STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245277	A. Building B. Wing	11/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Waterview Woods LLC	601 Grant Avenue Eveleth, MN 55734

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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 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. Based on interview and document review, the facility failed to ensure a registered nurse (RN) was scheduled for a minimum of eight hours a day. This had the potential to affect all 55 residents who resided at the facility.Findings include:Review of the facility Staffing Schedules dated 4/1/25 through 6/30/25, revealed there was no RN coverage for the following dates: 4/5/25, 4/6/25, 4/13/25, 4/20/25, 5/3/25, 5/4/25, 5/10/25, 5/11/25, 5/17/25, 5/24/25, 5/31/25, 6/1/25, 6/7/25, 6/8/25, 6/14/25, 6/15/25, 6/21/25, 6/22/25, 6/28/25 and 6/29/25.Review of the facility Condensed Employee Time Detail for the following dates identified a lack of RN coverage: 4/5/25, 4/6/25, 4/13/25, 4/20/25, 5/3/25, 5/4/25, 5/10/25, 5/11/25, 5/17/25, 5/24/25, 5/31/25, 6/1/25, 6/7/25, 6/8/25, 6/14/25, 6/15/25, 6/21/25, 6/22/25, 6/28/25 and 6/29/25.During an interview on 11/19/25 at 3:30 p.m., licensed practical nurse (LPN)-B stated she normally worked night shifts. There was usually one licensed staff with two nursing assistants in the building. There may be another nursing assistant that would float between floors to assist with rounds but that was more recent due to an increased census and increase in the number of call lights that were occurring. The facility always had a registered nurse that was reachable by phone.During an interview on 11/19/25 at 3:43 p.m., LPN care coordinator (CC)-B stated she was in her role as the second-floor unit manager at the facility for approximately 5 weeks. Because CC-B did not hold a registered nurse (RN) license, CC-B was working under the director of nursing (DON). CC-B trained with the former unit manager for a few weeks and, if CC-B had questions, she could ask the DON for guidance.During an interview on 11/20/25 at 10:06 a.m., RN-A stated she was the first-floor unit manager but helped with the second floor as well. RN-A worked Monday through Friday but was always available to nursing by phone. During an interview on 11/19/25 at 2:38 p.m., assistant administrator stated she was responsible for the facility staffing. Administration was aware the facility was lacking RN nurse coverage on the weekends. The facility had been cited previous years and there was a plan to house an agency RN in the assisted living section of the building. However, when the agency RN's contract was complete, the facility was unable to obtain further staffing. The assistant administrator stated the facility's licensed practical nursing staff were more than capable of resident care and there was a RN on-call 24/7 for the licensed staff to reach out to. During an interview on 11/20/25 at 2:21 p.m., the administrator stated, yes, administration was aware of the lack of RN coverage on the weekends, and the facility had been cited for the same concern in previous years. The facility did have a plan for an agency nurse to provide coverage, but the contract was complete, and the facility was unable to obtain further staffing. The facility had posted a RN job posting, had offered licensed practical nursing staff school cost reimbursement, and sought out agency placements but had not found a RN for weekend coverage. There were currently only two RNs staffed: the DON and the first-floor unit manager. The DON and first-floor unit manager were not expected to be in-house on weekends due to work/life balance and the facility had sought to get a staffing waiver, but this was not approved. The administrator stated she understood regulation required the facility to provide RN coverage for 8 hours per day but was unable to do so.A policy was requested but not received. The facility's Facility Assessment Tool dated 7/17/25, identified the facility staffing plan for licensed nurses providing (continued on next page)

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

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	direct care LPN, LVN with a 1:25-30 ratio Days and Evenings and 1:59 ratio Nights. The facility assessment also identified the facility planned to have a part time Infection preventionist (DON), a part time Minimum Data Set (MDS) coordinator, a full-time health unit coordinator (HUC), a full time DON and 2 full time nurse managers. However, the facility assessment failed to identify the facility need for a RN coverage 8 hours per day.

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review the facility failed to follow a self-administration of medication (SAM) form which indicated the resident should not self-administer medications. The facility also failed to have a provider order to self-administer medications and to keep medications at bedside. Lastly the facility failed to appropriately assess a resident with memory and decision-making concerns that was allowed to self-administer medications. This effected 2 of 3 (R25, R29) residents reviewed for self-administration of medications.Findings include R25's quarterly Minimum Data Set (MDS) dated [DATE], indicated R25 had mild cognitive impairment. Diagnoses included atrial fibrillation and sepsis. R25's care plan dated 10/21/24, identified R25 chose to self-administer oral medications left at bedside after setup by nursing. The goal was for the resident to safely administer medications set up by nursing and left at bedside per provider orders. Interventions included nursing to ensure medications were taken and assess that the resident was capable of self-administering medications left at bedside quarterly. R25's Self Administration of Medication (SAM) Evaluation form dated 1/17/25, identified R25 was able to self-administer medications due to having the manual dexterity sufficient to self-administer medications accurately and the ability to accurately report the medication use to nursing staff. The SAM form did not have knowledge of what the medication is for, ability to recognize the medications and verbalize understanding of the purpose of the medication, or knowledge of the correct times to take medications check marked, which indicated R25 could not demonstrate those steps. R25's active Order Summary Report dated 11/20/25 lacked orders R25 could self-administer medications after nursing setup or orders R25 could have medications left at bedside to take at a later time. R25's provider progress note dated 10/15/25 at 8:00 a.m., identified R25 could not make medical decisions due to cognitive impairment. The provider had discussed with the family at that time to acquire power of attorney (POA) to make R25's medical decisions for him. Diagnoses for this decision included infantile cerebral palsy, cerebellar atrophy, and cognitive impairment. Sister had obtained POA paperwork and would be completed. POA could be activated based on prior cognitive testing and below capacity evaluation performed that day. On 11/17/25 at 3:32 p.m., a plastic medication cup was observed on R25's bedside table with 5 different medications in it. There were no staff in the room at that time. On 11/17/25 at 4:52 p.m., the same plastic medication cup was still observed on R25's bedside table and there were no staff present. On 11/18/25 at 2:48 p.m. a plastic medication cup was again observed on R25's bedside table with 5 different medications in it. There were no staff present in the room, but the licensed practical nurse (LPN)-F was observed leaving R25's room five minutes prior.During an interview on 11/18/25 at 3:24 p.m., R25 could not state what any of the medications in the plastic medication cup were or what the medications were for. R25 could not state a general list of medications that he currently took on a daily basis. R25 could not report any signs of adverse reaction to medications taken or when the medications should be taken.During an interview on 11/18/25 at 3:26 p.m., LPN-F stated R25 did have some mental concerns and memory concerns. R25 did not like taking his medications in front of staff at all so we would give the afternoon medications to him after 2:30 p.m., and he would usually take them with dinner. We check back after dinner to make sure he took them. LPN-F stated R25 did have trouble remembering some of the medications he took and why the medications were important to take. The registered nurses and the nurse managers were the staff who filled out the SAM forms. LPN-F was not aware a provider order was needed to self-administer medications or leave them at bedside.R29's quarterly Minimum Data Set (MDS) dated [DATE], indicated R29 was cognitively intact. Diagnoses included heart failure, depression and anxiety. R29's care plan lacked documentation R29 could self-administer medications or have medications left at bedside. R29's active order summary report dated 5/14/25, indicated an order for Diclofenac Sodium external gel 1%, apply 4 grams (gr) to the lower back topically three times a day. (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/16/25, an order for Diclofenac Sodium external gel 1%, apply 2 gr to shoulder was added. The active order summary report lacked provider orders R29 could self-administer medications or keep medications at bedside. R29's SAM form dated 5/14/25, indicated R29 could not self-administer medications due to cognitive related diagnoses and a recent urinary tract infection. On 11/17/25 at 4:18 p.m., a tube of Diclofenac Sodium external gel 1% was observed on R29's nightstand. There were no staff present in the room On 11/19/25 at 2:40 p.m., a tube of Diclofenac Sodium external gel 1% was again observed on R29's nightstand. Again, no staff were present in the room On 11/19/25 at 2:43 p.m., registered nurse (RN)-A entered R29's room and confirmed the Diclofenac Sodium external gel 1% had been left in R29's room on the nightstand During an interview on 11/19/25 at 2:46 p.m., RN-A stated the nurse managers did the SAM evaluations. Items such as mental capacity, ability to safely take medications, understanding the medications, and identifying medications were all looked at when the decision to self-administer medications is decided. After the evaluation was done then conversation would occur with the interdepartmental team, which also included the resident's provider. If the provider felt the resident was mentally unsafe to make medical decisions, that would more than likely keep the resident from self-administering medications or keeping them at bedside. RN-A reviewed R 25's SAM report and provider notes. RN-A stated the provider documentation would probably disqualify the resident from self-administering medication. RN-A also reviewed R29's SAM and acknowledge the SAM evaluation said R29 could not self-administer of keep medications at bedside so that should not have been going on.During an interview on 11/20/25 at 10: 18 a.m., the director of nursing (DON) expected the IDT would discuss every resident that wanted to self-administer medications. If the ability to self-administer medications safely was there, the resident should be able to but if the ability was not there then staff should follow what is documented on the SAM report and observe all medications taken. The DON did not believe mental health concerns would always disqualify a resident from self-administering medications.Facility policy Self-Administration of Medications last revised 2/24 indicated 1. As part of the evaluation comprehensive assessment, the interdisciplinary team (IDT) would assess each resident's cognitive and physical abilities to determine whether self-administering medications was safe and clinically appropriate for the resident. 2. The IDT considered the following factors when determining whether self-administration of medications was safe and appropriate for the resident:a. The medication is appropriate for self-administration.b. The resident is able to read and understand medication labels.c. The resident can follow directions and tell time to know when to take the medication.d. The resident comprehends the medication's purpose, proper dosage, timing, signs of side effects and when to report these to the staff.e. The resident has the physical capacity to open medication bottles, remove medications from a container and to ingest and swallow (or otherwise administer) the medication; andf. The resident is able to safely and securely store the medication.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to provide a bed hold notice for 1 of 1 resident (R2) reviewed for hospitalization. Findings include: R2's admission Minimum Data Set (MDS) dated [DATE], identified R2 was cognitively intact and had a diagnosis of stroke with left sided hemiplegia (paralysis that affects one side of the body). R2's Face Sheet dated 11/20/25, identified R2 was admitted on [DATE] and discharged to an acute care hospital on [DATE]. R2's progress notes dated 11/9/25, identified R2 was transferred to a local hospital by Emergency Medical Services (EMS)(ambulance). The medical record lacked documentation a bed hold was given or discussed. R2's progress note dated 11/10/25, identified R2 called the facility and stated they were being transferred to a larger acute care hospital. The medical record lacked documentation a bed hold was give or discussed. During an interview on 11/20/25 at 12:12 p.m., the clinical manager (CM) stated when a resident was transferred to the hospital a bed hold was to be discussed with the resident or the resident's representative and then documented in the medical record. R2's medical record did not have any documentation regarding a bed hold for the 11/9/25 transfer. During an interview on 11/20/25 at 12:58 p.m., the director of nursing (DON) stated all residents who were transferred or went on leave were to have a bed hold done and documented. The facility's Bed-Holds and Returns policy dated May 2023, identified prior to transfers and therapeutic leaves, residents or resident representatives will be informed in writing of the bed-hold and return policy.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review, the facility failed to revise resident care plans with updated interventions for 2 of 2 residents (R7, R63) reviewed for behaviors and transmission-based precautions (TBP). Findings include: R7: R7's annual Minimum Data Set (MDS) dated [DATE], identified R7 had diagnoses which included dementia and post-traumatic stress disorder. In addition, R7's MDS identified he was severely cognitively impaired and had verbal behaviors that were directed towards others. R7's care plan initiated on admission 8/25/25, did not address behaviors until 11/18/25. R7's nursing notes identified the following: 8/17/25 at 1:39 p.m., Resident came out to nurse's desk asking CNA (certified nursing assistant) for pain pill. CNA stated she will let nurse know. Resident stated you are fat you are too f****** fat to work here. CNA stated you can go wait in your room for the nurse and I will let her know you want a pain pill, have a great nite ***. He then stated f*** you and went back to his room. 8/30/25 at 1:29 p.m. resident threatening resident that shares a bathroom with him. Resident saying, I'm going to beat you're a** get the f*** out of my way. Writer did go and speak to both residents. Encouraged other resident to use either tub room or employee bathroom if he needed. On 10/22/25, time not noted R7 threw medication at staff and said he was not going to take them. This documentation was requested but not provided. 10/25/25 at 2:00 p.m. removing dressing to stump a few times. resident was sitting on the toilet in the tub room, resident put light on for staff to assist of toilet. staff member went into bathroom and resident says you dumb f****** idiot, what the hell are you doing in here On 11/17/25 at 3:54 p.m., R7 was observed wheeling himself down the hallway away from the dining room, kitchenette area, another resident (R12) was wheeling toward the dining room kitchenette area. R7 said something to R12 voice sounded angry but unable to distinguish the words, R7 then began hitting R12 with his fists. Facility staff was immediately alerted, and the incident was reported to the director of nursing (DON). Licensed practical nurse (LPN)-A stated R7 could get aggressive with staff but they were not aware of R7 being aggressive with other residents. During an interview on 11/17/25 at 4:07 p.m., the DON stated nothing like this had occurred before. During an interview on 11/19/25 at 9:42 a.m., nursing assistant (NA)-A, stated R7 had behaviors mainly toward women, including throwing pills and swearing. NA-A did recall the incident in August when he would not allow the resident who shared the bathroom to use it. She recalled R7 was moved to a different room. NA-A verified there was nothing in the care plan related to R7's behaviors. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on11/20/25 at 9:47 a.m., licensed practical nurse (LPN)-A stated she knew R7 had behaviors and had had an altercation in August with a different resident and R7 was moved from the [NAME] side of the building to the East side. LPN-A verified the care plan did not address behaviors. During an interview on 11/20/25 at 12:16 p.m., LPN care coordinator (CC)-B verified R7's behaviors should have had been part of his care plan with interventions listed for staff to assist with de-escalation. LPN CC-B verified the care plan did not address behaviors until 11/18/25. During an interview on 1/20/25 at 12:31 p.m., the DON verified R7 had had a verbal altercation with a different resident in August, and the care plan should have been updated at that time to address behaviors. R63: R63's admission Minimum Data Set (MDS) dated [DATE], identified no cognitive impairment and a diagnosis of a MDRO (multidrug-resistant organism) (which are germs that resist multiple classes of antibiotics). R63's Face Sheet dated 11/20/25, identified R63 had 2 MDROs. One was Methicillin Resistant Staphylococcus Aureus (MRSA), and the other was Extended Spectrum Beta Lactamase (ESBL) resistance. Provider order dated 11/7/25, identified R63 was on contact precautions (infection control measures used to prevent the spread of pathogens through direct or indirect contact with an infected or colonized person). During observations on 11/19/25 at 9:00 a.m., R63's door had a sign that identified she was on contact precautions. R63's care plan dated 11/7/25, identified R63 had precautions with cares related to wound care and a MDRO. Interventions included staff to follow enhanced barrier precautions, and staff to enhanced barrier precautions when providing high contact cares. During an interview on 11/20/25 at 9:57 a.m., the clinical manager (CM) started the care plan was important because it was used to communicate type of care needed for the residents. If a resident was on contact precautions, it would have been important to identify that in the care plan. R63's care plan did not identify they were on precautions and should have. The CM said the information regarding the contact precautions did not populate the care plan and she did not know why. During an interview on 11/20/25 at 12:58 p.m., the director of nursing (DON) stated if a resident was on contact precautions, it would be expected the care plan would reflect that. The care plan was used for staff to reference and identify the care needed for the resident. R63's care plan should have been updated to reflect they were on contact precautions. The facility's Care Planning policy dated November 2024, identified the care plan shall be used in developing the resident's daily care routines and will be utilized by staff personnel for the purposes of providing care or services to the resident. The plan of care will be utilized to provide care to the resident. The care plan is to be modified and updated as the condition and care needs of the resident changes.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review, the facility failed to ensure a resident's hearing devices were in use for 1 of 1 resident (R35) reviewed for communication and hearing. In addition, the facility failed to ensure the family member was kept updated on changes of condition for 1 of 1resident (R35) reviewed for change of condition.Based on observation, interview and document review, the facility failed to ensure a resident's hearing devices were in use for 1 of 1 resident (R35) reviewed for communication and hearing. In addition, the facility failed to ensure the family member was kept updated on changes of condition for 1 of 1resident (R35) reviewed for change of condition.Findings include:R35's quarterly Minimum Data Set (MDS) dated [DATE], identified R35 had diagnoses which included moderate difficulty with hearing and had hearing aids, mild cognitive function, depression, and anxiety. In addition, R35's MDS identified he was rarely/never understood and had memory problems.R35's care plan dated 8/22/24, identified he had an alteration in communication and was hard of hearing. R35's care plan identified he had hearing devices. Interventions included to encourage resident to use hearing aids or pocket talker, if he refused have different staff reapproach if resident refuses. Staff were to offer hearing aids every morning, he had an alternate communication method listed as pocket talker. In addition, R35's care plan identified he was at risk for falls initiated on 8/22/24. Interventions included pommel wedge to prevent resident from sliding out, ensure staff were near if wheelchair was in the upright position, have tray table next to resident when in common area with fidgets and snacks in reach. Occupational therapy was to evaluate for a new wheelchair. The care plan identified R35 was assessed and provided with a tilt wheelchair to prevent sliding out on 12/11/24.R35's Order Summary Report identified Offer hearing aids every morning in the morning dated 5/2/25.R35's care conference dated 5/23/25, identified resident and guardian present. Guardian (G)-A identified the following, Resident's guardian voiced concerns of resident's Broda chair not appearing to be secure and not being updated on things such as medication changes and OT (occupational therapy) orders.R35's care conference dated 7/29/25, identified a new pocket talker had been received and was ready for use.R35's care conference dated 10/20/25, identified the following, Resident's guardianexpressed concerns of resident's hearing devices not being utilized throughout the day.During an observation on 11/18/25 at 10:36 a.m., R35 was seated in the dining area in a Broda chair, he was dressed and wearing sunglasses. Hearing aids were not in, no headphones on.During an observation on 11/18/25 at 1:22 p.m., R35 was in bed, he was awake, he was not wearing hearing aids and did not have headphones on. When spoken to, he stated, I can't hear you.During an observation on 11/19/25 at 8:42 a.m., R35 was sitting in his Broda chair in the dining area eating breakfast, he was not wearing any hearing aids or headphones.During an observation on 11/19/25 at 9:10 a.m., nursing assistant (NA)-A asked R35 a question several times, he finally responded with come back later. R35 was not wearing hearing aids or headphones.During an interview on 11/19/25 at 9:39 a.m., NA-A verified R35 did not hear very well, NA-A said he could read lips and stated he had headphones that helped him with his hearing. NA-A verified she did not use the headphones when R35 could not understand/hear her question.During an interview on 11/19/25 at 10:37 a.m., family member (FM)-A stated the staff were not using his hearing aids and did not know how to use them. FM-A stated she currently had the hearing aids for repair. She stated he had headphones that could be used while the hearing aids were being repaired but stated they were often not charged for use. FM-A stated they were not notified when R35 was moved from a wheelchair to the Broda chair.During an interview on 11/19/25 at 11:43 a.m., NA-B verified R35 was not wearing his hearing aids or headphones, she looked in his room and was not able to find them. NA-B found NA-A and asked her if she knew where they were, NA-A showed the headphones which were plugged in to charge.During an interview on 11/20/25 at 9:42 a.m., licensed practical nurse (LPN)-A stated R35 should have his hearing aids in daily, she stated they were either in his room or at the desk (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	charging.During an interview on 11/20/25 at 12:16 p.m., care coordinator (CC)-B verified R35 was supposed to wear his hearing aids or headphones daily to help with communication.During an interview on 11/20/25 at 12:31 p.m., director of nursing (DON) verified she would expect staff to make sure his hearing aids or headphones were put in/on in the morning so he would be able to hear and communicate with staff and others. The DON stated she would expect staff to keep the devices charged. The DON stated she was unsure when R35 moved from a wheelchair to the Broda chair, said it's been quite a while. The DON verified the guardian should have been involved and notified the change. A policy on hearing and communication was requested but not provided.Notification Of Changes Policy dated 3/2024, identified the objective was to ensure the facility made appropriate notifications timely to ensure any need to alter treatments could be made.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based observation, interview and document review, the facility failed to provide timely assistance with repositioning to prevent the worsening or development of pressure ulcers for 1 of 3 residents (R1) reviewed for pressure ulcers.Findings include:R1's quarterly Minimum Data Set (MDS) dated [DATE], identified she had diagnoses which included diabetes, morbid obesity, heart failure (a chronic condition where the heart can't pump enough oxygen rich blood to meet the body's needs), and pressure ulcer. In addition, R1's MDS identified her as cognitively intact and as having a pressure ulcer.R1's electronic medical record banner identified the following special instructions; elevation of lower extremities 4x (times) a day for 15 min (minutes) needs to be done every day.R1's care plan dated 12/20/24, identified R1 had an alteration in skin integrity to top of left foot, left heel, and buttock. Interventions included turn and reposition or reminders to offload every two to three hours and as needed.R1's Order Summary Report included the following order:10/4/25, Please encourage supine in bed at night to improve edema. She should also have her feet elevated 2-3 times throughout the day for 15-20 minutes each time, ideally above her heart level. ACE wraps for gentle compression on in the morning and off at night with sleeping. Please offload heel at all times. Every day shift.A review of R1's November progress notes did not document any refusals of care.On 11/18/25 10:39 a.m., R1was seated in her wheelchair in her room watching a television (TV) program. Left foot in a padded boot resting on the wheelchair foot pedal. Both feet dependent. Staff asked her if she planned to go to bingo in the afternoon.-11:08 a.m., no change in position, no staff in or out of her room-12:15 p.m., R1 remained seated in her wheelchair eating lunch-12:29 p.m. R1 remained in her wheelchair, talking on her phone-12:35 p.m., R1 remained in her wheelchair, both feet remained in dependent position, no staff offered to help her change her position or offload-12:40 p.m., staff entered and gave R1 her insulin injection, no offer was made to change position, offload or elevate feet. Both feet remained in a dependent position.-12:49 p.m., R1 remained in her wheelchair, no changes in position-12:52 p.m., staff entered to pick up the meal tray, no offer was made to change position-1:04 p.m., staff entered and checked on her activity plan, no offer made to change position, offload, or elevate feet-1:11 p.m., staff answered her call light and told R1 they would be right back-1:12 p.m., staff entered emptied her foley catheter and two staff straightened her in her chair as she was leaning to the right and left. R1 stated she had been sitting in her wheelchair since 7:30 a.m. R1 then left to go to bingo.R1 remained at bingo in the basement until 2:53 p.m., at which time she was brought back to her room. No offer for a position change, offloading or elevating her feet, which remained dependent on the wheelchair rests.-2:59 p.m., R1 put her call light on-3:02 p.m., R1's call light was answered, she asked staff to move items out of her recliner, which was completed, no offer was made for a position change, offloading, or elevating her feet, which remained dependent on her wheelchair rests.-3:23 p.m., R1 remained sitting her wheelchair with both of her feet dependentDuring an interview on 11/19/25 at 8:59 a.m., licensed practical nurse (LPN) care coordinator (CC)-B verified R1 had some open areas on her buttocks.During an interview on 11/19/25 at 9:46 a.m., nursing assistant (NA)-A stated she worked with two other NAs to complete repositioning for about 13 residents, R1 was not one she listed. NA-A then stated R1 should be repositioned every two hours and offers should be made to R1 to reposition her and elevate her feet.During an interview on 11/19/25 at 11:50 a.m., LPN-E stated NAs should tell her if a resident was refusing repositioning, she did not recall being told R1 refused repositioning on 11/18/25.During an interview on 11/20/25 at 8:21 a.m., R1 stated she had been up in her chair since 6:45 a.m., she stated staff did not offer to assist her with position changes unless she put on her call light and asked for a position change.During an interview on 11/20/25 at 9:40 a.m., LPN-A stated R1 should be repositioned every two hours, said she could lift her own legs. LPN-A verified they wait for R1 to ask to be repositioned and were not offering a position change, offloading, or elevating feet every two hours.During an interview on 11/20/25 at (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	12:16 p.m., LPN-B verified staff were not offering R1 position changes and they should have been making the offer every two hours.During an interview on 11/20/25 at 12:31 p.m., the director of nursing (DON) stated staff should be following the orders as written and offering repositioning for R1. The DON stated this was important to prevent further skin concerns and to help with healing current skin concerns.The Skin Assessment & Wound Management dated 2/2025, identified staff would review and update the care plan as needed, would educate the resident on skin problems and would include the risk and benefits of following care, and would follow ongoing treatments per provider order.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review the facility failed to implement interventions to prevent falls for 1 of 3 (R44) residents reviewed for falls.Findings include: R44's quarterly Minimum Data Set (MDS) dated [DATE] indicated R44 had moderative cognitive impairment. Diagnoses included alcohol dependence and delirium. R44's care plan dated 8/14/24, identified R44 was a fall risk related to dementia and safety. Interventions included wheelchair to be kept at bedside with brakes locked and auto-locking breaks on WC. Gripper socks were to be on when out of bed. On 11/17/2025 at 4:14 p.m., R44 was observed to self-transfer from the bed to the wheelchair. The wheelchair locks were not locked and R44 was wearing regular socks with his shoes lying on the floor. R44 was unsteady during transfer, leaned forward to grab the wheelchair and the wheelchair rolled backwards. R44 was able to grab both wheelchair arms and sit down before the wheelchair rolled away from R44. On 11/19/25 at 10:26 a.m., nurse assistant (NA)-C entered R44's room. R44 was in his bed. R44's wheelchair was next to the bed, but his locks were not locked and there were no auto-locking devises on the wheelchair. Staff new which interventions the staff needed to be aware through the resident care plan.During an interview on 11/19/25 at 10:26 a.m., NA-C stated R44 had a history of frequent falls. Interventions included gripper socks on his feet when out of bed and the wheelchair needed to be right next to the bed with the wheels locked. NA-C stated the staff did a pretty good job to keep the WC by the bed and the wheels locked when R44 was in bed. NA-C was unsure if auto locking breaks needed to be on R44's wheelchair. NA-C did confirm R44's wheels were not locked when she entered the room and there were no auto locking breaks on R44's WC at that time.During an interview on 11/19/25 at 2:43 p.m., registered nurse (RN)-A stated interventions were put in place by the inter-disciplinary team (IDT) for residents with a history of falls to attempt to keep the resident safe. Interventions were placed on the care plan, so all staff were aware and to follow. Maintenance would be notified when autolocking breaks were needed on a resident wheelchair.During an interview on 11/20/25 10:18 a.m. the director of Nursing (DON) stated all staff were expected to follow the resident plan of care and implement all resident fall interventions to keep the resident safe.Facility policy Care Planning last revised 11/24, indicated the care plan would be developed the daily care routines and used for the purpose of provided cares or services to the resident.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review the facility failed to monitor pain, provide non-pharmacological pain management, and consistently administer as needed pain medication to minimize pain for 1 of 1 resident (R61) who had pain. R61's admission Minimum Data Set (MDS) dated [DATE], identified R61 was cognitively aware and had diagnoses that included chronic obstructive pulmonary disease (COPD) (a progressive group of lung diseases that includes emphysema and chronic bronchitis, making it difficult to breathe due to airflow obstruction. Common symptoms are chronic cough, mucus, and shortness of breath, which worsen over time and are often exacerbated by smoking or exposure to irritants.), emphysema (a progressive group of lung diseases that includes emphysema and chronic bronchitis, making it difficult to breathe due to airflow obstruction. Common symptoms are chronic cough, mucus, and shortness of breath, which worsen over time and are often exacerbated by smoking or exposure to irritants.), acute and chronic respiratory failure with hypercapnia (Acute on chronic hypercapnic respiratory failure occurs when a patient with a pre-existing, long-term condition that causes high carbon dioxide levels experiences a sudden, acute worsening of the condition. This results in a dangerous buildup of and a drop in blood pH, which can be life-threatening. Treatment depends on the severity but can involve oxygen therapy, non-invasive ventilation, or, in severe cases, mechanical ventilation, along with addressing the underlying cause) and esophagitis (is the inflammation or irritation of the esophagus, the tube that carries food from the mouth to the stomach. Symptoms can include chest pain, heartburn, and difficulty or pain when swallowing. Causes range from acid reflux and certain medications to allergic reactions, infections, and radiation.) R61 use opioid pain medications and was receiving hospice services.R61's Pain Care Area Assessment (CAA) dated 11/17/25, identified R61 denied having any physical pain but does have discomfort with epigastric pain which is controlled with the use of Omeprazole (a medication that reduced the amount of acid produced in the stomach). However, the CAA failed to identify R61's opioid medication use.Care plan dated 11/12/25, identified R61 exhibited an alteration in comfort. Staff were directed to:- Provide nonmedicinal forms of pain relief such as positioning, rest, massage, etc.- Pain medication as ordered by physician- Document on effectiveness of pain medication- Encourage R61 to verbalize discomfort- Monitor for potential medication side effects related to pain medication usage including constipation, nausea and vomiting, sedation, lethargy, anorexia and increased confusion.R61's Physician order dated 11/11/25, identified Morphine Sulfate oral solution 10 milligram (mg)/5 milliliter (ml). Give 2.5 ml by mouth every 2 hours as needed for pain related to palliative care.R61's Physician order dated 11/13/25, identified Acetaminophen Tablet 650 mg. Give 2 tablet by mouth every 4 hours as needed for mild to moderate pain or fever related to palliative care. Limit Acetaminophen to 3250 mg in 24 hours from all sources. Okay to give per rectum if unable to swallow.R61's MHM Pain Evaluation V-4 dated 11/18/25, identified R61 took Morphine Sulfate Oral Solution 10 mg/5ml. Give 2.5 ml by mouth every 2 hours as needed 2-3 times a day for pain and inflammation. R61 stated that he had adequate pain relief and had not needed any use of as needed Acetaminophen. Staff were to continue to monitor for non-verbal/verbal cues of pain and report. R61's physician would be updated regarding changes in pain.R61's Medication Administration Record (MAR) dated November 2025, identified the following:- On 11/19/25 at 12:38 a.m., R61 was administered Morphine Sulfate 10 mg/5 ml. 2.5 ml by mouth for a pain rating of 4. The dose was identified as E for effective but did not identify time of result.- On 11/19/25 at 2:08 a.m., R61 was administered Acetaminophen 650 mg for a pain rating of 4. The dose was identified as E for effective but did not identify time of result.- On 11/19/25 at 6:20 a.m., R61 was administered Morphine Sulfate 10 mg/5 ml. 2.5 ml by mouth for a pain rating of 4. The dose was identified as E for effective but did not identify time of result.- On 11/19/25 at 10:36 a.m., R61 was administered Morphine Sulfate 10 mg/5 ml. 2.5 ml by mouth for a pain rating of 5. The dose was identified as E for effective but did not identify time of (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	result.R61's Nursing Progress Notes dated 11/19/25 through 11/20/25, failed to identify R61's pain and/or pain interventions attempted to control R61's pain.During an observation on 11/19/25 at 10:23 a.m., R61 had turned on his call light.- At 10:30 a.m., nursing assistant (NA)-A donned a disposable gown, gloves and surgical mask. Before NA-A could enter R61's door, NA-C approached NA-A and stated, tell him the nurse is aware but is in another room and will be there as soon as she can. NA-A entered R61's room, turned off R61's call light and asked what she could help him with. R61 asked if he could get his pain medicine. I asked 40 minutes ago, and it still hasn't come. NA-A explained to R61 the nurse was in another room but R61 was next on the list. R61 was lying in bed with his head of bed (HOB) elevated approximately 30 degrees with his face grimacing and stated Why is it taking so long? Don't they want me to have it? NA-A reassured R61 that the nurse would be in, and NA-A would remind her again. NA-A exited R61's room. NA-A did not offer R61 any type of nonpharmacological pain interventions such as repositioning.- At 10:36 a.m., R61 stated he had mid chest pain and rubbed at his sternum with his right closed fist. R61 is sweating and face grimacing. R61 stated it's a 5 on a 0-10 scale. It's like heartburn and R61 again rubbed at his sternum. I cough, it just burns and it's just shitty. I had trouble getting the pain medicine last night too. They don't like giving it to me but when I was in the hospital, they said it was a small dose of morphine, and I could get as much as I want. I don't want to abuse it, but it makes it, so I don't cough and I'm not so miserable.- At 10:41 a.m., licensed practical nurse (LPN)-C donned a gown, gloves and surgical mask and entered R61's room with a medication cup with a blue colored liquid medication and another medication cup with a medication tablet. LPN-C greeted R61 and stated she had R61's liquid morphine and a muscle relaxer. LPN-C handed the medications to R61 who took them with a sip of water. R61 asked LPN-C why it took so long, and LPN-C stated she was only told R61 was asking for pain medications a few minutes prior. R61 stated he told a NA, the tall one, and was told the nurse knew an hour prior. LPN-C stated she was unsure if R61 could have had a dose of pain medication an hour earlier but came as soon as she was aware. R61 then verbalized his medication orders and stated R61 could have a dose every 2 hours and R61 kept track. R61 then stated staff would not give him medication during the night either. LPN-C stated the night nurse administered R61 a dose of morphine shortly after midnight and R61 stated, yes, that was true, but he asked for it again at approximately 4:00 a.m. LPN-C then stated the night nurse had been busy with other residents who required transfer to the emergency department and was really busy. R61 then turned to look out the window and stated, that's no excuse.During an interview on 11/19/25 at 10:56 a.m., LPN-C stated NA-A had told LPN-C that R61 was requesting pain medicine a few minutes ago. LPN-C stated she understood the nursing assistants were busy, but staff did have walkies that they could use to communicate. However, there were a lot of agency staff, and not all staff would wear/use a walkie. Additionally, there were not enough walkies for all staff. [NAME] stated [NAME] only told me a few minutes ago. I get their busy and we do have walkies. We have a lot of agency staff and not everyone will wear a walkie. LPN-C stated she did not work second floor frequently but knew R61 received pain medication pretty frequently. LPN-C was unsure what the frequency of R61's order and would have to review his chart. LPN-C then stated she expected the nursing assistants to report pain right away to help with pain control. R61 had been on hospice but R61 had wanted to start physical therapy, and hospice was discontinued earlier that day. However, R61's physician orders remained the same as previous. I can't provide pain medication without being told.During an interview on 11/19/25 at 11:00 a.m., NA-A stated she told LPN-C right away when R61 asked. NA-A stated R61 had asked NA-C prior. During an interview on 11/19/25 at 11:01 a.m., NA-C stated R61 did ask for pain medication, however, LPN-C was busy. NA-C stated she always waited until she could tell a nurse a resident request face to face because the nurses were busy. The nurses could be in another resident room or doing dressing changes. NA-C did not want to bother them if they were doing something sanitary.During an interview on 11/19/25 at 3:30 p.m., LPN-B stated she always wore a walkie for the nursing assistants to be able to tell her resident requests/concerns, especially on night shift. There was one licensed staff for both floors and a nursing assistant on each (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	floor. However, so many walkies had gone missing there weren't enough to go around. The nursing assistants usually came to find her right away when a resident was requesting pain medicine and LPN-B expected them to do so. When a resident complains of pain, LPN-B would either say she would be able to come to the resident in a few minutes or go right away because residents in pain should not wait. A resident should never wait for pain control.During an interview on 11/20/25 at 7:56 a.m., LPN-A stated she had looked for a walkie that morning but could not find one and stated that's why she was keeping the medication cart at the nurses' desk as much as possible so LPN-A could see what was going on and be available. It was a pretty usual thing to not have a walkie. LPN-A pointed to the walkie charging station sitting on the nurse's desk. There are 6 slots and all empty. LPN-A stated nursing assistants should let her know of resident requests for pain medicine as soon as possible.During an interview on 11/20/25 at 8:00 a.m., NA-B and NA-D were sitting at the nurses' desk in front of the walkie charging station. NA-B was wearing a walkie, but NA-D was not. NA-B stated there just wasn't enough. Staff forget and take the walkies home; they get broken and sometimes they all end up on another floor. Staff just talked to each other. NA-B shrugged and stated it's been like that for a bit. Well, probably a couple months. If staff were in a room, didn't have a walkie and could not leave, staff could turn on the bathroom light and start yelling for help. Then pray that works. If a resident was asking for pain medicine and NA-B didn't have a walkie, she would look for the nurse right away and tell them face to face. During a telephone interview on 11/20/25 at 1:30 p.m., LPN-D stated she had worked with R61 the night shift of 11/18/25. LPN-D had given R61 a prn dose of morphine early in the shift and when R61 asked for it again it was 30-45 minutes too early. LPN-D administered a PRN dose of Tylenol instead. R61 did ask if he took the Tylenol if he could still have the morphine when it was time. LPN-D told R61 yes but when LPN-D peeked in his doorway R61 appeared to be asleep so LPN-D did not approach R61. LPN-D marked the dose of Tylenol as effective, and LPN-D didn't tell R61 she was going back so didn't think R61 was waiting for her. LPN-D believed R61 would turn on his call light again if he still needed it.During an interview on 11/19/25 at 3:43 p.m., LPN care coordinator (CC)-B stated R61 complaints of pain were unacceptable. A resident should never have to wait for pain medication. In R61's situation, the morphine was to help relieve R61's breathing and the cough/pressure R61 felt with that. The NA should have either found another nurse and/or CC-B to help the R61 if the NA felt she couldn't say anything over the walkie. CC-B expect residents to receive pain control timely.During an interview on 11/19/25 at 4:05 p.m., the director of nursing (DON) stated she was unaware there were not enough walkies for all staff to be able to communicate with each other and the DON expected nursing assistants to report resident requests for pain medication immediately to provide adequate pain control.The facility policy Pain Control Protocol revised 3/23/23, identified the facility was to ensure that residents with pain or at risk for pain, have an effective pain management plan in place with individualized interventions that are consistent with the resident's goals for comfort. Staff were directed to provide the following:Treatment/Management1. With input from the resident and/or resident representative, the provider and staff will establish goals of pain treatment, for example, freedom from pain with minimal medication side effects, less frequent headaches, or improved functioning, mood, and sleep.2. Nursing will evaluate for appropriate non-pharmacologic interventions to address the individual's pain.3. Provider will order appropriate medication interventions to address individuals' pain.4. The staff will evaluate and report how much and how often the resident utilizes PRN pain medication.a. Depending on severity and location of pain, the provider may start with PRN doses or supplement routine doses with PRN doses for breakthroughpain.b. If there are more than occasional PRN analgesic utilization (and depending on the success of nonpharmacological interventions), the provider may consider changing to regular administration of at least one analgesic with another medication for PRN use, increasing the routine dose of an existing analgesic or switching to another analgesic.5. Staff will provide the elements of a comforting environment and appropriatephysical and complementary interventions; for example, local heat or ice, repositioning, massage, and the opportunity to talk about (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	chronic pain.6. Resident's plan of care will reflect pain management needs.7. For the individual who is receiving opioid analgesics, the provider may order a regimen of laxatives and other measures to prevent constipation.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review the facility failed to make sure all medications in a resident room had active orders and were not expired. This affected 1 of 1 (R29) resident reviewed for medication storage.Findings include R29's quarterly Minimum Data Set (MDS) dated [DATE], indicated R29 was cognitively intact. Diagnoses included heart failure, depression and anxiety. R29's care plan lacked documentation related to creams at bedside and labeling requirements. R29's active order summary report dated [DATE], indicated an order for Diclofenac Sodium external gel 1% and Clotrimazole external cream 1%. The active order summary report lacked orders for any other medicated creams or lotions. On [DATE] at 4:18 p.m., a white basket with several tubes of medicated creams was observed in R29's room on the counter next to the bathroom and R29's other care items. On [DATE] at 2:40 p.m., a white basked with several tubes of medicated creams was again observed in R29's room on the counter next to the bathroom. On [DATE] at 2:43 p.m., registered nurse (RN)-A entered R29's room and confirmed there was a white basket on R29's counter that held several tubes of medication creams and powders. Several of the tubes had labels that were worn off and unable to read most of the label. RN-A went through the basked and found the following medications with the connected expiration dates in R29's room: Ketoconazole cream, expired [DATE],Triamcinolone acetonide cream, expired [DATE]Clotrimazole and betamethasone cream, expired [DATE]rosac cream expired, [DATE]hydrocortisone 2.5% cream, expired [DATE]Santyl cream, expired [DATE],Nystatin powder, expired [DATE]During an interview on [DATE] at 2:46 p.m., RN-A stated a family member must have brought all of the medicated creams and powders in for R29. When families bring in medications, they are told to bring them to the nurses' station to make sure they are still good to use and there is a current order for the resident to use the medicated creams. RN-A stated she was not aware they were in the room but did state obviously the front-line staff knew since the creams were sitting with R29's other daily care items. The nursing staff should have been reviewing the creams to make sure there were active orders to utilize the creams and the creams were not past their expiration dates.During an interview on [DATE] at 9:18 a.m., the consultant pharmacist (CP) stated it was important for facility staff to make sure all medications a resident had and received had active orders and were not expired for the safety of the resident. When medications are not ordered or expired, they could cause adverse reactions to the resident or could cause the resident to actually receive double of the same classification of medication.During an interview on [DATE] at 10:18 a.m., the director of Nursing (DON) stated all staff were expected to track current orders and expiration dates for all medications in a resident room for resident safety.Facility policy Medications Brought to the Facility by a Resident or Responsible Party last reviewed 2025, indicated medications brought into the facility by a resident or responsible party would be used only upon written order by the resident's attending physician, after the contents are verified, and if the packaging met the facility's guidelines. Unauthorized medications would not be accepted by the facility.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to ensure the consultant pharmacist recommendations were addressed for 1 of 5 residents (R1) reviewed for unnecessary medications.Findings include:R1's quarterly Minimum Data Set (MDS) dated [DATE], identified she had diagnoses which included diabetes, morbid obesity, heart failure (a chronic condition where the heart can't pump enough oxygen rich blood to meet the body's needs), and pressure ulcer. In addition, R1's MDS identified her as cognitively intact and as receiving insulin injections seven days of the week and receiving anti-psychotic medication.R1's care plan dated 12/20/24, identified a potential for psychotropic adverse drug reactions related to daily use of psychotropic medication. Interventions included monitoring for adverse drug reactions, medication review by pharmacist and medical provider, and updating the medical provider of efficiency of medications. R1's Order Summary Report identified the following order: 10/24/24, quetiapine 25 milligrams (mg) give 0.5 tablet by mouth at bedtime for sleep related delirium due to know physiological condition A review of R1's monthly medication reviews identified the following:10/15/25, This resident has an order for QUETIAPINE TAB 25MG - GIVE ONE-HALF TABLET BY MOUTH EVERY NIGHT AT BEDTIME with a start date greater than 3 months without a recent documented GDR attempt. RECOMMENDATION. Unless clinically contraindicated, could we please consider a Gradual Dose Reduction (GDR) at this time. If not, due to low dose, please document the benefits of current doseThere was no documented response from the provider on the form. 9/11/25, This resident has an order for QUETIAPINE TAB 25MG - GIVE ONE-HALF TABLET BY MOUTH EVERY NIGHT AT BEDTIME with a start date greater than 3 months without a recent documented GDR attempt. RECOMMENDATION. Unless clinically contraindicated, could we please consider a Gradual Dose Reduction (GDR) at this time. If not, due to low dose, please document the benefits of current dose Prescriber's Response: To be addressed by elder care at next 60 day dated 10/17/25A review of R1's elder care visit dated 11/13/25, identified R1 as taking quetiapine 25 mg tablet take 0.5 tablet by mouth at bedtime. Indications: Delirium, trouble sleeping. The note did not address the pharmacy recommendation to consider a gradual dose reduction of the quetiapine. During an interview on 11/20/25 at 11:52 a.m., the consultant pharmacist verified she had not received a response to her request to consider a gradual dose reduction from the September or October requests. She was not aware of how the facility forwarded the requests to elder care. During an interview on 11/20/25 at 12:16 p.m., with licensed practical nurse (LPN) and care coordinator (CC)-B, CC-B stated she did not know how elder care was involved in gradual dose reductions when they were referred to them. During an interview on 11/20/25 at 12:31 p.m., the director of nursing (DON) stated the gradual dose reduction was referred to elder care and whomever was going to be completing the 60-day elder care review should have been informed of the need to address the gradual dose reduction. The DON reviewed the 60-day elder care note and was unable to see any evidence it was addressed. The Consultant Pharmacist Services Provider Requirements dated 5/2022, identified the pharmacist would conduct a monthly medication review at least monthly, incorporating federally mandated standards of care in addition to other applicable professional standards as outlined in the procedure for medication regimen review and would make recommendations to medical providers.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review the facility failed to correctly label a prescribed medication for 1 of 1 resident (R29) reviewed for medication labeling.Findings include R29's quarterly Minimum Data Set (MDS) dated [DATE], indicated R29 was cognitively intact. Diagnoses included heart failure, depression and anxiety. R29's care plan lacked documentation related to creams at bedside and labeling requirements. R29's active order summary report dated 5/14/25, indicated an order for Diclofenac Sodium external gel 1%, apply 4 grams (gr) to the lower back topically three times a day. On 7/16/25, an order for Diclofenac Sodium external gel 1%, apply 2 gr to shoulder was added. On 11/17/25 at 4:18 p.m., a tube of Diclofenac Sodium external gel 1% was observed on R29's nightstand. there was no labeling on the tube to indicate the resident name, directions for use, open date of expiration date. On 11/19/25 at 2:40 p.m., a tube of Diclofenac Sodium external gel 1% was again observed on R29's nightstand. there was no labeling on the tube to indicate the resident name, directions for use, open date, or expiration date. On 11/19/25 at 2:43 p.m., registered nurse (RN)-A entered R29's room and confirmed the Diclofenac Sodium external gel 1% did not have any label on it to indicate the resident name, directions for use, open date, or expiration date During an interview on 11/19/25 at 2:43 p.m., RN-A stated any medication left at the bedside should have a label on it to indicate the right resident, right dose, right medication, right time and directions on use. There should also be an open date and an expiration date.During an interview on 11/20/25 at 9:18 a.m., the consultant pharmacist (CP) stated any medication left at bedside should have a label on it to indicate the right resident, right dose, right medication, right time and directions on use. There should also be an open date and an expiration date. Labeling is done for resident safety, so staff are aware the correct way to use.During an interview on 11/20/25 at 10:24 a.m., the director of nursing (DON) stated all medication at bedside should have a label on it to indicate the right resident, right dose, right medication, right time and directions on use. There should also be an open date and an expiration date for resident safety. The DON stated Diclofenac was a stock medication and was not aware staff could make their own label if pharmacy would not provide a label. Facility policy Medication Ordering and Receiving from Pharmacy/ Medication Labels dated 5/22, indicated a label would be affixed to the outside of the prescription container. Floor stock medications [are/may be] labeled as floor stock or house supply and kept in the original manufacturer's container (See IC8: HOUSE SUPPLIED (FLOOR STOCK) MEDICATIONS). The manufacturers or pharmacy's label should include the following:1) Medication name2) Medication strength3) Quantity4) Accessory/auxiliary instructions5) Lot number6) Expiration date7) Manufacturer and/or distributor

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review the facility failed to arrange dental services for a resident with broken teeth and possible cavities. This affected 1 of 2 (R44) residents reviewed for dental concerns.Findings include:R44's quarterly Minimum Data Set (MDS) dated [DATE] indicated R44 had moderative cognitive impairment. Diagnoses included alcohol dependence and delirium.R44's Oral/Dental Evaluation form dated 11/29/24, indicated there was plaque or debris in localized areas between the teeth. The form also indicated R44 had teeth broken and appears to have cavities. Halitosis (bad breath) was also present. R44's electronic medical record was reviewed from 11/29/24 to 11/19/25 and lacked documentation R44 was referred to dental for evaluation related to broken teeth and possible cavities. During an observation on 11/17/25 at 5:18 p.m., R44 was observed to have two broken teeth on the front lower tooth line. There were also areas of black and brown on various parts of his tooth to possibly could have been cavities. During an interview on 11/18/25 at 3:48 p.m. family member (FM)-D stated R44 had broken teeth since admission to the facility. FM-D was not aware R44 had possible cavities. FM-D stated the facility had not reached out to him to see if a dentist needed to see R44 related to the broken teeth or possible cavities since admission to the facility. During an interview on 11/19/25 at 10:18 a.m., health unit coordinator (HUC) stated when a resident needed dental services, staff reported it to her. At that time the HUC would send all appropriate information to the dental group to get schedule for a dental visit. No staff had ever reported R44 needed to see a dentist since admission to the facility.During an interview on 11/19/25 at 2:43 p.m., registered nurse (RN)-A stated clinical managers performed the oral/dental evaluation forms every quarter when the MDS is due. If there were broken teeth the resident or resident representative would be notified a dental referral would be made. the HUC would then be notified so the resident could be scheduled for a dental evaluation visit.During an interview on 11/20/25 at 9:56 a.m., the director of nursing (DON) stated an expectation staff would place dental referrals for any resident that had dental concerns that needed evaluation by the dentist such as broken teeth or possible cavities.The facility dental policy was requested but not provided.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review the facility failed to establish a process for antibiotic review in order to determine appropriate indications and resistance for use of an antibiotic for 1 of 1 resident (R3).Findings include:R3's Quarterly Minimum Data Set (MDS) dated [DATE], identified R47 had a mild cognitive impairment and had diagnoses that included Parkinson's Disease, visual hallucinations, anxiety, and dementia.Cognitive Loss/Dementia Care Area Assessment (CAA) dated 3/5/15, identified R3 triggered for Cognitive Loss CAA on most recent assessment related to R3's BIMS score of 13. Per staff, R3 had short term memory deficits and was aware that she was in a nursing home. R3's cognitive skills for daily decision-making skills were moderately impaired. R3's diagnoses included Parkinsons Disease, atrial fibrillation (irregular heartbeat), congestive heart failure (CHF), Adult Failure to Thrive, and Hypertension (high blood pressure). R3's husband and daughter assisted with decision making. R3/family plan for long term placement; R3 was admitted to hospice services today. Social services would continue to be available to R3. Proceed to Care Plan.Care plan revised 12/3/25, identified alteration in elimination exhibited by urine and bowel incontinence, need for occasional straight catheterizations, Parkinson's Disease, adult failure to thrive, weakness and abnormalities of gait and mobility. Staff were directed to provide the following: Assist of 1 for toileting. Provide assistance with peri-cares morning, bedtime and as needed.Provide incontinence products and assist to change as needed.Monitor bowel movements as they occur. Administer bowel medications as ordered. Toileting plan: offer toileting to resident every 2-3 hours, and after meals.MHM Target Behavior Form dated 9/26/25, identified excessive call light usage. Yelling toward staff members. Staff were to provide redirection and reassurance. Talk with R3 about the Vikings football team. Offer R3 one on one time.R3's Physician order dated 11/18/25, identified Ciprofloxacin HCl Oral Tablet 500 MG (Ciprofloxacin HCl) (An antibiotic) Give 1 tablet by mouth two times a day for urinary tract infection for 3 Days.R3's Consultant Pharmacist Note dated 11/19/15 at 8:16 p.m., identified the pharmacist identified no irregularities during R3's monthly medication review. R3's Nursing Progress Notes identified the following:On 11/3/25 at 3:05 a.m., R3 was on her call light numerous times. R3 appeared to be confused at times saying staff needed to change her body instead of brief. R3 also stated to this writer R3 feared falling into the black hole that was next to her recliner. R3 also told staff R3 believed she was sitting at the edge of her bed when R3 was in her recliner. On 11/4/25 at 9:58 p.m., R3 was convinced that staff were outside of her room, talking about her and R3 did not want to put her call light on. On 11/7/25 at 1:30 a.m., R3 was awake so far that shift, yelling hello, is anyone out there? R3 was asking the same questions to different staff, what time was it, where was the remote, can you sit my head up a little? R3 had received as needed dose of Seroquel (an antipsychotic medication used to treat various mental health conditions). Will continue to monitor.On 11/14/25 at 1:47 p.m., a urinalysis (a set of tests that looks at the appearance of your pee (urine) and checks for blood cells, proteins and other substances in it. You provider might use it as a routine screening test or to look for signs of infection, kidney or liver disease, diabetes or other health conditions.) was collected. Light yellow clear urine as output. Will be taken to Lab. However, the note failed to identify R3's symptoms and/or why the urinalysis was collected. On 11/14/25 at 8:16 p.m., R3's urinalysis results were received. Clear yellow urine negative for glucose, ketones, protein, nitrates but noted a small leukocyte esterase. Also noted 30-50 white blood cells (WBCs) and few squamous epithelial cells. Will update hospice of results. However, the note failed to identify R3's symptoms. On 11/16/25 at 6:16 a.m., R3 used her call light excessively throughout night. R3 was given an as needed dose of Dilaudid (an opioid pain medication) as well as toileted and fluids offered with repositioning. However, the note failed to identify R3's symptoms.On 11/17/25 at 9:47 a.m., R3's urine culture results were received and noted 50,000- 100,000 cfu/100,000 cfu/ml Proteus mirabilis (a Gram-negative bacterium commonly associated with urinary tract infections). Will update MD and (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	hospice accordingly.During an interview on 11/17/25 at 7:06 p.m., R3 stated she was just told yesterday she has a urinary tract infection (UTI). R3 stated she didn't have any symptoms of a UTI and denied burning, urgency or discomfort. My daughter said I had attitude changes. R3 stated an antibiotic had been started. During an interview on 11/18/25 at 1:53 p.m., licensed practical nurse (LPN)-C stated, normally, she would get a set of vitals, and try to do an assessment and nursing note when a resident complained of not feeling well or had symptoms of a UTI. LPN-C would then let the nurse manager know what she found and, more than likely, would collect a UA if it could be a UTI. The nurse manager would contact the provider. LPN-C stated R3 did not exhibit symptoms of a UTI. R3's daughter requested it and had said R3 was acting like she was getting a UTI a couple day prior. R3 had been acting normally LPN-C's shift when LPN-C collected the UA. R3 had no fever and no pain with urination. LPN-C stated, normally, she would monitor a resident with complaints of confusion and let the nurse manager know. That day, LPN-C did let the nurse manager know R3's daughter was requesting a UA and the decision to collect a UA was from the nurse manager. LPN-C stated she had only worked with R3 one shift since the UA collection, but R3 was acting her usual self then too. LPN-C did not enter a nursing note because she believed the nurse manager would do so. I can only think that because R3 really wasn't showing symptoms and it was R3's daughter's request, I didn't think it was needed. During an interview on 11/18/25 at 2:26 p.m., LPN-E stated when a resident complained of not feeling well, LPN-D would check them: what's their mental status, vitals, do they have any as needed medications, then notify the nurse manager and enter a nursing progress note. LPN-E would enter everything she did into the nursing progress note: what questions she asked the resident etc. and the follow up; even the conversation with the nurse manager. Staff had to ask the provider every time for a UA. The clinical manager completed an order on paper. LPN-E collected and labeled the urine sample, then it was taken to the lab. writes the order on paper. After that, it's taken care of by the nurse manager. I collect the UA and put the name label on it, and it gets taken to the lab. After that, the nurse manager takes care of it. R3 had a history of UTI but LPN-E stated she was unaware R3 had a UA completed nor that R3 was on an antibiotic. During an interview on 11/19/25 at 3:43 p.m., the LPN care coordinator (CC)-B stated there was an interdisciplinary team that reviewed resident conditions and CC-B was not familiar with all the residents. CC-B stated she would need to talk to the DON about R3. During a telephone interview on 11/20/25 at 9:49 a.m., the consultant pharmacist stated she did review R3's physician order for Ciprofloxacin on 11/19/25 but was pleased to see the length of treatment was 3 days versus 7 days. The consultant pharmacist stated she did see there was a UA result, and the consultant pharmacist did look for positive nitrites which would indicate an infection was brewing. R3's was negative but R3 did have a history of UTI. The consultant pharmacist did review R3's nursing notes, but staff did not always document thoroughly either. It's a small, tight knit community and the consultant pharmacist could see the providers performing a UA per the family's request. However, from an antibiotic stewardship standpoint, confusion was not an appropriate indication. Documentation was a strong factor during the monthly medication review process because it provided a full picture of what was going on with that resident and if the antibiotic was appropriate. During an interview on 11/20/25 at 10:06 a.m., registered nurse (RN)-A stated when a staff member contacts her regarding a resident, RN-A asked what the staff had experienced with the resident. What does their urine look like? Are they voiding? Any other symptom the resident was having, and RN-A updated the resident's provider either with a phone call or a fax. RN-A then completed a nursing note or she would tell the staff member to do a note. RN-A stated for R3, RN-A updated the hospice nurse that afternoon and requested a UA verbally. RN-A did not do a condition note. RN-A stated a family request for UA was not an appropriate reason. RN-A stated she was told R3 was yelling, using the call light and had been in the bathroom frequently, however, RN-A did not document this nor does R3's medical record reflect R3's symptoms. During a telephone interview on 11/20/25 at 11:29 a.m., RN-B stated the facility requested R3 have a UA because R3's daughter was complaining of R3 having increased confusion and behaviors for 3 days. R3 had a history of UTI and (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R3's daughter insists that R3 shows no other symptoms for UTI other than confusion. RN-B stated she had never attempted to educate R3 and/or R3's daughter regarding UTI symptoms and/or appropriate antibiotic treatment. We usually treat because that is the patient and family's wishes.During an interview on 11/20/25 at 11:54 a.m., the director of nursing (DON) stated R3's daughter had requested to have a UA done because she was noting confusion in R3. R3's daughter believes confusion was related to the UTI, however, R3 did exhibit behaviors and confusion related to her diagnoses and not necessarily to a UTI, but R3's daughter insisted it was an increase. In that situation, I would expect a resident with a history of UTI who was experiencing symptoms that the symptoms were clearly documented and obtain a UA if appropriate and ordered by the provider. Staff were expected to provide a full picture to the provider and document that as well. Regarding antibiotic stewardship, R3 did not meet the criteria for a UTI, however, the DON received a lot of resistance from providers when she questions the appropriateness of antibiotic orders. The facility was going to obtain the assistance of the medical director to override the inappropriate orders. With R3, the order was received on yesterday, 11/19/25, and I will contact the provider today, 11/20/25, to discuss the order to ensure she really needs the antibiotic. Normally, the DON would have requested an antibiotic timeout, requested more monitoring and/or push fluids to watch symptom management. Overall, more antibiotic resistance was being seen and the only way to minimize that was to have a good antibiotic stewardship program to ensure appropriateness. With R3, staff did wait for the UC result and the facility's rounding provider deferred to the hospice provider because it was comfort based. The facility's Antibiotic Stewardship Program revised 11/2024, identified prior to calling a provider to communicate a suspected infection, the nurse will obtain and have the following information available:Signs and symptoms of suspected infection (based on McGeer's criteria)History of present illnessCurrent medication listAllergiesLast INR results (if currently receiving warfarin)All pertinent lab, imaging or test resultsAppropriate indications for antibiotic use include:Criteria met for clinical definition of active infection or suspected sepsis; andPathogen susceptibility, based on culture and sensitivity, to antimicrobial (or treatment begun while culture is pending. Empirical use of an antibiotic on clinical criteria may be appropriate.