STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245272	A. Building B. Wing	06/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Martin Luther Care Center	1401 East 100th Street Bloomington, MN 55425

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0577 Level of Harm - Potential for minimal harm Residents Affected - Many	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to post survey results and/or a notice of the availability of such in areas of the facility that were prominent and accessible to the public. This had the potential to affect all 118 residents, families and visitors who may have wished to review the information without having to ask. Findings include: During survey entrance on 6/9/25 at 11:00 a.m., a three-ring binder labeled Survey Results was located on small table in an alcove around the corner inside the main entrance to facility. The receptionist desk had a stone front with a [NAME] and a sign posting Happy Pride Month. Adjacent to the receptionist desk was a partial wall with postings of facility events, calendars, and information. There was no signage or notice posted anywhere in the main entrance including the receptionist desk where individuals wishing to examine survey results did not have to ask to see them. During interview with lead receptionist (F-D) on 6/9/25 at 1:32 p.m., F-D stated, no, there is nothing around here at the desk or on the front of the desk to say anything about the survey results. People [sic] would have to ask me if they want to know where that binder is. During observation on 6/9/25 at 3:15 p.m., a white paper was observed to be taped to the front of the receptionist desk next to the [NAME] stating location of survey results. During resident council meeting discussion with R3, R26, and R32 on 6/10/25 at 10:03 a.m., all stated they were unaware of any kind of posting anywhere at the entrance of the facility to direct residents, staff and visitors of the location of survey results. During observation and interview with R32 on 6/10/25 at 10:25 a.m., R32 pointed to the receptionist desk and stated, See that sign on the left [white paper with directions to survey posting location], that was not there yesterday when I was up here. Someone must have taped it there yesterday but it was not there beforehand. During observation and interview with R319 on 6/10/25 at 1:06 p.m., R319 was sitting in wheelchair and stated, I wheel myself past the front doors several times a per day to smoke. I noticed the sign today and it was not there until yesterday afternoon . I know it was not there until yesterday afternoon. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0577 Level of Harm - Potential for minimal harm Residents Affected - Many	During interview with Administrator, assistant administrator (AA)-A, and administrative intern (AI) on 6/11/25 at 3:13 p.m., AA stated she was unaware of when the posting or notice for the location of survey results was posted at the receptionist desk. AA stated survey binder is in a visible area of the front [main entrance] and did not need to have a notice [informing residents, staff, and visitors of location of survey results]. Facility policy titled Required Postings-State Survey Results with revision date of 6/1/23 directs, Survey results must be: iii. Post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public.

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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 0578 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to ensure written Physician's Orders for Life Sustaining Treatment (i.e., POLST) were accurately entered, transcribed and reflected in the medical record in a timely manner to help guarantee correct resuscitation measures (i.e., DNR or CPR) would be performed in accordance with resident wishes for 2 of 2 residents (R50, R321) reviewed for advanced directives. These findings constituted an immediate jeopardy (IJ) situation for R50 who would have received cardiopulmonary resuscitation measures (CPR) against her declared wishes. The IJ began on [DATE], when R50's POLST, indicating R50's wishes for Do not Resusitate (DNR) was signed by the medical provider and it wasn't changed within the facility' electronic Medical Record (EMR) system (i.e., banner) to reflect R50's wishes. This error was not identified despite multiple opportunities; and a series of interviews with direct care nurses outlined they would implement the incorrect directions and begin CPR on R50 against her wishes due to this error. The assistant administrator (AA)-A, the director of nursing (DON), and several other management and/or corporate staff members (via Teams) were notified of the IJ for R50 on [DATE] at 8:24 p.m. The IJ was removed on [DATE] after a removal plan was implemented; however, non-compliance remained at an isolated scope with potential for more than minimal harm that is not immediate jeopardy (Level D). Findings include: R50 R50's admission Minimum Data Set (MDS), dated [DATE], identified R50 admitted to the care center on [DATE] from the acute care hospital, had intact cognition, and demonstrated no delusional thinking. Further, the MDS identified R50 as having a primary medical condition of, Medically Complex Conditions, along with diagnoses of heart failure, high blood pressure, renal failure or insufficiency, and diabetes mellitus. R50's original POLST, dated [DATE], identified directions which included, Follow these orders until orders change. These medical orders are based on the patient's current medical conditions and preferences. The POLST listed a series of sections to be completed using a marking (i.e., checkmark or X) next to the desired wishes for resuscitation. This identified a checkmark placed next to the options which directed, Do Not Attempt Resuscitation / DNR (Allow Natural Death), and Comfort-Focused Treatment (Allow Natural Death . The form was hand-signed by R50 on [DATE], and the medical provider on [DATE]. R50's progress note, dated [DATE], identified R50 was re-admitted to the care center from the hospital with an admission diagnosis listed, Acute Metabolic Encephalophagy [sic], and a subsequent note, also dated [DATE], identified R50 as having bilateral lower extremity cellulitis and various bruises on her arms, legs, and abdomen. R50's (Hospital) After Discharge Orders, dated [DATE], identified R50's physician orders upon discharge back to the care center. This included, Treatment Options: Full Resuscitation. (continued on next page)

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F 0578 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	R50's subsequent POLST, completed upon her return to the care center and dated [DATE], identified R50's name and had visible markings (i.e., selected) next to the options which read, Do Not Attempt Resuscitation / DNR (Allow Natural Death), and, Selective Treatment . Treatment Plan: provide basic medical treatments aimed at treating new or reversible illness. The POLST was signed by R50 and care center staff on [DATE], and the nurse practitioner (NP)-A on [DATE]. R50's Care Conference Summary - V8, dated [DATE], identified a care conference was held with R50, their representative, social services, and nursing on [DATE]. The summary contained a section labeled, 2. Nursing, which asked a question to be completed by staff which read, 1. POLST and Code Status match[?], which was answered, 1. Yes. The summary outlined R50's advanced directives were reviewed and accurately reflected their wishes with a corresponding answer, 1. Yes. However, R50's facility' electronic medical record (EMR) was reviewed on [DATE] as part of the routine survey process. This EMR contained R50's assessments, progress notes, and other pertinent clinical information used by the staff to provide care for R50 while at the campus. The EMR included a banner along the top of the system which contained medical information such as the patient name, date of birth (DOB), allergies, and included a section labeled, Code Status:, which had adjacent text reading, (Advance Directives [link; click-able]) Full Code. The link included in the banner response labeled, Advanced Directives, brought the user to R50's scanned POLST(s) within the medical record; both of which outlined R50's DNR/DNI wishes. The EMR banner information did not reflect or identify R50's wishes from the POLST, dated [DATE], to be a DNR. On [DATE] at 6:05 p.m., R50 was observed seated in a recliner chair while in her room on the transitional care unit (TCU). R50 had visible, white-colored bandages on both legs along with visible reddened skin on her right thigh and hip which had black-colored marker circling it's perimeter which R50 stated was a skin infection. R50 was interviewed about her current wishes for resuscitation should she be found without a pulse or not breathing. R50 replied, I'm a don't revive [DNR]. R50 stated she didn't want a situation to happen where her family member would have to make decisions about whether to stop life-extending measures after CPR (i.e., potential ventilation, tube feeding) adding, I don't want my [family] to have to unplug me. R50 stated the care center had asked her about these wishes several times and she was frustrated there was potential confusion about it adding aloud, I don't know why it's [DNR] not listed! R50 stated she would be very upset if she underwent CPR against her wishes adding, I wouldn't like it! R50 reiterated she didn't want her family member placed in a situation of whether to end her life if she was hospitalized and on a ventilator after CPR adding, I don't want to put [them] through all that. When interviewed on [DATE] at 6:10 p.m., registered nurse (RN)-B stated they were working on R50's unit and explained if a resident was found without a pulse or not breathing the first step would be check their code status. RN-B stated this was done using the Medication Administration Record (MAR; used to pass medications from mobile laptop on carts), and pointed to an open MAR which listed a resident' name and other various clinical information including a section labeled, Code Status, with corresponding directions (i.e., Full Code, DNR). RN-B verified the MAR is where they'd check for a code status and respond accordingly adding aloud, We go here [MAR]. RN-B stated the health unit coordinator (HUC) was responsible to enter resident' POLST information into the EMR and nurses were not routinely auditing it to their recall adding, The HUC [does]. RN-B stated it was important to ensure the code status matched the POLST adding if they were mis-matched then someone could get the wrong resuscitation efforts performed. RN-B added, Chances are [they would]. (continued on next page)

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F 0578 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	When interviewed on [DATE] at 6:14 p.m., RN-C verified they were working on R50's unit, and stated if a resident, including R50, were found without a pulse or not breathing then staff would immediately assess them adding if it was a 911 issue then they would ask the charge nurse(s) for help to get them transferred to the hospital. RN-C stated they would immediately start CPR on the resident if their code status directed. RN-C stated they checked for a code status using the MAR and pointed to an open example on their computer screen adding, This [pointing] is where you find it [status]. RN-C stated the code status was not kept anywhere else to their knowledge, and expressed they were unsure whom or how the code status information on the MAR gets updated with changes adding aloud, I don't know. RN-C explained a POLST was obtained for every resident upon admission or re-admission from the hospital if they were absent over 24 hours; and the physician typically would sign it the next time they're onsite. RN-C stated the HUC was responsible to check the accuracy for the information within the EMR and MAR, and RN-C verified the POLST and EMR should match. On [DATE] at 6:18 p.m., RN-D was interviewed, and verified they were currently assigned to care for R50. RN-D stated if R50 was found without a pulse or not breathing then they'd check her code status using the MAR and, if needed, begin CPR adding aloud, We do the CPR. RN-D reviewed R50's MAR screen with the surveyor and verified it directed to perform CPR on R50 with text reading, Full Code. The MAR lacked the click-able hyper-link to R50's POLST(s) as is present within the actual EMR system. RN-D stated since 'Full Code' was outlined, then staff do everything to try to resuscitate her including CPR with chest compressions. RN-D stated the HUC was responsible to enter the POLST information into the EMR and expressed, at least to their knowledge, the nurses were not auditing this adding, They [management] have never told us to. RN-D stated they were unsure who, if anyone, double checks entered resuscitation wishes once entered into the EMR system either adding aloud, For that one, umm, not sure. RN-D then left R50's MAR and entered into the EMR system which had the POLST(s) scanned into it. RN-D reviewed R50's most recent POLST (dated [DATE]) and verified it was signed with wishes for DNR/DNI. RN-D stated it was likely not updated in the EMR/MAR when it was signed and should have been; however, RN-D verified they would have performed CPR on R50 as directed by the MAR until seeing the signed POLST as pointed out by the surveyor. (continued on next page)

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F 0578 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	When interviewed on [DATE] at 6:29 p.m., the clinical services coordinator (CSC)-A verified they were responsible to manage the HUC staff. CSC-A explained the HUC would typically be the person to enter the POLST information into the EMR, however, if on a weekend then a nurse could do it, too. CSC-A stated when a POLST is obtained, then a corresponding order gets entered and it was important for every place with the information to match so there's no misunderstanding or what not. CSC-A stated the nurses should be checking the entered information about code status after the HUC to ensure it is accurate adding, Well, they're supposed to. CSC-A stated they had just recently started a check off sheet to audit code status within the EMR to ensure it matched the POLST for new admissions. CSC-A provided this orange-colored sheet and verified it started on [DATE], adding they had not been directed to go back and include residents who admitted prior to [DATE] (such as R50). CSC-A verified all POLST(s) were scanned into the EMR system, and none were kept within the hard chart or any other locations to their knowledge. CSC-A reviewed R50's medical record, including POLST(s) and EMR/MAR, and verified they didn't match. CSC-A expressed, That is not good. CSC-A stated when the POLST was signed on [DATE], the nurses should have obtained a corresponding telephone order from the provider which would be kept within the hard chart. CSC-A then retrieved and examined the hard chart but was unable to locate this telephone order expressing the nurses should have had it written in. CSC-A reiterated the nurses should be double-checking to ensure POLST(s) and the EMR match when POLST information is entered by the HUC. CSC-A acknowledged the potential for R50 to receive CPR against her wishes due to the mis-matched information adding aloud, She would be revived when she doesn't want to be, which is not good. CSC-A stated the mis-matched code status information could also cause confusion about treatment as the nurses wouldn't know which one [instructions] to follow. CSC-A stated they would immediately send an email to the medical provider to get this resolved adding, Thank you for catching that. On [DATE] at 7:14 p.m., the director of nursing (DON) and unit nurse manager (RN)-E were interviewed. DON explained R50 admitted in [DATE] for wound care and was hospitalized in [DATE] before returning to the campus on [DATE]. DON verified a new POLST was then obtained, and a corresponding telephone order was received from the NP on [DATE]. RN-E then provided it for review. R50's sheet which was labeled, Physician's Orders, and had three handwritten orders on it. This included, [DATE] [space] DNR/DNI, and was recorded as a telephone order from NP-A. The order had two separate sets of hand-written initials next to the order. (continued on next page)

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F 0578 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	DON and RN-E both verified the DNR wishes were not updated in the EMR when this POLST was obtained. DON stated if a resident was found without a pulse or not breathing, then staff should be clicking the 'Advanced Directives' link in the EMR to review the POLST for instructions. However, when questioned on the lack of that link on the MAR system, DON and RN-E pulled up the MAR to observe. They both verified it lacked the click-able link to take nurses to the POLST(s) in the EMR and just had immediate directions listed (i.e., Full Code) adding, It just says code status. DON verified the two staff initials present on the signed order (dated [DATE]) was supposed to mean it was checked for accuracy within the EMR system. DON acknowledged the likelihood of R50 getting CPR against her wishes based on the error adding, You're not wrong. DON explained a similar situation happened several months prior where a resident received CPR against their wishes at the campus and, as a result of that, they changed their process to check code status and POLST(s) for matching information around the end of [DATE]; however, the DON verified they had never directed staff to go to admissions prior to that and check for accuracy. DON stated they were unsure if anyone else had, either, adding aloud, I have no idea. DON stated it was important to ensure the POLST and EMR system matched adding, We don't want people to not get their choices honored. DON and RN-E both verified they would have started CPR on R50 if she had been found without pulse or not breathing based on the MAR instructions directing such, and the DON expressed they felt the error was due to the nurses not checking the code status orders in the EMR after they were obtained. DON expressed, That's the point of the two-check system, adding further, It's unfortunate [this happened]. On [DATE] at 11:52 a.m., NP-A was interviewed, and verified they were involved with R50's care at the campus. NP-A stated R50 had a history of cellulitis, history of cardiac disease, and stasis ulcers adding the wounds on her legs were unlikely to ever heal. NP-A described R50 as having several co-morbidities with her care and medical conditions. NP-A stated R50's wounds could deteriorate quite quickly and cause the need for hospitalization. NP-A stated they had been involved with R50's care since she admitted back in [DATE], and expressed she was a DNR/DNI the entire time to their knowledge adding aloud, I don't think she's changed her mind [about that]. NP-A stated the care center nurses obtain a POLST upon admission and then the providers would address it when here [onsite] next adding often times the staff would wait for it to be signed before it was accepted (i.e., implemented). NP-A stated they felt R50's chances of successful resuscitation if she was found without pulse were pretty limited, however, expressed R50 was older in age and, as a result, was at higher risk for any post-CPR issues such as fluid in the lungs or broken ribs. NP-A reiterated R50 as being unlikely to survive CPR but then added, I've been wrong before too. A facility provided Cardiopulmonary Resuscitation (CPR) (Code Blue) policy, dated 6/2024, identified licensed staff would be certified in CPR so they could respond appropriately to victims of cardiac arrest. A procedure was outlined which directed, All residents, upon admission, will have their code status (CPR or DNR) reviewed and placed as a Physicians Code order . CPR or DNR (Do Not Resuscitate) stipulations will be recorded on the POLST form and after completion of Section B and signature by MD/GNP [medical provider] will be filed under the advance directive tab in the chart. The policy continued, Code status physicians orders will be verified prior to initiating CPR. Verification of full code status should not significantly delay initiation of CPR. The policy directed CPR should be performed on a resident unless they have clinically irreversible signs of death (i.e., decapitation) or, The patient has a Do Not Resuscitate (DNR) order is in place. However, the policy lacked any further information on where staff should go to obtain the most recent code status order (i.e., MAR, EMR, POLST) in an emergency situation. (continued on next page)

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F 0578 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The IJ which began on [DATE] was removed on [DATE] after an acceptable removal plan was implemented. This plan included updating R50's code status to accurately reflect her wishes (i.e., DNR) in the EMR system; completing a whole-house audit of resident' code status(s) to ensure the POLST and EMR system information matched; and starting to educate staff on their policy and/or process to ensure no further mismatched information on resident' code status occurred. The removal plan was verified as having been implemented on [DATE], with multiple staff interviews outlining education had been started and was ongoing, and R50's EMR information being updated to reflect her current wishes for DNR/DNI. R321 R321's entry MDS was [DATE]. An admission MDS had not been completed at this time. R321's face sheet indicated R321 admitted to the facility on [DATE]. R321's diagnosis sheet included the following diagnosis: parkinsonism (a clinical syndrome characterized by tremors, rigidity and postural instability), restless legs syndrome, bipolar disorder (a disorder associated with episodes of mood swings ranging from depressive lows to manic highs) and unspecified symptoms and signs involving cognitive functions and awareness. R321's Provider Orders for Life-Sustaining Treatment (POLST), signed by R321 on [DATE], identified R321 wishes where Do Not Attempt Resuscitation/DNR (Allow Natural Death) which was indicated by a check mark in a box in section A. Section B indicated R321's wishes were selective treatment which would not include intubation, advanced airway interventions or mechanical ventilation. The provider signed the document on [DATE] (three days after resident's wishes were known). During an interview on [DATE] at 6:30 p.m., registered nurse (RN)-B verified that they were responsible for R321's care as they were the nurse responsible for R321's this shift. RN-B reviewed R321's electronic medical record (EMR) and stated R321 was a full code. RN-B stated that if R321 was found unresponsive we would call 911 and do everything possible, including CPR. RN-B stated they were trained to look at the banner in the EMR for a resident code status in an emergency. RN-B stated R321 should have a POLST in the chart but was unsure where to find it and re-iterated, we go by the banner in the chart in an emergency. RN-B stated again, we would start CPR on her since she is full code. During an interview on [DATE] at 7:02 p.m., R321 stated that if her heart were to stop, she has made it clear to staff to just let me go and stated I don't want them to do anything. R321 stated she had signed a document that indicated this. R321 stated she would be very upset if CPR was performed on her in an emergency and she wouldn't feel very good about it. R321 stated, I have stated my wishes clearly. During an interview on [DATE] at 7:31 p.m., registered nurse manager (RN)-E stated R321 was listed as a full code as the provider signed the POLST today ([DATE]). RN-E stated even if a resident signed a POLST, it would not be active until the provider signed it, even if it was days later. RN-E verified R321 signed the POLST on [DATE], indicating her wishes were to be DNR, however she continued to be listed as FULL code until [DATE] when the provider signed the POLST. RN-E again stated, it is not an active order until the provider signs it. (continued on next page)

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F 0578 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] at 11:52 a.m., NP-A was interviewed, and verified they rounded on the transitional care unit (TCU) often. NP-A stated the care center nurses obtained a POLST upon admission and then the providers would address it when here [onsite] next adding often the staff would wait for it to be signed before it was accepted (i.e., implemented). NP-A stated they were aware the nurses also called and obtained a telephone order for code status despite the POLST, and expressed in my opinion a signed POLST would be an order. NP-A acknowledged with the current process a POLST could sit for a little bit before getting a provider signature, and expressed the nurses could send it to triage for a signature, too. NP-A stated they were unaware of the triage providers being unwilling to sign POLST(s). During an interview on [DATE] at 12:48 p.m., director of nursing (DON) verified that she had not talked to the medical director about the triage providers not wanting to sign POLSTs without seeing the residents which caused the lapse in POLSTs being signed prior to the immediate jeopardy. DON stated it had now been addressed. A facility provided Cardiopulmonary Resuscitation (CPR) (Code Blue) policy, dated 6/2024, identified licensed staff would be certified in CPR so they could respond appropriately to victims of cardiac arrest. A procedure was outlined which directed, All residents, upon admission, will have their code status (CPR or DNR) reviewed and placed as a Physicians Code order . CPR or DNR (Do Not Resuscitate) stipulations will be recorded on the POLST form and after completion of Section B and signature by MD/GNP [medical provider] will be filed under the advance directive tab in the chart. Furthermore, the document lacked identification to obtain a provider order (i.e., verbal order) in a timely fashion to ensure the resident's wishes are honored after their wishes have been identified.

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F 0583 Level of Harm - Potential for minimal harm Residents Affected - Some	Keep residents' personal and medical records private and confidential. During observation and interview, the facility failed to implement interventions to ensure resident's personal care information was kept secured and out of public view when stored on 2 of 4 facility units with mobile medication carts. This had the potential to affect 9 of 9 residents (R8, R106, R110, R173, R174, R177, R325, R326, and R330) on the transitional care unit, and 3 residents (R70, R88, and R99) on the long-term care unit whose private and personal information was left unattended on medication carts left out in the hallway corridor. Findings include: During continuous observation and interview on 6/9/25 at 12:29 p.m. to 12:37 p.m., on the transitional care unit of facility, an unattended medication cart with visible care sheet exposing TEAM 4 NURSES CENSUS SHEET including columns with resident name, room number, diagnoses, bath days, diet orders, nursing care notes, skin impairment and labs. This included 9 residents. Housekeeper (HK)-A walked past the unattended care sheet and stated, I know the patient information should not be showing. In addition, there were thirteen instances of staff walking past the unattended care sheet and one instance where a resident was being transported in a wheelchair past the unattended cart. At 12:37 p.m., licensed practical nurse (LPN)-A approached the unattended med cart and stated, [care sheet] should not have been left like that. People can see the names and information for these people [pointing to the care sheet] and it is a HIPAA issue. During continuous observation and interview on 6/9/25 at 5:36 p.m., on the long-term care unit, registered nurse (RN)-A walked away from medication cart with visible care sheet titled Fox Crossing Group 3 Nurse Report Sheet left unattended and exposing R70, R88, and R99 personal information. RN-A had medications in a medication cup and walked into another residents' room. During this time two staff walked past the medication cart. At 5:42 p.m., RN-A returned to the medication cart and stated, It is not my info sheet. I don't know whose sheet that is. It should be covered. In addition, RN-A stated, [patient information] not supposed to be visible because of HIPAA law and private information. During interview with RN-B on 6/9/25 at 6:26 p.m., RN-B stated expectation of staff to ensure resident care sheets are covered at all times, for privacy and HIPAA purposes. Resident information is there. During interview on 6/10/25 at 8:59 a.m., trained medication aide (TMA)-A stated expectation of nursing staff, to lock cart and lock [computer] screen for HIPAA. Care sheets should not be left unattended due to HIPAA privacy. Facility policy titled Confidentiality and HIPAA Compliance effective date of 10/24, identified all resident information remains confidential and protected from unauthorized access or disclosure.

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	245272	A. Building B. Wing	06/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Martin Luther Care Center	1401 East 100th Street Bloomington, MN 55425

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to ensure voiced complaints about nursing services were acted upon and, if needed, investigated or resolved for 1 of 1 resident (R57) reviewed who complained staff were placing two incontinent products on them at night, and they did not want a particular staff person to help with certain cares. Findings include: R57's admission Minimum Data Set (MDS) dated [DATE], indicated R57 had intact cognition and did not have hallucinations or delusions. R57 rejected care daily. R57 was dependent on staff for toileting hygiene, dressing, rolling left and right and transfers. R57's diagnoses included heart failure, hypertension, coronary artery disease, atrial fibrillation, chronic kidney disease, diabetes mellitus, hip fracture, Parkinson's Disease, malnutrition, anxiety, and depression. During interview on 6/9/25 at 2:35 p.m., R57 stated staff often turned off her call light but did not help her with what she needed. R57 stated staff double briefed her multiple times with two incontinent products. R57 stated she told the staff they were not supposed to double brief her but they did so anyways. R57 stated she felt one staff member was angry working with her and moved her around without communicating to her a few months ago. R57 stated she was able to avoid the staff member assisting her with a shower, but the staff member still assisted her with other cares. R57 described the situations as disturbing. R57 stated floor staff, a nurse manager, and therapy staff were aware of the described situations. R57's progress notes lacked documentation to show R57's concerns were acted upon, investigated as needed, or resolved. The facility's Grievance Log entry dated 4/17/25, indicated R57 filed a verbal grievance related to care concerns and the nurse manager addressed the concerns. During interview on 6/12/25 at 9:36 a.m., the director of therapy (DT) reviewed notes from occupational therapy and stated there were notes which indicated R57 was observed double briefed and soiled. R57's Occupational Therapy Treatment Encounter Note(s) indicated: -5/29/25, R57 lacked awareness of soiled brief and bedding. Therapy staff assisted R57 with brief change and educated patient to use call light once awake for brief change to maintain skin integrity. -6/2/25, R57 was soiled through double briefs and nurse manager was notified. R57 was educated on using call light and requesting brief change as soon as wakes in the morning. Therapy assisted R57 with brief change and bed mobility. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 6/12/25 at 10:20 a.m., nursing assistant (NA)-K stated R57 expressed concerns about being double briefed to them, and NA-K observed her double briefed. NA-K stated they did not report R57's concerns to anyone else, because R57 stated the nurse manager was already aware. NA-K stated R57 asked them to be switched to a morning shower, since R57 did not want a named nursing assistant to work with her. NA-K stated they mentioned the request to the evening shift. During interview on 6/12/25 at 10:47 a.m., registered nurse (RN)-O stated residents were not supposed to be double briefed and was not aware of any related concerns, nor was RN-O aware R57 did not want a certain staff member to work with her. During interview on 6/12/25 at 1:00 p.m., nurse manager, RN-I, stated they spoke with R57 about concerns related to staff not providing timely assistance and pulled call light reports but were not aware R57 had concerns related to being double briefed. RN-I stated residents who were double briefed had a risk for skin breakdown. RN-I stated they were not aware R57 had concerns with a certain staff member, and further stated the facility process was to fill out a grievance and self-report if needed when a resident reported a concern. During joint interview on 6/12/25 at 1:49 p.m., the administrator and director of nursing (DON) stated they had a formal grievance process for resident concerns, if the concerns were not able to be addressed right away. Staff were able to fill out a grievance form or escalate the concern to the supervisor. The administrator and DON were not aware of R57's concerns. During interview on 6/12/25 at 2:01 p.m., the administrator stated R57's listed grievance dated 4/17/25, was related to spiritual care. The administrator stated they did not have a grievance related to R57's concerns and expected R57's concerns to be addressed via grievance form. The facility's Grievance Policy revised October 2024, indicated all residents or representatives have the right to voice concerns, complaints, or grievances regarding their care or any other matter. The grievance process ensured grievances were investigated thoroughly, tracked, and resolved promptly, with outcomes communicated clearly. The facility designated the administrator as the grievance official. The policy indicated residents could file grievances orally or in writing. When staff received a formal grievance, they documented on the Formal Grievance/Concern Form and promptly forwarded to the grievance official. The grievance official then ensured appropriate departments were notified and involved in investigation, logged grievance into facility's grievance log for tracking and monitoring, and attempted to respond verbally or in writing to the resident or representative within seven business days.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document reivew, the facility failed to ensure care planned interventions were followed for 1 of 1 resident (R57) reviewed for weight gain. Findings include: R57's admission Minimum Data Set (MDS) dated [DATE], indicated R57 had intact cognition and did not have hallucinations or delusions. R57 rejected care daily. R57 was dependent on staff for toileting hygiene, dressing, rolling left and right and transfers. R57's diagnoses included heart failure, hypertension, coronary artery disease, atrial fibrillation, chronic kidney disease, diabetes mellitus, hip fracture, Parkinson's Disease, malnutrition, anxiety, and depression. R57's care plan revised 6/9/25, indicated R57 had daily weights and directed staff to notify the provider for weight gain of more than three pounds per day or five pounds per week. R57's Weight Summary indicated: -5/31/25, 170 pounds with mechanical lift. -6/1/25, 170.4 pounds with Hoyer lift. -6/2/25, 171 pounds with Hoyer lift. -6/3/25, 172.2 pounds with mechanical lift. -6/4/25, 173.4 pounds with mechanical lift. -6/5/25, 175 pounds with mechanical lift. -6/6/25, 173.3 pounds with mechanical lift. -6/7/25, 175.6 pounds with mechanical lift. More than five pounds since 5/31/25. -6/8/25, 175.7 and 175.8 with mechanical lift. More than five pounds since 6/1/25. -6/10/25, 176.3 pounds with mechanical lift. -6/11/25, 177 pounds with sitting and mechanical lift. -6/12/25, 177.6 pounds with mechanical lift. R57's medical record lacked documentation related to notifying physician about weight gain. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 6/12/25 at 10:20 a.m., nursing assistant (NA)-K stated R57 needed a daily weight, and nursing assistants documented the daily weights. NA-K stated R57's lower leg swelling increased and decreased and was not consistent. During interview on 6/12/25 at 10:47 a.m., registered nurse (RN)-O stated they followed given parameters to notify providers about increased weight or edema. RN-O stated R57 would let nursing know if she had concerns about her weight or edema. During interview on 6/12/25 at 12:29 p.m., the dietician (DD) stated the interdisciplinary team worked together to monitor weights and discussed weight concerns in their morning meetings. DD stated they worked with nursing to investigate if residents looked like they had fluid retention if they gained weight or other concerns. DD reviewed R57's weights and acknowledged the weight gain. DD stated they will put R57 on their radar. During interview on 6/12/25 at 1:00 p.m., nurse manager, RN-I, reviewed R57's weights and expected staff to write a progress note to indicate they notified the provider about weight concerns and another progress note to indicate the provider's response. The facility's Individualized Care Plan dated policy dated 1/22/25, indicated a comprehensive care plan was created with comprehensive assessments and individualized to reflect resident's functional capacity and medical, nursing, psychosocial, activity, and other identified needs.

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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 and grooming (i.e., nail care, hair care, beard trimming) was provided for 2 of 3 residents (R20, R25) reviewed for activities of daily living (ADLs) and whom were dependent on staff for their care. Findings include: R20 R20's quarterly Minimum Data Set (MDS), dated [DATE], identified R20 had moderate cognitive impairment but demonstrated no delusional thinking or rejection of care behaviors. Further, the MDS outlined R20 required substantial assistance with personal hygiene cares. On 6/9/25 at 2:35 p.m., R20 was observed lying in bed while in his room. R20 had a meal tray placed on a bedside table over him while lying down, and he had rice and beans spilled onto his chest. R20's fingernails were observed and multiple nails had a visible, dark-colored substance or debris present under the edge of the nail to the nail bed. R20 was asked about his bathing and grooming at the care center and responded aloud, Bed Bath. R20 looked at his nails when asked about them and expressed he was unsure when they were last cleaned or clipped with an audible, I don't know. The following day, on 6/10/25 at 12:45 p.m., R20 was again observed lying in bed while in his room. R20's fingernails remained with visible dark-colored debris underneath of them as was observed the day prior. R20's care plan, dated 3/2025, identified R20 had an ADL self-care deficit due to limited mobility and weakness. The care plan listed multiple interventions for R20 including assistance of one with bathing and, PERSONAL HYGIENE: Requires assistance by 1 staff with personal hygiene and oral care. R20's most recent Weekly Bath and Skin Sheet - V4, dated 6/5/25, identified R20 received bathing and his skin was intact. The form outlined a section labeled, Nail Care, select all that apply, with options for staff to select from using a checkmark. This recorded a response, 3. Finger nails short and smooth; do not need trimming. However, the form lacked options to record the nail cleanliness or if they were offered to be cleaned. On 6/11/25 at 10:03 a.m., R20 was observed in bed. R20's fingernails remained soiled with visible, dark-colored debris and/or substance underneath multiple nails which had been observed since two days prior (on 6/9/25). Immediately following, on 6/11/25 at 10:06 a.m., nursing assistant (NA)-L was interviewed, and verified they had worked with R20 prior. NA-L explained R20 was bathed every week on Thursday morning and his fingernails should be clipped by the nurses if he was diabetic. NA-L verified there were clippers and a file to use for residents nail care, if needed. NA-L then observed R20 lying in bed at the request of the surveyor. NA-L verified their condition and expressed, It's dirty. NA-L stated R20's fingernails needed to be cleaned and the aide could do that task using an edge device they had. NA-L stated nails would be cleaned on R20's bath day, however, expressed if noticed to be soiled then they could be cleaned whenever adding, If you see it [can be cleaned]. NA-L stated clean nail beds and edges were important to reduce the risk of infection and general hygiene. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	When interviewed on 6/11/25 at 10:32 a.m., registered nurse (RN)-K stated they had worked with R20 only once or twice prior. RN-K explained the nurses would do nail clipping for R20 since he was diabetic, but the aides could clean his nails if they were found soiled. RN-K stated nails were cleaned on bath day but could be cleaned anytime they're noticed to be soiled adding aloud, As needed as well. RN-K stated any attempt to clean them, including if R20 refused it, should be documented in the medical record. RN-K stated having clean nail beds and edges was important to reduce bacteria on the hands and hygiene as well. R20's medical record was reviewed and lacked evidence R20 had been offered or had completed any nail care, including cleaning of them, since 6/5/25 despite being observed multiple days in a row with soiled nail beds and edges. On 6/11/25 at 11:08 a.m., unit manager (RN)-E and the director of nursing (DON) were interviewed. DON explained nail cleaning should be done on bath day and if refused, it should be recorded in the medical record. DON stated the aides could clean nails whenever noticed they needed it, too. This was important for personal hygiene care. A facility provided AM Cares policy, dated 4/25, identified all residents would be provided with assistance, as needed, for morning cares unless otherwise directed by the care plan. The procedure listed steps for the care including, 19. Nails are clean and trimmed to resident desired length. In addition, a provided Nails, Care Of policy, dated 9/2022, identified a purpose of providing cleanliness and preventing infection spread. The policy directed, 5. Complete nail care on bath day and as needed. R25 R25's admission Minimum Data Set (MDS) dated [DATE], indicated R25 was cognitively intact, had no hallucinations, delusions, and didn't refuse personal cares. MDS indicated R25 received maximal assistance with toileting hygiene, bathing, sit to stand and was dependent with transfers. MDS also indicated R25 received moderate assistance with personal hygiene, dressing and received set up to eat, and oral hygiene. R25's Medical Diagnosis record printed 6/12/25, indicated diagnoses of acute respiratory failure with hypoxia (low level of oxygen in the blood), atrial fibrillation (irregular heart rhythm that can lead to blood clots in the heart), type II diabetes, hemiplegia (paralysis of one side of the body) and hemiparesis (weakness or the inability to move one side of the body) following cerebral infarction affecting right dominant side, and muscle weakness. R25's Activities of daily living (ADLS) care plan printed 6/12/25, indicated R25 had self-care performance deficit related to weakness, respiratory failure, obesity, right side weakness from previous cerebral vascular accident (damage to the brain from interruption of its blood supply). R25's care plan indicated he needed assistance of one staff with bathing/showering, and personal hygiene. During observation and interview on 6/9/25 at 1:05 p.m., R25 was in bed. R25 had long dull hair separated in locks and had long disheveled mustache and beard. R25 stated staff used shampoo caps, no water to wash his hair and staff had not offered to help trim his beard. R25 stated he had a big hair knot on the back of his head and staff had not helped him to untangle his hair. R25 added Later today, I will have a bath. We will see how I will look tomorrow. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During observation and interview on 6/10/25 at 1:35 p.m., R25 stated last night the staff used a shampoo cap (a hair cap that contains a dry substance) but staff didn't do a good job and still had the hair knot on the back of his head. The staff member only rubbed the top of his head two to three times, and it was done. Staff didn't offer to help him with his beard. R25's hair looked dull and R25 stated his hair didn't feel clean. During observation and interview on 6/10/25 at 1:42 p.m., registered nurse (RN)-J observed R25 and stated he [R25] looks sweaty, his hair is greasy, and his beard should be trimmed. RN-J added his mustache was growing over his lower lip. R25 stated Today, for the first time in three months I looked at myself in the mirror and eek. During interview on 6/10/25 at 1:48 p.m., nurse manager/registered nurse (RN)-I stated residents should be helped to shave and the clinical services coordinator (CSC) should schedule a haircut appointment. During interview on 6/10/25 at 1:52 p.m., CSC-A stated scheduling a hair cut will depend on the resident . CSC-A added, sometimes the social workers will start the process, including talking to the residents and making the hair appointment for them. During interview on 6/10/25 at 1:55 p.m., social worker (SW)-A stated R25 moved two weeks ago to her unit, and last week RN-I informed her R25 wanted a haircut, and his beard trimmed. SW-A stated social workers were responsible to schedule hair appointments. SW-A stated residents' personal appearance was important for dignity and quality of life. During interview on 6/12/25 at 9:11 a.m., director of nursing (DON) stated residents' hair should be brushed every day and washed on shower days. DON stated if residents' preference was to received sponge baths instead of showers, their hair could be washed with shampoo and water in bed. DON stated hair shower caps should not be used on regular bases. DON stated washing residents' hair and shaving were important for hygiene and dignity. Facility's policy titled AM cares (morning cares) dated 4/25, indicated all patients were provided with set up, assistance, or total assistance for AM (morning) cares unless the plan of care states otherwise.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 comprehensively assess and develop a bowel management program to meet voiced needs and wishes for 1 of 1 residents (R8) who needed digital stimulation; failed to ensure physician orders for diabetic monitoring devices were acted upon and implemented timely to prevent unnecessary distress (i.e., finger sticks, pain) for 1 of 1 residents (R8); failed to ensure a developed skin condition was assessed and appropriately treated for 1 of 2 residents (R1); failed to ensure a request for diet modification was appropriately and timely referred for evaluation for 1 of 1 resident (R57); and failed to ensure medical devices were consistently applied to reduce edema for 1 of 1 resident (R10) reviewed for edema management; and failed to recognize and comprehensively assess a resident's hearing concerns resulting in a delay in identification and treatment of cerumen (earwax) impaction for 1 of 1 resident (R11) reviewed who had difficulty with hearing. Findings include: BOWEL MANAGEMENT: R8's admission Minimum Data Set (MDS), dated [DATE], identified R8 had intact cognition and demonstrated no delusional thinking. The MDS recorded R8 as having a history of traumatic spinal cord dysfunction with quadriplegia, and also being frequently incontinent of bowel. R8's Bowel and Bladder Assessment - V3, dated 5/12/25, identified R8 was incontinent of bowel and demonstrated no observed patterns. The evaluation contained a section labeled, Bowel, but this was left blank and not completed. A subsequent section labeled, Bowel Planning, had areas to mark what, if any, interventions would be done or added to the care plan. However, this just had a single checkmark next to an option which read, Focus: Has bowel incontinence ., and no interventions were selected. On 6/9/25 at 2:01 p.m., R8 was observed lying in bed while in her room. R8 stated she was a quadriplegic and was having ongoing frustrations with her bowel management at the care center. R8 explained at home she used to have someone help her with digital stimulation (technique used to help empty the bowel by manually stimulating the rectum) which worked the best to help her avoid feeling bloated. R8 stated she had tried multiple laxatives and they just do not work well. R8 explained she had ask care center staff to help her with digital stimulation, however, they told her doing that was against their policy and couldn't be done so, as a result, a bunch of laxatives were ordered and those just stay in my body without offering relief. R8 reiterated she needed someone to help her with digital stimulation to most effectively empty her bowels and voiced frustration with repeatedly being told by staff we don't do that. R8 stated the rationale she was provided by the staff was doing that technique was like an invasion or something [bodily privacy]. R8's medical record was reviewed, and a series of medical provider note(s) and/or orders were identified. These included: (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R8's Standing Orders for Skilled Nursing Facilities, undated, outlined the orders listed on the document applied to patients in skilled nursing facilities (SNF) and outlined actions nursing staff could take for various scenarios. This included a section labeled, Constipation (Perform steps sequentially), and listed a first step reading, 1. Consider rectal check to determine if impaction is present. On 5/8/25, a Comprehensive Visit was completed by the nurse practitioner (NP) for R8's initial assessment to the care center. The evaluation outlined R8 had been hospitalized for a wound and outlined R8's hospital discharge summary which included, Neurogenic bladder/bowel . *Urinates via urostomy. Uses rectal stimulation every other day for BM [bowel movement] . patient care order for digital stimulation every other day entered. The NP note included a section labeled, Assessment and Plan, which outlined, - bowels regimen - pt [patient] has established regimen with dig/stim and does not tolerate meds well - will check with staff regarding ability to meet with her and establish routine. On 5/12/25, a physician order was placed in the hard chart which directed no enemas and, [2] Start rectal stimulation along with manual removal of feces every other day when diarrhea symptoms resolve. On 5/19/25, a Follow-up Visit note was completed by the NP. The evaluation outlined, Since last visit, [R8] reports frustration with the bowel regimen at the [care center]. Nurse manager reports they are unable to provide dig stimulation and manual removal of stool. [R8] reports she has been waking up every day with various amt [amount] of [NAME] in her pad because of not getting her routine/she is concerned about skin breakdown . [R8] notes at home that she has a good routine established with her PCAs [aides]. The evaluation including a section labeled, Assessment and Plan, which outlined, . [R8] frustrated by facility being unable to accommodate her bowel regimen. Several other options offered - laxatives, dulcolax suppository . does not want enema unless pink lady which not available per facility . she prefers to get home as soon as possible. On 5/21/25, a series of physician orders were placed. These included, Recommend dulcolax supp now and can repeat tomorrow if no BM, and again, If facility will do dig stim - this would also work with dulcolax supp. In addition, a hand-written order outlined to give Sennosides (laxative) 8.6 milligrams (mg) two tablets orally everyday for three days as needed (PRN). On 5/25/25, a handwritten order was recorded which directed to give Miralax (another laxative) 17 g (gram) every day for constipation. On 5/27/25, a set of orders were obtained which outlined PRN orders for a docusate sodium enema and a bisacodyl suppository for constipation. The order concluded with, 4. If not success from enema - can administer bisacodyl 5 mg tablet - take 1 [by mouth] daily as needed for constipation. On 5/30/25, a Follow-up Visit noted was completed by the NP. The evaluation outlined, Since last visit, [R8] notes ongoing frustration with her bowel management. She had several bowel meds over the past week without any success. She reports over a week since last BM. She notes requiring dig/stimulation in order for bowel movement and facility reports they are not able to perform this activity. The evaluation including a section labeled, Assessment and Plan, which outlined, - bowel management continues to be an issue. Also checked with pharmacy and we are unable to get the pink lady enema that she request [sic] due to it being a compound medication. Continue bowel meds, ok to send [R8] into ER for further management if develops nausea or abdominal pain. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R8's care plan, printed 6/11/25, identified R8's actual or potential issues along with interventions to address them. The plan outlined R8 had bowel incontinence with a initiation date listed, 05/10/2025, and listed two interventions which included to provide peri-care after each incontinence episode and to see her other care plans for mobility, ADLs, cognition and communication. A subsequent section, revised 5/28/25, identified R8 had constipation due to decreased mobility and quadriplegia with a goal listed, [R8] will have a normal bowel movement at least every 2 to 3 days through the review date. The plan listed several interventions including following the facility' bowel protocol, giving medications for constipation per physician orders, and recording R8's bowel movements every day. However, the care plan lacked any rationale for why a digital stimulation could not be performed in accordance with R8's voiced wishes. In addition, R8's medical record lacked any rationale or dictation explaining why the care center could not perform a digital stimulation for R8 in accordance with her wishes to help promote more consistent bowel movements. On 6/11/25 at 9:02 a.m., nursing assistant (NA)-C was interviewed, and verified they had worked with R8 multiple times prior. NA-C stated R8 had a catheter which they emptied the urine from and would, at times, call to use the bed pan for stools. NA-C stated R8 had no bowel incontinence they'd ever seen adding, No, not with me. NA-C stated they had never heard R8 complain about her bowels, either, and verified the NA staff recorded the bowel movements in the record. R8's POC (Point of Care) Response History, printed 6/11/25, identified the past 14 day(s) worth of NA charting for R8's bowel movements with spacing to record what size of stool occurred (i.e., small, medium, large). This report showed R8 had only one stool for the entire period with a small bowel movement recorded on 6/5/25. The remainder of the days and each shift were each answered with, None. R8's Treatment Administration Record (TAR), dated 6/2025, identified R8's current treatments along with spacing to record their administration. This included a nursing order which read, Monitor BM, and listed a start date, 05/07/2025. The TAR provided spacing to record a BM for every shift (i.e., three times a day) and recorded the following: From 6/1 to 6/5/25, R8 had only a, 1 recorded which, per the legend on the TAR, meant, 1 = Away from home with Meds. On 6/6/25, R8 had a medium BM recorded. On 6/7/25, R8 had a small BM recorded. There were not other recorded BM(s) since 6/7/25 and, in total, only two verified BM(s) were recorded on the TAR. R8's corresponding Medication Administration Record (MAR), dated 6/2025, identified R8's medications and their administrations. These included orders for Miralax daily which was recorded as administered for each day except two doses (6/7, 6/8); along with space to record what, if any, PRN bowel medications were given. However, the MAR lacked evidence any PRN bowel medications were given despite R8 only having three (inc. two small) recorded BM(s) for the previous 11 day period. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 6/11/25 at 9:17 a.m., registered nurse (RN)-R was interviewed, and verified they were assigned to care for R8 currently but added, I've never worked with her before. RN-R stated from [their] understanding R8 had bowel incontinence and had not been having complaints of constipation to their knowledge. RN-R reviewed R8's MAR and verified several PRN medications for bowels were available, and explained residents' were evaluated for constipation through nursing assessment which included asking the resident, in this case R8, if they had a bowel movement or felt constipated. RN-R stated they had just talked with R8 who reported they had not had a bowel movement recently. RN-R stated the NA staff would record BM(s) in the record and that information could be reviewed by the nurses, too, to help determine if intervention is warranted. RN-R stated R8 had hemiplegia and that could cause problems with her bowels. RN-R then reviewed the completed NA charting for R8's bowel movements (i.e., POC) and verified only one bowel movement was recorded for the past 14 day period adding aloud, I'm not liking what I'm seeing. RN-R stated the lack of a bowel movement gave some cause for concern adding, This would require intervention. RN-R stated they had not been told of R8 having only a single recorded BM (via POC) for the past several days in report and expressed the lack of information from night shift, at times, could be challenging. RN-R stated they were unsure if the campus allowed digital stimulation of the bowels and expressed they would check the facility' policy before doing it; however, if needed, RN-R stated performing a digital stimulation and manual removal of the bowels potentially could be something we could implement. RN-R stated they felt they could perform the technique if it was allowed via policy. RN-R stated there was not much difference between a rectal check (as outlined on the standing orders) and digital stimulation, either. RN-R stated they were unaware R8 had been told she couldn't have a digital stimulation done and expressed aloud, That doesn't make sense to me. RN-R stated the person responsible to assess and, if needed, implement more parameters for R8's bowel regimen would be the charge nurses or nurse manager adding, Typically it's assigned to them. When interviewed on 6/11/25 at 9:38 a.m., RN-L verified they were the current charge nurse, and explained they had been told by the director of nursing (DON) that digital stimulation and manual removal of stool wasn't allowed under facility' policy. This was due mostly to the risk of injury, and RN-L added, That was my understanding. RN-L reviewed R8's POC and MAR charting and verified the lack of consistent bowel movement adding, That is what I'm seeing [too]. RN-L stated the floor nurses should be monitoring this charting and responding, if needed. RN-L stated there were no set parameters for R8's bowel regimen, such as do this then that, and they would get clarification from the medical provider about it. RN-L stated they were aware the NP was involved and ordering different things and bowel meds to help R8 regulate her bowel better. RN-L stated any further assessment of R8's bowel management program or regimen would likely be done in the interdisciplinary team (IDT) process and directed the surveyor to speak with the DON. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 6/11/25 at 11:11 a.m., unit manager (RN)-E and the DON were interviewed. RN-E explained a bowel diary was implemented for three days upon admission to track BM patterns then, afterwards, the bowel and bladder assessment would be completed by either the managers, charge nurses, or cart nurses. RN-E explained the NP would typically discuss bowel regimens with patients, too, and also help to formulate a plan for them. RN-E stated R8 was a quadriplegic and more complex so the NP was involved. DON stated the cart nurses should be noticing if a resident is going extended periods without a BM and evaluating their patterns then adding, It should be the cart nurses who are noticing that. DON stated this could be tracked within the record system using a clinical alert as well so next shifts were aware of it, too. DON reviewed the provided Bowel Management Program policy (dated 4/2025) and verified it did not forbid use of digital stimulation or manual removal of stool. DON stated the nurses could complete a digital stimulation as long as they were trained to do so and an order was obtained for it. DON acknowledged the scattered notes of R8's charted bowel movements and expressed more information would be gathered upon the next assessment which happened quarterly. DON stated evaluating bowels and providing a bowel management program for R8 was important so as to help prevent bowel obstruction. A facility provided Bowel Management Program policy, dated 4/2025, identified all bowel records would be reviewed by the night nurse or designee, and standing orders could be followed for residents with constipation. This included completion of a rectal check, encouraging fluid intake, and offering PRN bowel medications. The policy lacked any dictation or direction not allowing a digital stimulation and manual removal of stool. DIABETIC DEVICE: R8's admission Minimum Data Set (MDS), dated [DATE], identified R8 had intact cognition and demonstrated no delusional thinking. Further, the MDS recorded R8 as having diabetes mellitus and receiving near-daily insulin injections during the review period. On 6/9/25 at 1:55 p.m., R8 was interviewed, and expressed her blood glucose levels had been going really high since she came to the care center which she attributed to eating more since admission. R8 denied concerns about the elevated glucose levels, however, expressed frustration with the lack of a [NAME] device to monitor her glucose levels with on her own. R8 stated she had asked about getting one from someone at the care center awhile prior, but no follow-up was done and she never heard about it again adding, It never showed up. R8 reiterated she'd like to have one as it wouldn't require so many finger sticks to check her glucose then adding, I really would like that. R8's Telephone Encounter note, dated 5/28/25, identified an order from the nurse practitioner (NP) which outlined, Okay to use FreeStyle Libre for blood sugar checks. The note had handwritten initials on the left margin. R8's Medication Administration Record (MAR) and Treatment Administration Record (TAR), dated 5/2025, identified R8's current physician orders and treatments with spacing to record their administration. These identified an order, FreeStyle Libre 2 Sensor . Apply 1 device transdermally one time a day every 14 day(s) for [diabetes], with an order date recorded, 05/28/2025. The MAR provided a single space to record this administration on 5/30/25, however, it was answered with, 9 [Other/See Nurse's Notes] and staff initials only. R8's corresponding progress note, dated 5/30/25, identified the FreeStyle device text per the order with documentation, Not available. The note lacked what, if any, actions were taken to obtain it despite being ordered. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	When interviewed on 6/11/25 at 9:17 a.m., registered nurse (RN)-R verified they were assigned to care for R8 currently but added, I've never worked with her before. RN-R verified R8 used insulin and the MAR directed she was supposed to have a FreeStyle Libre in place, however, they hadn't seen one on her when helping her earlier that day. RN-R stated, I'm not sure if that's true [MAR order]. RN-R explained the devices were obtained with a provider order and then nurses would apply them after they're sent from pharmacy. RN-R stated the care center had switched pharmacy services and the new one tends to be a little slower getting items and prescriptions to them. RN-R stated they were unsure why R8 didn't have the Libre, as ordered, and expressed aloud, I will need to do some digging [into it]. RN-R stated any floor nurse could send the prescription to pharmacy or follow-up about it, if needed. RN-R verified there wasn't one in the medication cart, either, to their knowledge adding aloud, I haven't seen one. On 6/11/25 at 10:40 a.m., RN-L was interviewed, and verified they were the current charge nurse working on R8's unit. RN-L stated they had reviewed R8's medical record and found the provider order (dated 5/28) for the FreeStyle Libre and, due to the surveyor asking about the lack of it, had just called pharmacy who voiced they had faxed a clarification to the campus on 5/29/25, however, this was unable to be located. RN-L added, I did not see any clarifications [from pharmacy]. RN-L stated they updated the pharmacy with the needed information and the device would be sent out that same day. RN-L stated nobody had reported the device not being present until that day to them and expressed the nurse who charted it as not available (on 5/30) should have followed-up to ensure it was ordered and available. RN-L stated this was important so we're providing the best care and following the doctor's orders, adding use of the device would save R8 having to receive so many finger sticks with a lancet. RN-L verified this was not identified or acted upon until that day (6/11). A facility policy on diabetic equipment management was requested, however, none was received. NON-PRESSURE SKIN: R1's quarterly Minimum Data Set (MDS) dated [DATE], indicated R1 had intact cognition and no hallucinations or delusions. R1 had other behavioral symptoms not directed toward others and did not reject cares. R1's diagnoses included hyperlipidemia, dementia, hemiplegia and hemiparesis, and stroke. The MDS indicated R1 had no ulcers, wounds, or other skin problems. R1 had application of ointments/medications other than to feet. R1's skin integrity care plan revised 7/24/24, indicated R1 had potential for impaired skin integrity related to fragile skin and limited mobility. Interventions included assess skin with weekly bath, barrier cream as needed, observe for signs/symptoms of infection, observe skin with daily cares, turn and reposition every two hours in bed and/or chair, and use a draw sheet or lifting device to move. R1's personal preferences care plan revised 7/24/24, indicated R1 signed a risk vs benefits form on 8/1/23 for occasional refusals of showers and/or baths. R1's medication and treatment administration record dated 6/1/25 to 6/12/25 indicated: -8/18/21, mometasone furoate external ointment 0.1% apply to left arm/right leg topically one time a day for skin allergies. -1/3/23, tacrolimus ointment 0.1% apply to eye lids, neck, topically as needed for itch twice a day as needed. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-3/13/23, apply house barrier cream to buttocks twice a day and as needed per standing house orders for redness. -5/28/24, calmoseptine external ointment 0.44-20.6% apply to perineal area topically three times a day for IAD (incontinence-associated dermatitis). -7/18/24, weekly skin body audit and pain assessment performed. If any new alterations in skin integrity, follow the Skin Alterations and Wounds checklist. One time a day every Thursday evening. The entry for 6/5/25 was blank. -11/6/24, ammonium lactate external lotion 12% apply to bilateral lower feet and/or lower legs topically two times a day for xerosis (severely dry skin). -11/13/24, cetirizine HCl (hydrochloride) tablet 5 milligram (mg) by mouth one time a day for eczema (skin condition which causes a skin rash, dry skin, and itchiness). -11/23/24, bath/shower every Thursday evening shift. The entry for 6/5/25 was blank. R1's Assessments, indicated the last documented Weekly Bath and Skin Sheet assessment was 5/8/25. The assessment indicated a bath/shower was completed. The assessment further indicated R1's skin was not clear and intact, and the skin issue was a known concern and was monitored. R1's progress notes lacked information on weekly skin checks after 5/8/25 and did not mention skin alterations or monitoring from 5/8/25 or after. During observation and interview on 6/9/25 at 1:53 p.m., R1 was observed lying in bed. R1's forehead and left cheek were visibly dry with area of white-colored skin (i.e., flaky) present. R1 stated his wife put Aveno lotion on his face. R1 stated the staff were aware he should have lotion on his face but did not assist him as often as they should. During interview on 6/11/25 at 1:47 p.m., trained medication assistant (TMA)-A, who also worked as a nursing assistant, stated R1 had barrier cream staff applied to R1's bottom during incontinent cares and no creams for R1's face, arms, or legs. TMA-A stated they were not aware of any skin concerns for R1. During observation and interview on 6/11/25 at 1:54 p.m., registered nurse (RN)-H stated they did not frequently work with R1 and were not aware of any skin concerns. RN-H stated they applied barrier cream to R1's bottom and would have to defer to his chart to recall if they applied other creams to him. R1 stated staff had facility lotion if there were concerns regarding R1's face. RN-H entered R1's room and observed his face. R1's face looked the same as previously mentioned. R1 stated his face itched, and he had Aveno lotion in his drawer. RN-H stated she would check R1's orders to see if there were any creams for his face. R1's progress note on 6/11/25 at 2:04 p.m., indicated tacrolimus ointment 1% was applied as needed for itch. A follow-up progress note on 6/11/25 at 6:20 p.m., indicated the treatment was effective. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During follow-up interview on 6/12/25 at 10:04 a.m., TMA-A acknowledged R1's dry face and stated R1 did not always allow staff to help him with dressing, personal hygiene, or showers/bed baths. TMA-A stated bed bath/shower refusals were charted in residents' charts, and nurses could complete skin assessments even when residents refused showers/bed baths. During interview on 6/12/25 at 10:47 a.m., registered nurse (RN)-O stated they completed weekly skin checks for residents on their shower days. If there was a change in skin condition, staff were to document in the skin check or skin alteration assessment. Resident refusals of showers/bed baths were recorded under the weekly skin assessments or in progress notes. During interview on 6/12/25 at 1:00 p.m., nurse manager, RN-I, expected staff to recognize changes in skin conditions and follow-up on observations of skin concerns. RN-I expected staff to complete weekly skin assessments or open a skin assessment and mark refused if the resident did not allow a skin check. RN-I stated R1 often refused cares. The facility's Management of Skin Alterations policy dated 5/1/25, indicated staff would identify and review residents whose clinical conditions increase the risk for skin breakdown to ensure necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection, alterations from worsening and new injuries from developing. The policy indicated each resident would have a weekly body audit performed by a licensed nurse, and residents' skin would be observed daily and as needed. Staff were to complete a checklist for skin alterations when identified and initiate daily skin alteration monitoring checks to document if signs of worsening. DIET MODIFICATION: R57's admission Minimum Data Set (MDS) dated [DATE], indicated R57 had intact cognition and did not have hallucinations or delusions. R57 rejected care daily. R57 required supervision/touching assitance for eating and was dependent on staff for rolling left and right and transfers. R57's diagnoses included heart failure, hypertension, coronary artery disease, atrial fibrillation, chronic kidney disease, diabetes mellitus, hip fracture, Parkinson's Disease, malnutrition, anxiety, and depression. The MDS indicated R57 had a mechanically altered and therapeutic diet. R57's care plan dated revised 6/9/25, indicated R57 required assistance of one staff to eat in dining room. R57's diet order dated 3/18/25, indicated R57 had a regular diet with minced and moist texture and regular consistency liquids. R57's Nutrition Progress Note dated 4/2/25, indicated R57 was to move to long term care, remained on a regular diet with minced and moist level texture and regular consistency liquids. R57 required one to one assistance with meals related to cognition and/or dementia. During interview on 6/9/25 at 2:54 p.m., R57 stated she had an almost pureed diet and wanted her diet changed. R57 stated staff members were aware about her request for a diet change for at least a month and a half. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During observation on 6/11/25 at 8:04 a.m., R57 sat at a table in the dining area. R57 had oatmeal, fruit, and other food items which complied with a minced and moist diet. R57 ate her breakfast without staff assistance. During interview on 6/12/25 at 9:36 a.m., the director of therapy (DT) stated speech saw R57 for swallowing dysfunction and R57 was discharged due to meeting all goals on a minced and moist diet with thin liquids. DT stated speech therapy was able to see R57 again if she desired to advance her diet texture. R57's Speech Language Pathologist Discharge summary dated [DATE], indicated a discharge recommendation to assess diet texture if R57 desired an advanced diet at next level of care. During interview on 6/12/25 at 10:20 a.m., nursing assistant (NA)-K stated R57 used to need more help to eat but now ate by herself. NA-K stated R57 wanted their diet changed to a regular diet for the past couple weeks. NA-K stated they would normally alert the nurse about diet change requests. NA-K stated they did not communicate R57's request to the nurse, because R57 stated they talked to the dietician. During interview on 6/12/25 at 10:47 a.m., registered nurse (RN)-O stated R57 was diabetic and did not know about any concerns with her diet. During interview on 6/12/25 at 1:00 p.m., nurse manager, RN-I, stated they were not aware about R57's request for a changed diet and would contact speech therapy. RN-I stated it was important for R57 to enjoy her food and eat enough from a nutritional standpoint. The facility's Therapeutic Diets policy dated 5/29/25, indicated the facility would provide an individualized therapeutic diet to meet the clinical needs and desires of a resident to achieve outcomes/goals of care. EDEMA MANAGEMENT: R10's annual Minimum Data Set (MDS) dated [DATE], identified impaired cognition and diagnoses of Alzheimer's disease, diabetes mellitus, and hypertension. R10 used a wheelchair, relied on staff for personal hygiene, and for dressing. R10's active provider orders directed Velcro wraps (a skin protective device) be applied in the a.m. (morning) and removed in the p.m. (evening). The order specifically indicated black socks first, then foot piece, and lastly the calf piece, and for R10 to be monitored daily for edema. R10's care plan dated 4/14/25, indicated skin impairment and listed assessments and treatments to protect R10's skin. The plan also directed staff to place Velcro wraps on in the morning and remove at night. The directions were to apply black socks first then place foot piece, then calf piece and check for tightness. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation and interview on 6/9/25 at 3:11 p.m., R10 wore yellow grip socks slouched down to the ankles and black croc sandals. R10's Kardex (a version of the care plan for reference) hung in the wardrobe and was visible to staff. Nursing assistant (NA)-I stated the morning shift should have applied the black socks and Velcro wraps while R10 was in bed. NA-I attempted to apply the Velcro wraps over the yellow grip socks several times without looking at the instructions/diagram that hung over R10's bed. A large handwritten sign indicated, do not send Velcro wraps to laundry. NA-I was unable to identify black socks should be applied before the Velcro wraps. NA-I stated the previous shift would give directions on how to care for residents or the nurse would give updated information. NA-I was unaware the Kardex was available in R10's room, and confirmed the Velcro wraps were not put on according to the directions. During an interview on 6/9/25 at 3:30 p.m., licensed practical nurse (LPN)-C stated residents did not like to wear protective devices on the memory care unit and would often remove them, then confirmed the treatment assessment record (TAR) was used to document when the protective devices were applied and removed. During an observation on 6/10/25 at 9:03 a.m., R10 was holding a purse and seated in a wheelchair wearing gray long pants, yellow grip socks slouched to the ankles, and black crocs. No black socks were seen. R10's pant legs appeared bunched up in multiple spots below the knee. Review of R10's June 2025 TAR indicated staff documented having applied black socks and Velcro wraps. During an interview on 6/10/25 at 9:09 a.m., nursing assistant (NA)-H stated the residents told them what they needed, and the nurse told the assistants what cares to complete. If there was a change in an order the night shift would report that information. During an interview on 6/10/25 at 9:13 a.m., licensed practical nurse (LPN)-B stated the assistants completed cares and referenced the computer and assignment sheets, and knew the residents well. LPN-B confirmed the aides applied the protective equipment, but the nurse was responsible to document their use. LPN-B confirmed the aids knew to use the Kardex to complete all ordered cares and the nurse was responsible to ensure those or[TRUNCATED]

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to ensure a referral for potential cataract surgery was facilitated and/or completed in a timely manner to help improve vision and quality of life for 1 of 1 resident (R20) reviewed who was diagnosed with cataracts and expressed difficulty with his vision. Findings include: R20's quarterly Minimum Data Set (MDS), dated [DATE], identified R20 had moderate cognitive impairment. The section to record R20's vision status, located under Section B - Hearing, Speech, and Vision (B1000, B1200) - was left blank. On 6/9/25 at 2:32 p.m., R20 was observed lying in bed while in his room and his television was turned on and positioned on the opposite wall of the head of the bed. R20 had no eye glasses on at this time. R20 was interviewed and spoke with a soft, at times mumbling, voice but articulated clearly, My eyes aren't good. R20 was unsure if he'd seen an eye doctor recently when asked and then voiced aloud, Been awhile. On the bedside dresser, a single pair of black-framed eye glasses were present. R20 didn't respond when asked if they were his or not, however, held out his hand and took the glasses from the surveyor. R20 placed them on his face and looked at the television. R20 expressed the glasses helped a little bit to see the television. R20 nodded to affirm he'd like to see any eye doctor about his vision when asked. R20's In-House Senior Services Consent, dated 2/2023, identified R20 was offered and accepted to be seen by the care center's in-house optometry services. R20's care plan, printed 6/10/25, identified R20's actual or potential problems along with goals and interventions to address them. This outlined R20 had a guardian in place and planned to remain in long-term care (LTC). However, the care plan lacked any further actual or potential problem statements about R20's vision. R20's In-House Follow-Up Visit, dated 4/22/25, identified R20 was seen by the optometry service and listed dictation, Patient reports having trouble reading. R20 was listed as having high blood pressure, diabetes and and several other medical conditions. A section labeled, Recommendations, outlined R20 was found to have cataracts in both eyes that were limiting his vision. The text continued, On 10/23/24, [physician] called guardian [GA-B] . to discuss cataract surgery. It said the mailbox was full and couldn't leave a message . SMS message was sent to him to call back . never called back so no referral was sent . If facility and/or guardian wish to have surgery done for [R20], please contact INHSS [In-House] and a referral can be sent. The recommendations concluded, 4) I have discussed with him that the new glasses will improve the patients vision BUT WILL STILL BE BLURRY DUE TO CATARACTS. R20's Care Conference Summary - V8, dated 5/7/25, identified R20's resident representative (i.e., guardian) was included in the meeting along with the registered nurse manager (RN)-Q and licensed social worker (SW)-A. However, the completed form lacked evidence the recommendation for cataract surgery was discussed or reviewed. (continued on next page)

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/10/25 at 12:59 p.m., R20's listed guardian (GA)-A was interviewed via telephone. GA-A explained they had just recently resigned a few days prior from the service of being R20's guardian; however, prior, had been working with him for over a year. GA-A denied knowledge of R20 needing cataract surgery or the In-House note (dated 4/22) which outlined that. GA-A expressed, That's brand new to me. GA-A expressed another guardian whom worked with R20 before them may have more information and provided their contact information. Following, on 6/10/25 at 1:15 p.m., a telephone interview was completed with R20's now current guardian (GA)-B, who stated they had been with R20 for many years and were versed in his care needs. GA-B stated nobody from the care center had ever discussed or presented anything about R20 needing cataract surgery adding, They haven't communicated that. GA-B stated cataract surgery was fairly mild and he would be in agreement to pursue that if R20 needed it or wanted it. R20's medical record was reviewed and lacked evidence the recommendation for cataract surgery was discussed or offered to R20's guardian(s) despite the initial recommendation from the optometry service being dated several months prior (10/2024); nor did the record have evidence the facility had made any subsequent attempts to contact them about it since the optometry service had been unsuccessful. On 6/10/25 at 1:37 p.m., SW-A was interviewed, and stated the nursing department would address optometry appointments more than I would. SW-A stated they had not had any calls or discussion with R20's guardian(s) about the need for cataract surgery and expressed they were not exactly sure of the process for that. SW-A stated nobody had told them about the optometry note which outlined the need for cataract surgery and expressed, had someone, then they would have contacted the medical provider and guardian about it. When interviewed on 6/12/25 at 9:02 a.m., RN-Q verified they were the nurse manager who helped oversee R20 until just recently. RN-Q verified they had reviewed R20's medical record, and explained they recalled contacting R20's guardian at some point about the cataract surgery referral, however, failed to document it within the medical record. RN-Q stated they had talked with R20 himself about it and, at that time, R20 didn't want to pursue it. However, RN-Q expressed R20 was likely not able to make that decision himself. RN-Q verified the record lacked documented evidence of any discussion, either with R20 or his guardian(s), and expressed the follow-up afterward must had been missed adding, Life happened and we just moved on. RN-Q stated the manager or social worker would typically try to keep contacting guardians if there was a medical need to be addressed and reiterated those attempts should be documented within the medical record. This was important to do for patient's rights for care and just his [R20' well-being. On 6/12/25 at 9:34 a.m., the director of nursing (DON) was interviewed. DON verified attempts to contact family or guardians for medical care input should be documented within the medical record. DON stated they believed the cataract referral was never completed as the person who helps set-up appointments usually follows through on them adding the referral likely never reached them. DON stated following up on medical referrals was important for R20's quality of life and so he can see. (continued on next page)

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A facility provided Consultant Visit Policy - Audiology, Optometry, Podiatry, and Dental Services policy, dated 10/2024, identified the facility would be responsible for scheduling and coordinating consultations for residents. The policy outlined, The staff will ensure that all necessary appointments, follow-ups, and documentation are completed in compliance with regulatory standards. The policy outlined a section labeled, Audiology and Optometry Services, which directed vision needs would be assessed upon admission and referrals would be made if the resident required glasses or other corrective devices.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review, the facility failed to ensure a range of motion (ROM) program was provided for 1 of 1 resident (R74) reviewed for mobility. Finding includes: R74's quarterly Minimum Data Set (MDS) dated [DATE], indicated R74 was cognitively intact, had no delusions, hallucinations, had no behaviors and refused cares one to three days during a 7-day period. MDS indicated R74 had limited lower extremity ROM and did not received ROM in the last 7 days prior the MDS assessment date. R74's MDS indicated she received set up assistance for oral hygiene and eating, maximal assistance with showers/bathing, toileting hygiene, dressing, personal hygiene, and was dependent with transfers, and wheelchair mobility. R74's clinical diagnosis report printed on 6/12/25, indicated chronic respiratory failure, chronic pain, anxiety, restless leg syndrome, weakness, unspecified abnormalities of gait and mobility, chronic congestive diastolic heart failure(a condition where the heart muscle stiffens, making it difficult for the heart to relax and fill with blood during the relaxation phase), subluxation (is a partial dislocation, where the bones in a joint are still partially touching) of the hips, and diabetes type II. R74's care plan printed 6/12/25, indicated R74 had limited ROM related to multiple sclerosis, chronic pain, and recurrent bilateral hip subluxations. The care plan's interventions directed nursing staff to assist resident in daily performance of supine ROM, strengthening exercises. It indicated a printout was on the bulletin board and resident also had a copy, and directed staff to please attempt this in the afternoon per R74's preference. This care plan was initiated in 9/6/22, had a revision date of 11/14/24, and indicated 7/29/25 as a target day. R74's ROM/Mobility assessments dated 3/24/25, and 4/24/25, indicated R74 had limited ROM of lower extremities, used a wheelchair, and her care plan was current. R74's treatment administration record (TAR) for the month of June 2025 printed on 6/12/25, indicated an order to Assist with lower extremity ROM program. Directions are on the resident's bulletin board. Two times a day per therapy. This order was dated 5/9/23. A review of R74's TAR records for the last 7 months revealed the following information: - December 2024, R74 received ROM 18 times out of 50 opportunities, and refused or did not receive ROM 32 times out of 50 opportunities. - January 2025, R74 did not received ROM 44 of 44 opportunities. - February 2025, R74 either refused or did not receive ROM 49 out of 49 opportunities. - March 2025, R74 either refused or did not receive ROM 44 out of 44 opportunities. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- April 2025, R74 either she refused or did not receive ROM 60 out of 60 opportunities. - May 2025, R74 either refused or did not receive ROM 62 of 62 opportunities. - June 2025 - R74 either refused or did not receive ROM 20 out 20 opportunities. During interview on 6/9/25 at 3:34 p.m., R74 indicated the nursing staff was supposed to assist her twice a day with her ROM program. R74 stated her care plan indicated she had to receive assistance every day. During interview on 6/11/25 at 11:01 a.m., nurse manager/registered nurse (RN)-I stated R74 always refused ROM exercises in the mornings. RN-I stated, often R74 didn't like how staff did it. RN-I stated based on documentation, R74 was refusing to participate and they would need to investigate why, talk to the nurse practitioner, and request an order to reassess R74. During interview on 6/11/25 at 1:57 p.m., RN-J stated today, I went into her room to do wound care, but I didn't talk to her about her ROM program, and I didn't do it. During interview on 6/11/25 at 2:04 p.m., RN-P stated he didn't really do ROM with R74, but while performing wound care, he straightened R74's legs. RN-P added we only get to move her legs when we boost her up in bed. On 6/12/25 at 9:07 a.m., RN-I provided written information which indicated R74 had the right to refuse to participate. She has exercise bands in her room and self exercises using them. During interview on 6/12/25 at 9:07 a.m., director of nursing (DON) verified TARs documentation, ROM assessments and the failure to reassess R74 in a timely manner. DON stated the provider needed to be updated about resident's refusal to participate in the ROM program. DON stated we need to get another physical therapy and/or occupational therapy assessment for [R74]. Maybe we need to give her pain medication before receiving assistance with her ROM program. DON added her care plan also needed to be reviewed. Facility's policy titled Restorative Nursing program, dated 10/2021 indicated the purpose of the program was to ensure resident's abilities in ADLs did not deteriorate and residents maintain their highest practicable well-being. The policy indicated; the restorative nursing programs will be identified in the resident's care plan. The care plan must identify the resident's strengths, problems, risks, measurable goals, outcome-based goals and who is responsible for the implementation of the plan. The policy also indicated the RN will be responsible for assessing the resident's strengths and needs.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to ensure acute symptoms of distress or pain were recorded; and non-pharmacological interventions attempted or documented prior to the use of as-needed (i.e., PRN) narcotic medications to help promote continuity of care and care-planning for 1 of 5 residents (R50) reviewed for unnecessary medication use. Findings include: R50's admission Minimum Data Set (MDS), dated [DATE], identified R50 had intact cognition and demonstrated no delusional thinking. Further, the MDS outlined R50 received scheduled pain medication but no PRN pain medications; and reported occasional pain which she rated at 4/10 on the numeric rating scale. On 6/9/25 at 12:40 p.m., R50 was observed seated in a recliner chair while in her room. R50 had visible white-colored bandages on both legs and reported she sustained a fall the week prior which she felt injured her hip adding, I think I cracked it. R50 denied significant, unresolved pain issues at this time when asked. R50's care plan, printed 6/9/25, identified R50's actual and potential problems along with interventions to address them. This outlined R50 had pain related to bilateral venous wounds and listed a goal, Will verbalize adequate relief of pain or ability to cope with incompletely relieved pain ., along with several interventions including administering pain medication and monitoring the response, encouraging her to report pain at the onset, and a series of non-pharmacological interventions which could be attempted including redirection, offering food, music, and ice/heat. The care plan also directed to monitor/record/report any pain characteristics every shift and PRN; and monitor/record/report an non-verbal signs of pain. R50's Orders, dated 5/1/25, identified the nurse practitioner (NP) wrote orders for R50 which included, Add tramadol [a narcotic] 50 mg [milligrams] every day PRN [for] chronic pain. In addition, the order directed R50 to remain on the current tramadol 50 mg twice a day which was scheduled. R50's Medication Administration Record (MAR), dated 6/2025, identified a total of nine (9) administrations of the PRN tramadol for the month thus far. These included: On 6/3/25 at 5:37 a.m., R50 received a dose which was recorded as, E [effective]. A corresponding progress note, dated 6/3/25, identified the medication was provided with dictation, per pt [patient] request. However, the note lacked any recorded symptoms or what, if any, non-pharmacological interventions were attempted prior to the narcotic being provided. On 6/7/25 at 6:04 a.m., R50 received a dose which was recorded as, E. A corresponding progress note, dated 6/7/25, identified the medication was provided but lacked any recorded symptoms of pain or what, if any, non-pharmacological interventions had been attempted prior to the narcotic being provided. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/9/25 at 3:00 a.m., R50 received a dose which had results recorded as, U [unknown]. A corresponding progress note, dated 6/9/25, identified the medication was provided but lacked any recorded symptoms of pain or what, if any, non-pharmacological interventions had been attempted prior to the narcotic being provided. A subsequent note, also dated 6/9/25, was authored nearly 12 hours later in the day which outlined, [R50] presents with complains [sic] of Right hip pain . describes as throbbing . rated 9/10 . Care team updated. However, again, this note lacked what, if any, non-pharmacological interventions were being attempted to reduce the PRN narcotic use, if able, or supplement it to promote comfort. On 6/10/25 at 2:59 a.m., R50 received a dose which was recorded as, E. A corresponding progress note, dated 6/10/25, identified the medication was provided but lacked any recorded symptoms of pain or what, if any, non-pharmacological interventions had been attempted prior to the narcotic being provided. In total, the nine administered doses had only one (1) dictated note which outlined any rationale for the medication being provided (6/3/25); and all of the notes located within the record for the provided doses lacked evidence of what, if any, non-pharmacological interventions had been attempted prior to giving the PRN narcotic to see if those would help reduce the need for medication. When interviewed on 6/12/25 at 9:43 a.m., nursing assistant (NA)-M stated they had worked with R50 prior and described her as heavy a little bit with cares. NA-M stated R50 would sometimes have complaints of pain and then they just tell the nurse. NA-M stated they didn't offer ice packs or anything to R50 but expressed they would if asked by the nurse or R50 herself. NA-M stated R50 would often just ask them about the pain pill. NA-M expressed R50 rarely had complaints of pain until she sustained a fall (on 6/3/25) adding, That is when the pain started. On 6/12/25 at 10:20 a.m., licensed practical nurse (LPN)-E stated they had worked with R50 prior and helped with her wound cares. LPN-E stated R50 did have complaints of pain, at times, and would often request her PRN tramadol to help. LPN-E stated they do ask her about using ice packs and expressed R50 would accept them, at times, adding aloud, She does. LPN-E explained if R50 requested her PRN tramadol, then they'd assess her using the pain scale (0-10 rated) and the orders as there was possibly something else she could be given like her scheduled Tylenol. LPN-E stated symptoms of pain or the rationale for giving PRN medication should be recorded in the notes along with what non-pharmacological interventions were attempted adding, [recorded] in the nurses notes. On 6/12/25 at 12:21 p.m., the director of nursing (DON) was interviewed. DON verified a PRN narcotic medication should have pain symptoms recorded to justify the medication along with what non-pharmacological interventions were attempted prior. DON stated this would typically be recorded in the progress notes and should be done to show what helps. DON stated providing non-pharmacological interventions prior helps to go minimal before you use the meds. DON stated they were reviewing R50's medical record for this information, however, hadn't finished yet so they would provide additional documentation showing this, if located. No further information was received during the recertification survey (exited 6/12/25). (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A facility provided Medication Administration policy, dated 3/2023, identified steps to giving medication which included, 20. Whenever a PRN medication is given, the licensed nurse/TMA [trained medication aide] administering the medication documents on the EMAR (MAR) in the appropriate space as indicated by the date and the PRN order entry, adding further the documentation should included, . The residents specific complaint or the symptoms for which the medication is being given. However, this policy lacked information on non-pharmacological interventions with PRN or how such should be recorded.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation and interview, the facility failed to ensure medications were securely stored safely and under direct observation of authorized staff in areas where residents, staff and guests could access medications in two medication carts affecting 2 of 4 units of the facility. Findings include: During a continual observation on 6/10/25 at 3:00 p.m., an unattended and unlocked medication cart was observed in the hallway of the Bridgeway unit against the wall right outside a resident room with two other resident room doors facing the cart. During observation, a resident was observed sitting on her walker approximately 3 feet away from the unattended unlocked medication cart. Numerous unidentified staff members walked past the cart, along with another resident and family member. At 3:18 p.m., registered nurse (RN)-H returned to the medication cart and was observed interacting with the resident on the walker, reviewing the electronic medical record, and opening the cart without unlocking it. RN-H did not remove keys from their pocket to unlock the medication cart. RN-H verified they were the nurse responsible for the medication cart, had gone on break over an hour ago, and had been working on an admission since their break. RN-H stated, I don't remember if it was locked, when asked if the cart was locked or unlocked, adding I am not really sure, the keys are in my pocket. RN-H stated that it had been a long day and might have forgotten to lock it. RN-H stated it was important that medication carts were locked as there were medications and narcotics in the carts and didn't want people to come in and open it up. During an observation on 6/11/25 on 7:41 a.m., an unattended and unlocked medication cart was observed in the hallway of the Fox Crossing unit against the wall right outside a resident room. RN-K returned to the medication cart and verified they were responsible for the medication cart, and stated they left the medication cart when they were distracted as the aid needed assistance. RN-K verified the medication cart was unlocked and unattended, and stated they should have locked the cart before they left as other people could have gotten in the cart and taken medications that didn't belong to them and that could be dangerous for them. During an observation at 6/11/25 at 8:30 a.m., an unattended and unlocked medication cart was observed in the hallway of the Fox Crossing unit against the wall right outside a resident room. During the observation, two unidentified staff walked past the unlocked medication cart. Upon returning to the unlocked and unattended medication cart, RN-K verified the medication cart was unlocked and stated they should have locked it before going into the resident room. During an interview on 6/12/25 at 12:47 p.m., director of nursing (DON) stated the expectation would be unattended medication carts are locked as they contain medications. DON verified unlocked and unattended medication carts would be a safety concern. A facility policy titled Medication storage, revision date 10/21, indicated medication rooms, carts, and medication supplies are locked or attended by persons with authorized access.

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F 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide routine and 24-hour emergency dental care for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review, the facility failed to ensure dental needs were coordinated with a dental provider for further care to reduce the risk of complication [i.e., cavities, oral pain] for 1 of 1 resident (R25) reviewed for dental care and services. Findings include: R25's admission Minimum Data Set (MDS) dated [DATE], indicated R25 was cognitively intact, had no hallucinations, delusions, and didn't refuse personal cares. MDS indicated R25 received maximal assistance with toileting hygiene, bathing, sit to stand and was dependent with transfers. MDS indicated R25 received moderate assistance with personal hygiene, dressing and received set up for eating and oral hygiene. MDS section L-oral/dental status indicated R25 had obvious or likely cavity or broken natural teeth. R25's Medical Diagnosis record printed 6/12/25, indicated diagnoses of acute respiratory failure with hypoxia (a medical emergency that occurs when the body's tissues don't have enough oxygen), atrial fibrillation (irregular heart rhythm that can lead to blood clots in the heart) , type II diabetes mellitus, hemiplegia (paralysis of one side of the body) and hemiparesis (weakness or the inability to move one side of the body) following cerebral infarction (stroke) affecting right dominant side and muscle weakness. R25's care plan of Activities of daily living (ADLs) printed 6/12/25, indicated R25 had an ADL self-care performance deficit related to weakness, respiratory failure, right side weakness from previous cerebral vascular infarction and directed staff to assist resident with brushing teeth twice daily. R25's admission assessment dated [DATE], included Section H which assessed oral and dental status, indicated obvious or likely cavity or broken natural teeth. This section also indicated R25 had not seen a dentist for two years and wanted to see the dentist. R25's electronic medical record (EMR) included an Apple Tree Dental consent form signed by R25 on 3/26/25. The consent authorized Apple Tree to provide comprehensive and periodic oral care, evaluation, x-rays, preventive care and a house call/facility visit. During observation and interview on 6/9/25 at 12:13 p.m., R25 stated he had some teeth needing repair. R25 said he lost a crown, the other tooth just broke, and he had some cavities on his front lower teeth. R25 said the staff knew he had broken teeth. During interview on 6/11/25 at 8:33 a.m., charge nurse/registered nurse (RN)-L indicated on resident's admission dental status was assessed and dental services were offered. RN-L stated if residents signed a dental consent, the consent was faxed to Apple Tree Dental by the clinical services coordinator (CSC)-A. During interview on 6/11/25 at 9:33 a.m., CSC-A stated R25 was seen by Apple Tree Dental on 4/7/25. Apple Tree Dental report indicated resident had two fractured teeth. (continued on next page)

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F 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 6/11/25 at 9:35 a.m., health unit coordinator (HUC)-1 stated Apple Tree Dental could not treat R25 at the facility. HUC-1 stated R25 needed to be seen at an off-site clinic. HUC-1 stated she contacted R25's son, who stated going to an appointment with R25 was not convenient. HUC-1 stated she had not investigated other transportation options. During interview on 6/12/25 at 9:18 a.m., director of nursing (DON) stated an appointment needed to be made and worst case scenario, the facility will have to send an employee with him. We have sent employees with residents before, because nobody could accompany them to their appointments. DON stated even if R25's teeth were not bothering him now, his teeth could eventually cause pain and problems while eating. DON stated facility needed to aid residents to meet their needs. Facility's policy titled Consultant Visit Policy - Audiology, Optometry, Podiatry, and Dental Services dated 10/2024 indicated the facility will be responsible for scheduling audiology, optometry, podiatry, and dental consultation for residents. The staff will ensure that all necessary appointments, follow-ups and documentation are completed in compliance with regulatory standards.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review, the facility failed to ensure food was served in a timely manner to preserve desired temperatures of food for 4 of 4 residents (R1, R3, R40, R113) reviewed who expressed concerns for food temperatures and palatability. This had the potential to affect all residents who consumed food from the facility kitchenettes. Findings include: During survey entrance on 6/9/25 at 11:00 a.m., the facility provided a document titled Mealtimes for [NAME], TCU, Eagle Crest, Prairie Spirit: Breakfast-7:45 am Lunch-11:45 am Dinner-4:45 pm. During observation of the facility's three kitchenettes, a sign was posted on the walls adjacent to the serving line facing the dining rooms. It stated: Menu Cheat Sheet with instructions to obtain meal tickets in advance to meal service and staff should be taking the resident's meal orders WITH the resident, not for them. Review of resident council (RC) meeting minutes for: 6/10/24: indicated 19 residents were in attendance for the meeting and section identified as Nutrition state, Residents reported that some items are still arriving cold at times. 8/16/24, and 9/17/24: identified residents concern with portion sizes and staff not picking up meal ticket requests early enough which caused residents to wait longer and took too much time in the dining rooms. 10/14/24: new process for obtaining resident meal preferences. Nursing aides will collect meal tickets electronically before meals occur and the dietary staff will then prepare resident trays. 11/11/24: residents reported that meals are being served late 12/16/24: Resident reported that meals are not being served in a timely manner and are arriving cold at times; resident reported that there are still errors in what they are served vs. what they ordered. 3/10/25: Residents reported staff and residents are still struggling at times to use the new ordering system. 4/7/25: residents turned in a petition for returning to the old menu system (paper) 6/9/25: Residents reported that service is still slow at times and food is cold at times; (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During interview with nursing assistant (NA)-A on 6/9/25 at 5:57 p.m., NA-A stated residents complain about the food. Most say that it is cold or that we ran out of something. During interview with registered nurse (RN)-B on 6/9/25 at 6:26 p.m., RN-B stated he had heard residents complaining about the food but did not document or follow up with dietician or supervisor. During interview with NA-B and NA-C on 6/9/25 at 6:32 p.m., both stated, food complaints are mostly about the food they [residents] get is not what they [residents] ordered. NA-B stated expectation of nursing assistants to use an iPad (tablet computer) to ask each resident what they would like for their meal for the following day. The information was then printed in the dining room kitchenettes where the dietary aides would obtain the food and serve it onto a meal tray with requested food and drink orders. Then the nursing assistants and staff would serve the residents in the dining rooms first before serving room trays for residents who eat in their rooms. During interview with licensed practical nurse (LPN)-B on 6/10/25 at 8:28 a.m., LPN-B stated she was familiar with resident complaints concerning food including receiving food that was not ordered or requested. R1 R1's quarterly Minimum Data Set (MDS) dated [DATE], indicated R1 had intact cognition and no hallucinations or delusions. R1 had other behavioral symptoms not directed toward others and did not reject cares. R1's diagnoses included hyperlipidemia, dementia, hemiplegia and hemiparesis, and stroke. R1 required setup and clean-up assistance with eating. During interview on 6/9/25 at 1:57 p.m., R1 stated he ate breakfast and the evening meal in the dining area. R1 stated sometimes he waited for his food for a while, and the food was not always warm when he received the meal. R1 stated he would ask staff to electrify his food, but staff were usually busy and had other residents to take care of to. R3 R3's annual Minimum Data Set (MDS) assessment, dated 3/26/25, indicated R3 had intact cognition with no hallucinations or delusions and was independent with eating. During an interview on 6/09/25 at 3:22 p.m., R3 stated meals were served warm off and on and sometimes served cold. R3 stated he typically eats breakfast and lunch in the dining room and supper in his room. R3 further indicated, staff have not offered to reheat meals and this has been and issue for awhile. R40 R40's quarterly MDS, dated [DATE], indicated R40 had intact cognition with no hallucinations or delusions and was independent with eating. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 6/09/25 at 3:39 p.m., when R40 was asked about the food was, it really isn't very good and I don't know if there's anything anybody can do about it. Furthermore, R40 stated there are good cooks and bad cooks. R40 stated sometimes the food is warm and other times it is not. R40 stated she eats meals in the dining room. R113 R113's admission MDS, dated [DATE], indicated R113 had intact cognition with no hallucinations or delusions and was independent with eating. During an interview on 6/9/25 at 2:50 p.m., R113 stated the food was horrible. R113 stated she eats meals in her room and the food cold when it gets delivered to her. R113 stated she orders the meals and when she gets her meals, it is not what she ordered and is told they don't have it. R113 stated the kitchen is a hot mess. R113 stated she ordered chicken strips, and they were cold and overcooked to the point she couldn't cut them with a knife. R113 stated her meal the other day was brought with completely melted ice cream. During interview with R113 on 6/10/25 at 1:33 p.m., R113 stated nursing assistants, don't talk [to residents] and help them put in [food order/requests]. R113 stated, happens all the time. R113 stated, food feels like it was prepared the day before and given to me the next day. It is always cold. I have asked the aides to heat up my food but I feel like I am a troublemaker. If I lived here long term, I would not be happy with the service. During interview with NA-E on 6/10/25 at 1:42 p.m., NA-E stated expectation for nursing assistants to obtain resident meal preferences and options the day before service. NA-E stated staff helped enter orders for residents who could not talk, and some [residents] complain that they get food they did not order. During continuous observation and interview with culinary supervisor (CS) on 6/11/25 at 11:57 a.m., CS was approached by a dietary aide and was informed that R89 did not have a meal ticket printed up. CS reviewed the electronic meal ticket system and stated R89 was not asked what she wanted for meals yesterday which is why she did not get a meal ticket for today. CS walked with surveyor to R89's room and asked R89 if she was asked about her meal preferences and options for 6/11/25. R89 stated, no one took my order yesterday. During interview with CS on 6/11/25 at 12:11 p.m., CS stated I am aware of many residents complaining of missing meals or cold food or [not] getting the correct that was ordered. During interview with culinary director (C)-D on 6/11/25 at 12:16 p.m., C-D stated, I am aware of the complaints and we are trying to address the food temp and deliver of food once it [sic]is gets up [sic] the floors. During interview with CS on 6/11/25 at 12:18 p.m., CS stated the food issues were related to nursing aides with their role in obtaining resident food orders. There is a disconnect in the process with aides taking the orders and the staff delivering the trays. In addition, We keep educating and encouraging the aides. Everyone should get the correct food and appetizing temp of food. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During dining room observation and interview with CS on 6/11/25 at 12:30 p.m., in dining room serving both long term care residents and transitional care unit residents, CS stated expectation of lunch meal to be served at 11:45 a.m. Staff were serving food trays to residents in the dining room and began to start serving resident room trays. CS stated, We are running late today. There was a dining room table with a male and female resident seated at it and no food had been delivered to it. At 12:33 p.m., CS stated, I am aware of complaints from resident council[sic] I am aware of cold food complaints. I will get feedback from dietician that food is [sic] late. At 1:06 p.m., kitchenette was still preparing a resident room tray for delivery. A test tray was requested at 1:11 p.m., for surveyor and CS to review. Temperature of the Chicken and Dumpling soup was 133.7 degrees Fahrenheit (F). CS stated expectation of serving temperature to be 135 degrees. F. The mashed potatoes and gravy was 111.3 degrees F. CS stated expectation of serving temperature to be 135 degrees F. CS tasted the meal and stated, mashed potatoes are not hot. Temp could be warmer. Facility policy on food temperatures and timing of serving food was requested but not received.

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F 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide special eating equipment and utensils for residents who need them and appropriate assistance. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to ensure assessed and care-planned adaptive equipment for eating was provided to promote independence and personal hygiene during meals for 1 of 1 residents (R20) reviewed who needed special utensil handles. Findings include: R20's quarterly Minimum Data Set (MDS), dated [DATE], identified R20 had moderate cognitive impairment and required set-up assistance with eating. On 6/9/25 at 2:35 p.m., R20 was observed lying in bed while in his room. R20 had a meal tray placed on a bedside table over him while lying down, and he had rice and beans spilled onto his chest. R20 took more bites of food from the provided tray which had a ceramic plate with regular, metallic utensils (i.e., fork, spoon) on it. The meal tray had a white-colored menu slip on it which recorded R20 as having a diabetic diet and no adaptive equipment was listed on it; however, on the wall immediately next to R20's bed was a white-colored sign which had black writing, Keep red [bold] foam utensils in resident's room. Hand wash after meals. R20's room and meal tray were observed and no red-colored foam utensils were visible despite R20 eating his meal unattended in his room. R20 had a soft, mumbled voiced but responded, I use these [pointing to utensils] when asked if he used other silverware usually. Following, on 6/9/25 at 2:42 p.m., nursing assistant (NA)-L stated they had worked with R20 prior, and explained the lunch meal was typically passed around 11:45 a.m. to residents in their rooms. NA-L observed R20 in bed with the surveyor and stated R20 was a slow eater so he was still eating his lunch meal. NA-L was questioned on the white-colored signage which directed the use of red-colored handles, and NA-L responded aloud, He's supposed to use those. NA-L then opened R20's bedside dresser drawer and located two red-colored, foam handles which slide over the regular utensil to provide a thicker surface to hold onto. NA-L added aloud, Here they are. NA-L stated they should be used for all meals as they were adaptable equipment I think. NA-L verified R20 would not be able to apply or remove them without help and expressed for some reason they weren't used for the lunch meal adding, I don't know why not, maybe [the aide] forgot. R20's medical record was reviewed and lacked documented rationale or evidence why R20 had not been provided the red-colored handles for meal as just observed. R20's care plan, printed 6/10/25, identified R20's current or actual problems along with interventions to address them. The plan identified R20 had an ADL (activities of daily living) self-care deficit due to limited mobility and weakness. The care plan directed, Please leave the built up red foam handled utensils in [R20] room. Wash between uses. Please provide [R20] a clothing protector with each meal per his preference. This intervention had a date listed, 01/02/2025. (continued on next page)

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F 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/10/25 at 9:00 a.m., occupational therapist (OT)-A was interviewed, and verified they had worked with him and his eating abilities prior due to difficulty with feeding himself. OT-A explained R20 struggled using regular utensils and, as a result, they placed a communication to nursing for the red-colored foam handles. OT-A verified R20 should be using them at all meals adding, He does the best job feeding and drinking himself with these things. OT-A then provided the communication forms which had been sent to the nursing department. R20's Therapy-Nursing Communication Form, dated 1/7/25, identified R20's name along with directions, - Please leave the built-up handled (red foamed utensils) utensils in his room. Wash them please. On 6/10/25 at 1:44 p.m., the director of nursing (DON) stated they were covering R20's unit since the previous nurse manager took a new role. DON stated they were aware of R20 using the red-colored foam handles and verified they should be used at meals since they're listed on the care plan. DON stated using them would help with better nutrition and a better quality of life for R20. Further, DON verified the handles would be considered adaptive equipment. A facility provided Adaptive Eating Equipment policy, dated 3/2024, identified the care center would provide special eating equipment, utensils, and assistance as appropriate to assure the person can use the devices while consuming meals and snacks. The policy directed, Adaptive/assistive devices should be noted on each individual's meal identification (ID) card/ticket and in the person-centered care plan and or in the medical record.