated that if a resident with a prosthetic needed matching shoes, she would expect the prosthetic company to notify them. The DON stated she was unsure if anyone had reached out to the prosthetic company regarding shoe wear recommendations.A policy regarding social services was requested but not received.

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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 interview and document review, the facility failed to ensure consultant pharmacist (CP) recommendations were acted upon timely for 1 of 5 residents (R129) reviewed for unnecessary medications. In addition, the facility failed to develop and/or implement a procedure outlining follow-up time frame expectations in the drug regimen review process for 1 of 5 residents (R118) reviewed for unnecessary medications. Findings include: R129 R129's admission Minimum Data Set (MDS) dated [DATE], indicated R129 had intact cognition and received high risk medications to include antianxiety and anticoagulant. R129's diagnoses include panic disorder, generalized anxiety disorder, atrial fibrillation, and peptic ulcer. R129's diagnoses lack evidence of diabetes mellitus (DM). R129's provider orders indicated the following: -Dated 3/30/26, Meloxicam Oral Tablet.Give 7.5 mg by mouth two times a day for INFLAMMATORY. R129's provider order lacked evidence of additional instructions to give with food or milk. -Dated 3/30/26, Eliquis Oral Tablet.Give 5 mg by mouth two times a day for Heart. -Dated 3/31/26, Jardiance Oral Tablet.Give 10mg by mouth one time a day for dm2 [diabetes mellitus type 2]. -Dated 3/31/26, Buspirone HCl Oral Tablet.Give 10 mg by mouth three times a day for psych. R129's consultant pharmacy medication review (MRR) dated 3/31/26 included the following: - R129 was taking Meloxicam and NSAID which should not be given on an empty stomach to help prevent upset stomach, ulceration, or bleeding. Recommendation included, Add to the instructions: Give with food or milk. - R129 was taking Jardiance for DM2 which was not listed as one of R129's diagnoses. Recommendation included, Verify and add this diagnosis to the diagnoses list to justify use of the above order. - R129 was taking Buspirone for psych and Eliquis for heart which were not appropriate diagnoses for use of these medications. Recommendation included, Clarify with the provider the diagnosis associated with this medication and update the MAR [medication administration record]. R129's MRR dated 4/29/26 included the following: - R129 was taking Jardiance for DM2 which was not listed as one of R129's diagnoses. Recommendation included, Verify and add this diagnosis to the diagnoses list to justify use of the above order. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- R129 was taking Buspirone for psych and Eliquis for heart which were not appropriate diagnoses for use of these medications. Recommendation included, Clarify with the provider the diagnosis associated with this medication and update the MAR [medication administration record]. R129's MAR dated April 2026, instructed give Eliquis heart, give Jardiance for dm2, give Buspirone for psych, and lacked evidence of administration instructions for Meloxicam. R129's MAR dated May 2026, instructed give Eliquis heart, give Jardiance for dm2, give Buspirone for psych, and lacked evidence of administration instructions for Meloxicam. During interview on 5/14/26 at 12:37 p.m., CP stated would expect medications to be given for appropriate indications or associated with appropriate diagnoses. CP further stated would expect facility to respond to recommendations timely and would not expect to have to re-issue the same recommendation with subsequent monthly reviews. CP stated would have expected R129's medication indications for use would have been updated appropriately by now. During interview on 5/14/26 at 1:22 p.m., director of nursing (DON) stated would expect MRRs with recommendations that could affect resident safety be addressed as soon as possible. DON would not provide a timeframe for expected response for non-urgent recommendations stating, If it is not going to harm the resident, it is not a safety issue and therefore, did not consider lack of appropriate indication or diagnosis a safety concern. DON stated was aware the MRR process had room for improvement. R118 R118's quarterly Minimum Data Set (MDS) dated [DATE], indicated R118 had intact cognition and was diagnosed with respiratory failure and debility. The MDS indicated R118 was independent with most activities of daily living (ADLs). R118's order summary dated 3/10/26, included an order dated 3/10/26 for Nystatin Powder applied topically to the groin in the morning and did not include an end date. R118's pharmacist review dated 3/30/26, indicated R118 had an order for nystatin powder to the groin in the morning for redness. The review indicated antifungals should be discontinued when healing was complete, as prolonged, unnecessary use can cause drug-resistant fungal infections. The review indicated Candida [yeast] rashes typically take one to two weeks to resolve with treatment, so the pharmacist recommended the nystatin powder be discontinued. The review did not include a date by which a response was required. The review indicated no response 4/30/26. During an interview on 5/14/26 at 12:26 p.m., the consultant pharmacist (CP) stated the facility did not have a laid out time frame for when nonurgent recommendations needed to be completed, as it was based on the resident and the specific recommendation, but she would typically expect a provider to respond to a nonurgent recommendation within 60 days. The CP confirmed she did not include a time frame on the recommendation for when she expected a response for nonurgent concerns. Facility policy dated 9/2023, indicated CP would review the medication regimen of each resident monthly and report in writing any irregularities. The policy further indicated follow up timeliness (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	would depend on severity of irregularity and be determined through consultation between the CP and DON.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observation, and interview, the facility failed to ensure food was served at palatable temperatures for 1 of 1 residents (R88) who were observed and served cold food.Findings include: During the lunch dining service at the transitional care unit on 5/12/26 at 12:03 p.m., nursing assistant (NA)-A rolled a meal tray to R88's room to deliver lunch of honey mustard chicken, potato fingerlings, and a mixture of cooked vegetables. Dietary aide (DA)-A temped the food prior to NA-A delivering the tray into R88's room. Results of the temperatures were as follows:Honey Mustard Chicken was 117 degrees Fahrenheit (F)Potato fingerlings were 118 degrees F, andMixed vegetables were 100 degrees F.DA-A stated the chicken was supposed to be 145 degrees and above when we are serving. DA-A stated, I would want the food to be warmer than this when I eat it.During interview with DA-A and cook (C)-A on 5/12/26 at 12:06 p.m., both stated the food sits on the trays too long [before residents are served].During interview with R88 on 5/12/26 at 12:46 p.m., R88 stated, the chicken was cooked but definitely not warm or hot enough for my liking.During interview with dietary manager (D)-MGR on 5/13/26 at 12:38 p.m., D-MGR stated facility struggled with serving food at desirable temperatures because the residents in the dining room were served first and then the staff started plating the food for residents who ate in their rooms. The food was plated and rested on the rolling cart for a lengthy time before it was rolled to each resident. D-MGR stated R88's food lost temperature and it was not desirable to serve food that is 117 degrees.Facility policy titled Food Safety Requirements effective 4/1/26 state, Foods and beverages shall be distributed and served to residents in a manner to prevent contamination and maintain food at the proper temperature.