STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245279	A. Building B. Wing	06/04/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Good Samaritan Society - Specialty Care Community	3815 West Broadway Avenue Robbinsdale, MN 55422

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and document review the facility failed to ensure staff consistently wore hair restraints and gloves while serving food. Additionally, the facility failed to maintain food temperatures within the desired range. The facility also failed to consistently cover food items placed in the freezer and date the items with the date placed and the date food items were to be used by. This had the potential to affect all 88 residents who resided at the nursing home. Findings include: On 6/1/26 at 5:11 p.m., dietary aide (DA)-A was observed setting up kitchenette area for evening meal service. DA-A had her hair pulled back in a ponytail, with strands of hair hanging free from the ponytail on the sides of her head. DA-A was wearing a standard uniform top. Further, Dietary manager (DM)-A delivered a tray of sherbet to the kitchenette without a hair net in place. At this time, DA-A removed the aluminum foil from the chafing dishes, stirred the chicken noodle soup, and began to prep for food service. DA-A applied a glove on the hand which handled the bread for the egg salad sandwich. DA-A removed the glove and replaced it with another glove, however, did not perform hand hygiene in between. At 5:16 p.m. DA-A had gloves on both hands while she removed the crusts from bread to prepare a sandwich. At 5:17 p.m., DA-A removed the second glove and did not perform hand hygiene. On 6/1/26 at 5:19 p.m., DA-A proceeded to check temperature of food items. DA-A reported the temperature of the egg salad filling for sandwiches was 56.8 degrees Fahrenheit (F). The egg salad sandwich filling was observed to be in a stainless serving container, sitting on the counter, and was not placed in an ice bath. DA-A also checked the temperature of the mashed potatoes and reported them to be at 115.5 degrees Fahrenheit. DA-A stated she was unaware of what temperatures food items were to be at. On 6/1/26 at 5:21p.m., DM-A returned to the kitchenette, wearing a hairnet, covered by a cloth visor. DM-A had brought out an apron for DA-A to wear. DM-A was informed of food temperature of egg salad filling and removed food item to take down to kitchen to chill. On 6/1/26 at 5:28 p.m., DA-A stated if staff wore a ponytail holder, a hairnet was not needed. DA-A stated her hair had not fallen out of the ponytail holder. DA-A stated she did not typically use a hairnet as she pulled her hair back into a ponytail. On 6/1/26 at 5:39 p.m., egg salad filling was brought back up to kitchenette in the stainless-steel serving container, placed in an ice bath. DM-A stated this was blast chilled, placed in a salted ice bath, while in freezer. The egg salad filling was temped at this time and was noted to be at 36.4 degrees F. DM-A stated temperature of cold food should be 40 degrees or less. DM-A stated there (continued on next page)

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

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	was no concern regarding salmonella for residents who had previously received sandwiches prior to temping as the filling was not out long enough in the danger zone. The potatoes were temped again at this time upon request and were noted to be at 160 degrees F. DM-A stated all hot food should be at 145 degrees F. DM-A stated when aware potatoes were at 116 degrees F., they should have been pulled, and a fresh batch made. DM-A stated she had realized she was not wearing a hairnet when delivering sherbet and went to obtain one. DM-A stated she had not noticed DA-A was not wearing a hairnet but should be. DM-A stated a hairnet was to be used to keep hair out of food. DM-A stated the expectation for those behind the serving line was to wear hairnets, aprons, and gloves on both hands. DM-A stated a ponytail was not adequate as a hair restraint. On 6/4/26 at 8:54 a.m., an observation was made during the breakfast service process in which DA-B was served breakfast while wearing a stocking cap which ended just under ears, and his hair was shoulder length and extended down to the neckline of shirt. On 6/4/26 at 9:35 a.m., DM-A stated DA-B should have worn a hairnet underneath the knit cap to restrain hair extending beyond the edge of the cap. The facility policy, Food Temperature Monitoring-Food and Nutrition Services, reviewed/revised 3/23/26, identified food temperatures are taken and recorded before each meal service. The policy also identified temperatures are taken at other times during or at the end of meal service to ensure temperatures are held within acceptable ranges. The policy indicated that food was served at proper serving temperatures, and further identified proper temperatures as below 41 degrees Fahrenheit for cold foods or above 135 degrees Fahrenheit for hot foods. The facility policy, Employee Hygiene and Dress Code-Food and Nutrition Services, reviewed/revised 5/27/25, identified hairnets or hair restraints and beard nets or beard restraints were to be used when cooking, preparing, assembling food or ingredients. This includes dish rooms and storage areas. See specific state guidelines. Hair is to be covered completely. The policy further states aprons are to be put on a clean apron at the beginning of each shift. The facility policy, Hand Washing and Glove Use-Food and Nutrition Services, reviewed/revised 6/6/25, hands are washed thoroughly before putting gloves on and after taking gloves off. On 6/1/26 at 1:06 p.m. initial kitchen tour was conducted with dietary manager (DM)-A. The walk-in freezer had egg rolls on second shelf on right side of freezer. The egg rolls were wrapped with plastic wrap with one end opened to the air of the freezer. There was no date on the plastic wrap. There was a package of unidentified meat wrapped with aluminum foil, there was no date observed on the package. The walk-in cooler had a jar of Grey Poupon mustard with no date opened indicated, In addition there were hot dogs wrapped with plastic wrap and no date indicated on the wrap. On a shelf below a counter there was a large plastic tub of panko that was not dated when opened and placed into the plastic tub. DM-A stated items were expected to have an opened date and placed into appropriate containers; (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	there was to be no items left open to the air. On a follow-up visit to the kitchen on 6/3/26 at 12:28 p.m. there was an opened undated package of pizza crust and a plastic bag of carrots in the walk-in freezer. DM-A stated the staff were usually good about dating items when opened. Facility Food-Supply Storage–Food and Nutrition Services policy dated 3/13/26 indicated foods that had been opened or prepared were placed in an enclosed container, dated, labeled and stored properly.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. Based on interview and document review the facility failed to implement routine surveillance of signs and symptoms of illness/infection which were not currently being treated with antibiotic therapy or other treatment. This had the potential to impact all 88 residents who resided at the facility, as well as staff, and visitors. Findings include: A review of the Infection Surveillance Reports was completed for the months of March, April, and May of 2026. The documents included the total number of infections, whether facility or community acquired infections, the facility acquired infection incidence rates, and the number of multidrug resistant organisms (MDROs). The surveillance logs further classified the types by category of infection. The data gathered on this log included resident name, room number, infection type, signs and symptoms reported, and status (active or resolved). The log also included the type of treatment or antibiotic, antifungal or antimicrobial in place. The log lacked identification of completed testing (labs, chest x-ray, etc.). Although the logs contained an area for comments, this area was not utilized for reporting any completed lab results.During interview on 6/3/26 at 2:07 p.m., the Infection Preventionist (IP), also director of nursing (DON), stated she currently used the Point Click Care electronic medical record (EMR) for surveillance tracking. IP stated the PCC EMR was able to pull data up and input the information into the Infection Surveillance Report. The log lacked capability to pull testing and lab results into the form as they were not hyperlinked to the surveillance report. IP stated this information may be entered into the comment section, however, had not implemented this process. The infection control surveillance log lacked tracking instances of signs and symptoms presented which were not being treated with antibiotics, antifungals, or antimicrobials.IP stated although not tracked on the surveillance log, signs and symptoms of potential illness or infections were reviewed daily Monday through Friday by running reports and reviewing the documentation based on the control f (find) feature of the progress notes. IP stated when she reviewed the progress notes, she looked for things such as an increase or decrease in temperatures and vital signs, symptoms of cough, shortness of breath, altered respiratory status, nausea, vomiting and diarrhea. The progress notes were also monitored for new admissions, indwelling devices, history of MDRO's, and new wounds. In addition to symptoms of illness/infection, a review of new orders was also completed. Upon demonstrating this process for the day of interview, the report generated 99 pages. Although the information was culled out for the day of review, this data was not recorded or compiled for subsequent review for trending of current trends of symptoms (urinary tract infections, upper respiratory symptoms, or gastrointestinal symptoms) or tracking for patterns of symptoms or trending of illnesses. IP stated she monitored the daily progress notes for symptoms of upper respiratory infections and if symptoms were noted, testing would be performed. IP stated the same process was used for symptoms of vomiting or diarrhea, and testing for c. diff (clostridium difficile). IP stated there were no formalized logs of those who were currently being monitored only and that data was captured only by running daily reports or review of individual progress notes. At the time testing was performed due to persistent symptoms, the individual would then be tracked on the suspected log.IP acknowledged the benefit of monitoring via the surveillance log signs and symptoms of infections and illness to capture any potential trends which would allow the opportunity to implement training, education, and placement of interventions to help decrease the potential for spread of illness and infection.The facility policy, Infection Prevention and Control Program, All Service Lines-Enterprise, reviewed/revised 3/25/26 identified the purpose of the infection control program was to provide a safe, sanitary, and comfortable environment and prevent the development and transmission of communicable diseases and infections. The policy identified the surveillance system was to be implemented to provide a safe, sanitary, and comfortable environment and prevent the development and transmission of communicable diseases and infections.

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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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure residents receiving psychotropic medications were adequately monitored for potential adverse consequences, including failure to implement side effect monitoring for 4 of 6 residents (R7, R10, R41, and R91) reviewed for psychotropic medication monitoring, and failure to obtain and document orthostatic blood pressures as ordered for 3 of 6 residents (R10, R41, and R91) reviewed for psychotropic medication use.Findings include:R7R7's comprehensive Minimum Data Set (MDS) dated [DATE], identified R7 had moderate cognitive impairment and required assistance with activities of daily living (ADL)'s. R7's diagnoses included deep vein thrombosis (DVT; a blood clot that forms in a deep vein, usually in the leg), hypertension (high blood pressure), benign prostatic hyperplasia (BPH; enlargement of the prostate gland that can affect urination), renal insufficiency (reduced kidney function), diabetes mellitus (a condition in which the body has difficulty regulating blood sugar levels), and cerebrovascular accident (CVA; a stroke caused by interrupted blood flow to the brain). The MDS further identified R7 received psychotropic medications.R7's physician orders identified Escitalopram Oxalate Oral Tablet 20 mg (milligram) by mouth one time a day for depression, initiated on 1/14/25.R7's electronic health record (EHR) failed to identify evidence side effect monitoring had been implemented to assess for potential adverse consequences related to the psychotropic medication. R10R10's comprehensive MDS dated [DATE], identified R10 had severe cognitive impairment and required assistance with ADL's. R10's diagnoses included non-traumatic brain dysfunction (impaired brain function not caused by a physical injury), atrial fibrillation (an irregular and often rapid heart rhythm), hypertension (high blood pressure), and non-Alzheimer's dementia (a decline in memory, thinking, and reasoning abilities not caused by Alzheimer's disease). The MDS further identified R10 received antipsychotic medications.R10's physician orders identified Brexpiprazole Oral Tablet 1.5 mg by mouth two times a day for agitation related to dementia, initiated on 3/23/26, and Haloperidol 2 mg by mouth one time a day for delusions related to unspecified dementia, initiated on 6/1/26.R10's EHR failed to identify evidence side effect monitoring had been implemented to assess for potential adverse consequences related to the antipsychotic medications.R10's physician orders further identified an order to document orthostatic blood pressure one time a day, starting on the 1st and ending on the 1st of every month, for antipsychotic medication monitoring, including blood pressure and pulse readings in the lying, sitting, and standing positions. The order was initiated on 4/1/26.Review of orthostatic blood pressure documentation identified: 4/1/26: Lying blood pressure was documented as 110/76 with pulse 72. Sitting and standing blood pressures were both documented as 118/70 with pulse 90. 5/1/26: Lying, sitting, and standing blood pressures were all documented as 120/66 with pulse 90. 6/1/26: Lying, sitting, and standing blood pressures were all documented as 147/98 with pulse 98.R10's EHR failed to identify evidence orthostatic blood pressures were obtained as ordered. The identical blood pressure and pulse readings documented for multiple positions called into question whether separate measurements were obtained in the lying, sitting, and standing positions. R41R41's quarterly MDS dated [DATE] identified R41 had severe cognitive impairment and required assistance with ADL's. R41's diagnoses included non-traumatic brain dysfunction (impaired brain function not caused by a physical injury), hypertension (high blood pressure), peripheral vascular disease (PVD; a condition involving reduced blood flow through blood vessels outside of the heart and brain), hyperlipidemia (elevated levels of fats, such as cholesterol and triglycerides, in the blood), arthritis (inflammation or degeneration of the joints causing pain and stiffness), Alzheimer's disease (a progressive brain disorder that affects memory, thinking, and behavior), stroke (damage to the brain caused by interrupted blood flow), and non-Alzheimer's dementia. The MDS further identified R41 received antipsychotic medications.R41's physician orders identified risperidone Oral Tablet 0.25 mg by mouth (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	three times a day for hallucinations, initiated on 5/8/26.R41's EHR failed to identify evidence side effect monitoring had been implemented to assess for potential adverse consequences related to the antipsychotic medication.R41's physician orders further identified an order to document orthostatic blood pressure one time a day, starting on the 3rd and ending on the 3rd of every month, for antipsychotic medication monitoring, including blood pressure and pulse readings in the lying, sitting, and standing positions. The order was initiated on 2/3/26.Review of orthostatic blood pressure documentation identified: 2/3/26: Not obtained. Documentation indicated the resident refused. The record failed to identify evidence the monitoring was attempted again at a later time. 3/3/26: Sitting blood pressure was documented as 120/50 with pulse 82. Lying and standing blood pressures were both documented as 126/56 with pulse 76. 4/3/26: Not obtained. Documentation indicated the resident refused. The record failed to identify evidence the monitoring was attempted again at a later time. 5/3/26: Lying, sitting, and standing blood pressures were all documented as 112/70 with pulse 78. 6/3/26: Lying, sitting, and standing blood pressures were all documented as 128/56 with pulse 72.R41's EHR failed to identify evidence orthostatic blood pressures were obtained as ordered. The identical blood pressure and pulse readings documented for multiple positions called into question whether separate measurements were obtained in the lying, sitting, and standing positions. R91R91's quarterly MDS dated [DATE], identified R91 had severe cognitive impairment and required assistance with ADL's. R91's diagnoses included schizophrenia (a chronic mental health disorder that affects a person's ability to think clearly, perceive reality, manage emotions, and interact with others). The MDS further identified R91 received antipsychotic medications.R91's physician orders identified Olanzapine Oral Tablet 5 mg by mouth two times a day related to paranoid schizophrenia, initiated on 3/25/26 and discontinued on 6/1/26; Olanzapine Oral Tablet 2.5 mg by mouth two times a day related to paranoid schizophrenia, initiated on 6/1/26; and risperidone Oral Tablet 2 mg by mouth two times a day for paranoid schizophrenia, initiated on 6/9/25.R91's EHR failed to identify evidence side effect monitoring had been implemented to assess for potential adverse consequences related to the antipsychotic medications.R91's physician orders further identified an order to document orthostatic blood pressure one time a day, starting on the 17th and ending on the 17th of every month, for antipsychotic medication monitoring, including blood pressure and pulse readings in the lying, sitting, and standing positions. The order was initiated on 7/17/25.Review of orthostatic blood pressure documentation identified: 1/17/26: Lying and sitting blood pressures were both documented as 136/78. No pulse readings were documented, and no standing blood pressure was documented. 5/17/26: Lying, sitting, and standing blood pressures were all documented as 142/68 with pulse 66.R91's EHR failed to identify evidence orthostatic blood pressures were obtained as ordered. The identical blood pressure and pulse readings documented for multiple positions, as well as incomplete documentation, called into question whether separate measurements were obtained in the lying, sitting, and standing positions. During an interview on 6/4/26 at 9:41 a.m., licensed practical nurse (LPN)-B stated nurses or TMA's completed orthostatic blood pressure monitoring. LPN-B stated that for residents who were unable to stand, staff would obtain sitting and lying blood pressures.During an interview on 6/4/26 at 12:14 p.m., RN Case Manager (CM)-C stated orthostatic blood pressures should be completed monthly and include blood pressure measurements in the lying, sitting, and standing positions. CM-C stated orthostatic blood pressures were important because antipsychotic medications could cause side effects that increased a resident's risk for falls. CM-C stated they would not expect blood pressure readings to be exactly the same in all three positions because some variation would typically occur. CM-C further stated that if a resident refused the monitoring, staff should document the refusal and attempt the monitoring again later. CM-C reviewed the orthostatic blood pressure documentation for the identified residents and confirmed several readings were identical in all positions. CM-C stated they would ensure nursing staff were educated on the correct procedure for obtaining orthostatic blood pressures.During an interview on 6/4/26 at 12:59 p.m., a call was placed to the consultant pharmacist and a message was left requesting a return call regarding (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	psychotropic medication monitoring and orthostatic blood pressure monitoring. As of survey exit, the consultant pharmacist had not returned the call.During an interview on 6/4/26 at 12:59 p.m., director of nursing (DON) stated psychotropic medication monitoring should be completed monthly and include blood pressure measurements in the lying, sitting, and standing positions. DON stated that if a resident refused the monitoring, staff should allow time, reapproach the resident, and, if the resident continued to refuse, reschedule the monitoring in the TAR and document the interventions attempted. DON stated staff would not expect blood pressure readings to be exactly the same in all three positions.During an interview on 6/4/26 at 1:16 p.m., CM-C stated the facility did not have anything in place for monitoring psychotropic medication side effects. CM-C stated there was no documentation of side effect monitoring for residents receiving psychotropic medications and acknowledged there probably should have been documentation so staff would know whether the medication was having a negative effect on the resident.During an interview on 6/4/26 at 1:29 p.m., DON stated documentation for monitoring medication side effects was something the facility was just beginning to implement. DON stated the facility had begun reviewing medication side effects during morning meetings. DON stated side effect monitoring was important so staff would know whether residents were experiencing adverse effects from psychotropic medications.The facility's Psychotropic Medications - Rehab/Skilled policy, reviewed/revised 12/9/25, identified that each resident's drug regimen must be free from unnecessary medications, including medications used without adequate monitoring or in the presence of adverse consequences that indicate the dose should be reduced or discontinued. The policy required ongoing monitoring throughout the administration of psychotropic medications, including continued mood and behavior documentation to evaluate the medication's effect on behaviors, monitoring for medication side effects, and monitoring for effectiveness and potential adverse consequences. The policy further directed nursing staff to document side effects, notify the physician and family/legal representative when side effects occurred or worsened, and complete ongoing assessments to evaluate resident response to psychotropic medications. The policy also required the reduction committee to review psychotropic medications at least every three months, including evaluation of target symptoms, medication effectiveness, and any medication-related adverse consequences experienced by the resident during the previous quarter.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 interview and record review, the facility failed to revise comprehensive care plans to reflect significant changes in resident status, conditions, preferences, and interventions, for 3 of 3 residents (R111, R7, and R75) reviewed for care plan revision. Further, the facility failed to update the care plan with specific interventions for 2 of 2 residents (R1 and R122) reviewed for privacy of care. Findings include: R111 R111's discharge return anticipated MDS dated [DATE], identified R111 had moderate cognitive impairment and required assistance with ADLs. R111's diagnoses included cancer (a disease in which abnormal cells grow uncontrollably), septicemia (a serious bloodstream infection), and non-Alzheimer's dementia (a decline in memory and cognitive functioning not caused by Alzheimer's disease). The MDS further identified R111 was receiving hospice services. R111's EHR identified hospice services were discontinued on 5/11/26. R111's care plan printed of 6/2/26, identified a focus area which stated, The resident has a terminal prognosis R/T prostate cancer E/B on Optage Hospice, with an initiation date of 12/9/25. However, the care plan continued to indicate R111 was receiving hospice services after hospice services were discontinued on 5/11/26 and failed to be revised to reflect the resident's discharge from hospice. R111's care plan printed 6/4/26, further identified The resident requires Enhanced Barrier Precautions (EBP) R/T wound. R111's EHR identified the wound had healed and R111 remained on EBP due to the presence of a urinary catheter. The care plan failed to be revised to reflect the resident's current need for EBP precautions and continued to identify the healed wound as the basis for the intervention. R7 R7's comprehensive Minimum Data Set (MDS) dated [DATE] identified R7 had moderate cognitive impairment and required assistance with activities of daily living (ADL)'s. R7's diagnoses included diabetes mellitus (a chronic condition that affects how the body uses blood sugar) and cerebrovascular accident (CVA; damage to the brain caused by interrupted blood flow). The MDS further identified R7 received insulin, an anticoagulant, and an antidepressant. R7's care plan printed 6/2/26, identified a care plan focus titled, The resident has respiratory infection: Influenza A, with an initiation date of 12/25/25. R7's electronic health record (EHR) failed to identify ongoing signs, symptoms, treatment, or diagnosis of Influenza A. The care plan continued to identify Influenza A as an active care plan focus despite resolution of the condition and failed to identify revision or discontinuation of the focus area. R75 R75's comprehensive MDS dated [DATE], identified R75 had severe cognitive impairment and (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	required assistance with ADLs. R75's diagnoses included non-Alzheimer's dementia (a decline in memory and cognitive functioning not caused by Alzheimer's disease) and post-traumatic stress disorder (PTSD; a mental health condition that can develop after experiencing or witnessing a traumatic event). The MDS further identified R75 displayed physical and verbal behavioral symptoms directed toward others, as well as other behavioral symptoms not directed toward others, one to three days during the assessment period. The MDS also identified wandering behavior one to three days during the assessment period. R75's care plan printed 6/2/26, identified dining preference interventions indicating the resident preferred to sit alone during mealtimes and liked to sit in the dining room by the television next to the window. R75's EHR further identified behavior management interventions had been implemented, including placement of a bookshelf sticker on the resident's door and installation of a door chime to alert staff when residents entered or exited the room. Review of the care plan failed to identify either intervention. Observation on 6/2/26 at 12:13 p.m. identified R75 exited his room and sat at a dining room table with another resident while waiting for lunch. A door chime sounded when the resident's room door opened. Observation on 6/2/26 at 12:20 p.m. identified R75 ate lunch with two other residents and engaged in conversation with them. Observation on 6/2/26 at 12:22 p.m. identified another resident sat at the table with R75, and R75 greeted the resident. Observation on 6/3/26 at 8:13 a.m. identified R75 exited his room for breakfast and a door chime sounded when the door opened. R75 then sat in the dining room with two other residents in the main dining room. During an interview on 6/4/26 at 9:27 a.m., nursing assistant (NA)-E stated R111 was on hospice and was on EBP precautions due to having a urinary catheter. During an interview on 6/4/26 at 9:31 a.m., NA-D stated R75 was easily agitated and was protective of his personal space. NA-D stated a door chime alerted staff when the resident's door opened so staff could ensure other residents did not enter the room. NA-D further stated a bookshelf sticker had been placed on the resident's door approximately one month earlier. NA-D stated R75 initially sat in the small dining room when he was admitted to the facility but had been sitting in the main dining room with other residents for quite some time. NA-D also stated R7 had not been sick in quite a while. During an interview on 6/4/26 at 9:33 a.m., licensed practical nurse (LPN)-B stated R111 had graduated from hospice services and the facility had discussed the possibility of restarting hospice services; however, R111 did not meet the criteria. LPN-B stated R111 was on EBP precautions due to a urinary catheter and had not had a wound for several months. R75 previously exhibited exit-seeking behaviors but had mellowed considerably and spent more time outside of his room. To address those behaviors, a door chime and bookshelf sticker had been implemented approximately one month earlier to alert staff if another resident wandered into R75's (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	room. R7 had not had Influenza since the previous year. LPN-B stated care plans should be updated to reflect changes in resident conditions and interventions and could be updated by nursing staff, although the nurse manager completed most care plan revisions. During an interview on 6/4/26 at 12:32 p.m., registered nurse case manager (CM)-C stated R75 was territorial regarding his personal space and could be paranoid at times, although his behavior had improved. CM-C stated a bookshelf sticker and door chime had been implemented on 5/7/26 and had been effective interventions; however, neither intervention was included in the care plan. CM-C stated it was important for staff to be aware of the interventions and confirmed they should have been care planned. CM-C further confirmed R75 initially sat in the small dining room but currently sat in the main dining room with three other residents and stated the dining preference intervention should have been revised to reflect the resident's current preference. R111 was discharged from hospice services on 5/11/26 following hospitalization. CM-C reviewed the EHR and confirmed hospice services continued to be identified in the record and on the care plan despite the hospice discharge. CM-C further confirmed R111 no longer had a wound and remained on EBP precautions due to a urinary catheter and stated the care plan should have been revised to accurately reflect the resident's hospice status and current reason for EBP precautions. R7 no longer had Influenza A and that the care plan continued to identify Influenza A as an active respiratory infection despite the diagnosis occurring in 2025. CM-C stated the care plan should have been revised to remove the resolved condition. During an interview on 6/4/26 at 12:59 p.m., director of nursing (DON)-A stated hospice discharge notifications should prompt review and revision of the care plan and that a significant change MDS should be completed following discharge from hospice services. DON-A stated care plans should be updated whenever a resident experienced a new diagnosis, condition, intervention, preference change, or other significant change in status. DON-A further stated care plans served as the primary communication tool for staff and should accurately reflect the resident's current needs, interventions, and preferences to ensure staff understood how to provide appropriate care. The facility's policy, Care Plan - R/S, LTC, Therapy & Rehab, revised 12/1/25, indicated each resident would have an individualized, person-centered comprehensive care plan that addressed the resident's medical, nursing, physical, functional, emotional, psychosocial, and educational needs. The policy indicated care plans would be based on assessments, the Resident Assessment Instrument (RAI), physician orders, and identified resident problems, needs, and concerns. The policy further indicated the comprehensive care plan would be modified to reflect the care currently required and provided to the resident. Care plans were to be reviewed at least quarterly and reviewed, evaluated, and updated whenever there was a significant change in the resident's condition. R1 R1's significant change assessment of 3/24/26 indicated R1 had moderate cognitive impairment. The assessment identified R1 was able to communicate his needs and wishes and was able to understand information relayed to him. R1 was identified as needing assistance with activities of daily living (ADL's-dressing, grooming, and bathing). R1's medical diagnoses included headaches, (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	cardiorespiratory debility (lack of function related to heart and respiratory problems), heart failure, hypertension (high blood pressure), renal chronic kidney disease (alteration in kidney function related to removal of waste through the kidney), diabetes (alteration in the way the body processes sugar), CVA (cardiovascular accident-stroke), hemiplegia/hemiparesis (loss of use/mobility of one side of the body), and anxiety. R1's care plan from admission of 1/3/26 lacked indication of use of camera, rationale for use, and placement by family for monitoring and interaction with R1. A facility document, titled Electronic Monitoring Notification and Consent Form (GSS 686) dated 11/17, identified R1 would like camera placed on 3/15/26, and would include video and audio. The form was not signed by family member and staff member until 4/6/26. R1's progress notes of 4/6/26, identified staff had discussed video surveillance in progress and provided the GSS 686 for completion. At that time the document was reviewed and completed with signatures of both family member and staff. The progress notes reflected a sign was placed on door to indicate to staff/visitors electronic monitoring was in place. R122 R122's admission Profile indicated admission on [DATE], medical diagnoses included: Wernicke's encephalopathy (neurological symptoms (impaired vision and confusion) caused by lesions of the central nervous systems after exhaustion of B-vitamin reserves, alcohol dependence (in remission), anemia (low red blood cells or hemoglobin) and osteoarthritis (inflammation of joints). R122's care plan initiated 4/2/26, and last revised 4/24/26, lacked indication of use of video camera with audio capability for resident, as well as rationale for use, and other interventions related to this (signage, staff awareness, interaction with family through audio). A facility document, titled Electronic Monitoring Notification and Consent Form (GSS 686) dated 11/17, identified R122 would like camera placed on 4/6/26, and would include video and audio. The form was signed by family member and staff member on 4/6/26. R122's progress notes of 4/6/26, identified staff had discussed video surveillance in progress and provided the GSS 686 for completion. The note indicated staff member had left document for signature by family member. The documentation indicated once consent was signed, the camera was to be plugged in, and consent turned into the nurse's station. A copy of the signed consent was on file. A subsequent note of 4/10/26, indicated family was observing via camera and alerted staff of R122s need for help. During interview on 6/4/26 at 12:57 p.m. licensed social worker (LSW)-A, stated R1 had cameras found in his room without staff awareness. LSW-A stated family was contacted, a GSS-686 consent was completed, and the camera was put into place by family members. The appropriate signage was placed on the door to advise staff and visitors of the camera use. LSW-A stated the use of cameras should have been outlined in the care plan, and this task was the responsibility of the nurse manager in charge of R1's care. On 6/4/26 at 1:31 p.m. Social Services Director (SSD)-A stated the GSS 686 for R1 was obtained right away for consent for use of the camera, a sign was posted on the door, and administrative staff was (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	notified. SSD-A stated R122's family member was contacted on 4/6/26 as well, and a consent was left for signature. The note left for family was to provide nursing staff with consent and were then able to proceed with use of the camera. SSD stated social services were responsible for obtaining the consent and posting the signage for camera use, however, nursing staff was responsible to update the care plan to reflect the use of the camera. On 6/4/26 at 10:55 a.m. registered nurse/clinical manager (CM)-B stated she was not working at the facility when the cameras were put into place. Both R1 and R122 had involved family members who had requested cameras to be put into use. CM-B stated signage was posted on the door to alert staff and visitors of the use of the camera. CM-B stated she had not completed the care plan process with R1 and R122. The facility policy, Electronic Monitoring in Resident/Client/Patient Rooms-Enterprise, date reviewed/revised 5/18/26, initially referred to a separate policy: Photography and Video Imaging, Patient, Visitor, Workforce Member-Enterprise. This policy is broken by states which allows this monitoring. The document reflects for Minnesota, residents or, under certain circumstances, their authorized resident representative, may conduct electronic monitoring in a resident's room or private living space after certain conditions are met (such as written consent and notification, including that of any roommate). The procedure identified the electric monitoring device may be used by the resident, or their authorized representative if appropriate, after requirements have been met. This includes review of information required, and signature of a consent to allow such use. The procedure directs staff to have signs posted to inform staff/visitors of use. The policy lacks indication regarding placing the information in the care plan, or subsequent documentation in follow up regarding ongoing use of the video camera. A review of the policy, Photography and Video Imaging, Patient, Visitor, Workforce Member-Enterprise, date reviewed/revised 5/18/26, was completed and also reviewed the perimeters in which this was allowed, along with consent required for use. The facility policy, Care Plan-R/S, LTC, Therapy and Rehab, date reviewed/revised 12/1/25, indicated that each resident will have an individualized, person-centered, comprehensive plan of care that will include measurable goals and timetables directed toward achieving and maintaining the resident's optimal medical, nursing, physical, functional, spiritual, emotional, psychosocial, and educational needs. The policy stated further: This plan of care will be modified to reflect the care currently required/provided for the resident.

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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, interview, and document review, the facility failed to assure medication labels properly reflected provider orders for 2 of 7 residents (R110, R89) observed during medication administration.Findings include:On 6/1/26 at 4:10 p.m., medication observation was completed with licensed practical nurse (LPN)-A during R110's medication pass. LPN-A provided R110 with quetiapine fumarate 25 mg 1/2 tablet (1/2 tablet to total 12.5 mg-milligram/a unit of measurement) at that time, however, medication label read to give 1/2 tab(let) daily and went on to direct staff to give one tablet (25 mg) at bedtime. LPN-A stated medication administration record (MAR) directed staff to give at 4:00 p.m. LPN-A stated she was unsure if the previous dosing schedule had changed. LPN-A stated the medication label should match the orders on the MAR. LPN-A stated there were stickers available to place on the prescription label to identify a change in orders but acknowledged there was no label in place.Upon review of the orders, it was noted the orders directed staff to give quetiapine fumarate 25 mg 1/2 tablet (12.5 mg) by mouth one time a day for depression at 4:00 p.m. and 25 mg by mouth one time a day for depression at 8:00 p.m.On 6/4/26 at 1:30 p.m., a review of the medication label and the prescription label was completed with the clinical manager (CM)-A. The label directed staff to administer 1/2 tablet (12.5 mg) by mouth once daily. Give one tablet (25 mg) at bedtime. CM-A acknowledged the label lacked indication regarding spacing of doses. CM-A stated there were stickers available to place on label to direct staff to electronic medical record. On 6/3/26 at 7:47 a.m., registered nurse (RN)-B provided R89 with the inhaler, Anoro Elipta, for one puff inhalation. The inhaler was noted to be in a plastic tray, and lacked any labeling to include resident name, medication date of dispensing, date of expiration, or directions for use. The inhaler was dated as opened 4/29/26.Additionally, resident was administered the following doses of insulin:Lantus Insulin (Insulin Glargine Subcutaneous Solution 100 mg/ml) 38 units sub q (within the upper level of flesh, but not into the muscle) however the label directed staff to administer 40 units sub q. Novolog Insulin Aspart Injection 100 unit/ml 11 units, however, the label directed staff to administer nine units of insulin sub q.RN-B stated the insulin labels should have been updated by pharmacy to reflect the current doses ordered, or a sticker should have been placed on the insulin pens to reflect there was a change in orders and to refer to the EMR. RN-B stated the inhaler should remain in the original packaging until supply was depleted.On 6/4/26 at 7:58 a.m., director of nursing (DON) stated all medications should be labeled with the resident's name, name of medication, date dispensed, med dispensed, date of expiration, and directions for use. DON stated the labels on the medication card should match the instructions on the MAR. If there were changes to the orders, there were stickers which would be placed which identify directions were changed and direct staff to refer to EMR.The facility policy, Medications: Administration Including Scheduling and Medication- R/S, LTC, date reviewed/revised 3/30/26, identified with medication pass, the staff were directed to read the label on the medication container and compare with the MAR when removing the container from the supply drawer. The policy lacked direction as to what to do if there were a discrepancy between the label and the prescription label.

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to ensure resident grooming needs were met for 1 of 1 resident (R83) in the sample reviewed for nail care. Finds include: R83's admission Record (Face Page - print date of 6/4/26), documented the following diagnoses: Muscle weakness, disorientation, atrial fibrillation and essential hypertension. R83's Comprehensive Minimum Data Set (MDS) dated [DATE], assessed resident to be moderately cognitively impaired and required set-up to maximal assist with activities of daily living (ADLs). R83's Care Area Assessment for ADLs (CAA) dated 3/30/26, documented resident's limiting factors for the need of ADL assistance being causes for being dependent were physical limitations such as weakness, limited range of motion, poor coordination, poor balance, visual impairment or pain. During observation and screening on 6/01/26 at 3:26 p.m., R83 had very long fingernails on all 10 fingers, which looked to be 1/4 inch and longer in length. R83 stated he was unable to cut them himself and stated he wished them to be trimmed. During daily observation from 6/1/26 though 6/4/26, R83 continued to have long fingernails. A review of R83's electronic medical record, under the section of Tasks, it was documented R83 received weekly baths on Wednesdays. In review of R83's car plan (last revised 3/21/26), documented resident's dependence on staff, including the assist of one staff person during bathing task. On the morning of Thursday 6/4/26 (the day after resident's scheduled shower day) at 9:20 a.m., R83 was sitting at the central dining room area table feeding himself breakfast. R83's fingernails were long and uncut. R83 stated he received his shower last evening. No one offered to trim / cut his fingernails.During an interview on 6/4/26 at 9:46 a.m., nursing assistants (NA)-A and NA-B reviewed the electronic medical record task section and verified R83 received his shower the previous day at approximately 4:22 p.m. Both NA-A and NA-B stated residents should have their nails trimmed / cut with their weekly showers / baths. However, both NAs stated the NAs were not to cut fingernails but rather only the nurses. Both NA-A and NA-B stated they were only allowed to use emery boards and use fingernail polish on residents. In an observation and interview on 6/04/2026 at 9:55 a.m., registered nurse (RN)-A verified R83's nails should have been trimmed / cut yesterday with his shower. RN-A stated the NAs were allowed to trim / cut resident nails, as long as they were not diabetic. RN-A estimated 883's fingernails were all at least 1/4 inch in length. RN-A asked R83 if he wished his failed to be cut, with residents stating yes.During a further observation and interview on 6/4/26 at 10:04 a.m., registered nurse care manager (CM)-A stated resident fingernails should be trimmed / cut weekly with baths / showers. CM-A further stated the NAs were to complete this task for residents noted to have long nails, unless they were diabetic. The NAs should inform the nurse of a diabetic needing nail care. When CM-A asked R83 if he wanted his nails cut, R83 responded yes. During a final interview on 6/4/2026 at 12:50 p.m., the director of nursing (DON) stated it was the facility's expectation, resident would have their nails trimmed / cut with their weekly bath / shower if it was needed and/or the resident requested. If a resident refused nail care, staff should report the refusal to the nurse. DON stated all NAs have the ability to perform nailcare except for diabetic residents. In review of the facility's skills checklist), entitled: Nail Care Clinical Skill Checklist (undated), did not indicate when nails should be trimmed / cut but rather only the following:[certified nursing assistants] check with care plan prior to procedure. Licensed nurses see physician orders. [certified nursing assistants] are not to do nail care on residents with diabetic or circulatory problems.The policy went on to indicate the skills required by the facility for staff to perform nail care, what to observed for and what to report to the nurse. In review of the facility's policy entitled: Nail Care (last revised 4/2/26) further clarified which resident the NAs (not diabetic or residents receiving anticoagulants) were able to do, supplies need and the process in performing nail care.

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure a resident and/or resident representative was informed of and participated in treatment decisions regarding psychotropic medications, including failure to obtain informed consent prior to the initiation of a psychotropic medication for 1 of 5 residents (R41) reviewed for psychotropic medication use.Findings include:R41's quarterly Minimum Data Set (MDS) dated [DATE], identified R41 had severe cognitive impairment and required assistance with activities of daily living (ADL's). R41's diagnoses included non-traumatic brain dysfunction (impaired brain function not caused by a physical injury), Alzheimer's disease (a progressive brain disorder affecting memory and thinking abilities), stroke (damage to the brain caused by interrupted blood flow), and non-Alzheimer's dementia (a decline in memory and cognitive function not caused by Alzheimer's disease). The MDS further indicated R41 had experienced two or more falls since admission.R41's physician orders dated 4/7/26, identified an order for risperidone, a psychotropic medication, which had been initiated on 1/29/26, when R41 was admitted to the facility.Review of R41's electronic medical record (EMR) failed to identify documentation that informed consent for the psychotropic medication had been obtained from the resident and/or resident representative prior to the medication being initiated. Further review identified the consent had been obtained after the medication was started.During an interview on 6/4/26, at 12:26 p.m., RN Case Manager (CM)-C stated psychotropic medication consents were obtained upon admission and reviewed with the resident and/or family member. CM-C reviewed R41's EMR and stated she was unable to locate the consent in the EMR, so she contacted the family on 6/2/26 and obtained verbal consent over the phone. CM-C stated the consent form was important to ensure the resident and/or family agreed with the medications being administered and understood the associated risks and benefits of the medication.During an interview on 6/4/26 at 12:59 p.m., the director of nursing (DON) stated consent should have been obtained when the medication order was received, either upon admission if the resident was admitted on the medication or when a new psychotropic medication was initiated. The DON stated the consent should have been signed by the resident or the resident's family member prior to administration of the medication.Review of the facility's Psychotropic Medications Policy, reviewed/revised 12/09/2025, identified residents and/or their family or legal representative were to be notified when psychotropic medications were initiated or when residents were admitted on psychotropic medications. The policy further identified the Permission for Use of Psychotropic Medications (GSS #478) consent form was required to be completed and signed for the use of psychotropic medications.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview the facility failed to maintain a broda chair (a specialized brand of wheelchair and positioning recliner designed for individuals with limited mobility who require long-term, comfortable sitting) in good repair for 1 of 1 resident (R40) reviewed who utilized a broda chair.Findings include:F40's quarterly Minimum Data Set (MDS) dated [DATE], indicated R40 had moderate cognitive impairment and was dependent on staff for activities of daily living (ADLs). R40's diagnoses included anemia, dementia, Huntington's disease, anxiety, depression and bipolar disorder. On 6/3/26 at 3:13 p.m. R40's broda chair was observed with four cracks on head rest cushion, the cracks were vertical on the cushion about six inches in length with the inner foam visible in the cracks. Cushioning on right side of R40's head was observed to have several cracks of varying length with inner foam visible in the cracks. Cushioning on left side of R40's head was observed to have an area of about eight inches by 6 inches of cracks with a diagonal jagged crack about seven inches in length with an area below about 6 inches by five inches of cracks, foam was visible in all cracked areas. The upper corners of the left side cushion with stuffing and foam observed sticking out. Follow up observation on 6/4/26 at 11:22 a.m. indicated R40 continued to be placed in the broda chair with cracked cushions with inner foam and stuffing visible. When interviewed on 6/4/26 at 11:28 a.m. certified nursing assistant (CNA)-C stated when equipment was broken or in poor repair, they were to complete a maintenance work order or inform hospice if the resident was on hospice for the equipment to be repaired or replaced. CNA-C stated were not aware R40's broda had cracked cushions When interviewed on 6/4/26 at 11:31 a.m. registered nurse (RN)-C stated R40 wore a helmet that had probably caused cracks in the cushions of the broda chair and due to R40 being on hospice they would have to be notified the broda chair cushions required repair or replacement. RN-C stated they were not aware if hospice was informed of the broda chair condition. When interviewed on 6/4/26 at 11:40 AM clinical care manager (CM)-B stated they had noticed several chairs that needed repair or replacement but had not yet informed hospice of the need. CM-B stated the concern with cracked cushions was infection control and the cushions could not be cleaned appropriately. When interviewed on 6/4/26 at 12:53 p.m. director of nursing (DON) stated the expectation was for equipment to remain in good repair, maintenance requests or update to hospice was expected to be completed in a timely manner to ensure cleanliness and infection control was maintained. Facility policy regarding resident equipment was requested, however, none was provided.

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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. Based on interview and record review, the facility failed to provide and document written notice of an involuntary transfer/discharge to a resident and/or resident representative prior to transfer to another facility, for 1 of 1 resident (R100) reviewed for transfer and discharge requirements.Findings include:R100's clinical record identified R100 was transferred from the facility to a sister facility on 8/22/25.Review of R100's electronic health record (EHR) failed to identify documentation that the resident and/or resident representative received written notice of the involuntary transfer/discharge prior to the transfer. The record failed to identify documentation of a Notice of Involuntary Discharge (NOID), notification of appeal rights, evidence of notification to the resident and/or resident representative, documentation of attempted contact with resident and/or resident representative, or notification to the Ombudsman program regarding the discharge.During an interview on 6/4/26 at 11:01 a.m., Social Worker (SW)-A stated when residents were discharged , the facility typically issued a Notice of Medicare Non-Coverage (NOMNC), discussed appeal rights, reviewed discharge information with the resident, coordinated communication with outside providers, and arranged transportation if needed. SW-A stated that for facility-initiated discharges, options were reviewed with the resident and discharge planning was discussed. SW-A stated she was aware there had been months of discussions involving the Ombudsman program and regional staff regarding R100 and issues related to unpaid bills. SW-A further stated she knew a great deal of information leading up to the discharge but did not know all of the events surrounding the discharge. SW-A confirmed there was no documentation regarding attempts to contact the resident's daughter or documentation related to discharge planning. SW-A stated the Administrator ultimately took over management of the discharge process.During an interview on 6/4/26 at 11:26 a.m., the Administrator stated R100 was transferred to the facility's sister facility on 8/22/25 and the resident's long-term care needs continued to be met. The Administrator stated notice of the discharge had been relayed to the resident; however, she could not provide documentation or evidence supporting that notification. The Administrator further acknowledged there were missing pieces in the discharge record and confirmed she could not locate documentation of the required discharge notice.During an interview on 6/4/26 at 11:35 a.m., the Ombudsman stated she had discussed R100's discharge with the facility on 9/18/25 and informed facility staff that the required discharge process had not been followed. The Ombudsman stated she was unable to find evidence that a Notice of Involuntary Discharge had been issued, evidence that the resident and/or resident representative had been notified, or evidence of attempts to contact the resident representative regarding the discharge. The Ombudsman further stated there was no documentation supporting these actions and confirmed the Office of Ombudsman for Long-Term Care had not received notification of the discharge.The facility's Discharge and Transfer - Rehab/Skilled, Therapy & Rehab policy, reviewed 1/15/26, required that before a resident was transferred or discharged , the facility notify the resident and resident representative in writing of the transfer/discharge and the reason for the move using the Notification of Transfer or Discharge (GSS #223A) or other state-required form. The policy further required the facility provide information regarding appeal rights and assistance with obtaining and completing an appeal form. A copy of the transfer/discharge notice was required to be sent to the Office of the State Long-Term Care Ombudsman. For transfers related to non-payment, the policy required at least 30 days' advance notice before the transfer or discharge occurred. The policy also required the facility to provide and document sufficient preparation, orientation, and discharge planning to ensure a safe and orderly transfer or discharge.

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition Based on interview and record review, the facility failed to timely complete a comprehensive assessment after a significant change in status, including failure to complete a Significant Change in Status Assessment (SCSA) following discharge from hospice services, for 1 of 1 resident (R111) reviewed for MDS assessment requirements.The Resident Assessment Instrument (RAI) User's Manual identified enrollment in hospice services and discharge from hospice services as events that may constitute a significant change in status requiring completion of a Significant Change in Status Assessment.Findings include:R111's most recent Minimum Data Set (MDS) assessment identified diagnoses which included chronic obstructive pulmonary disease (COPD; a chronic lung disease that makes breathing difficult) and chronic respiratory failure (a condition in which the lungs are unable to adequately exchange oxygen and carbon dioxide). The MDS further identified R111 received hospice services.R111's clinical record identified hospice services were discontinued on 5/11/26.Review of R111's electronic health record (EHR) on 6/4/26 identified documentation continued to reflect R111 was receiving hospice services, including on the resident profile and care plan, despite hospice services having ended on 5/11/26.During interview on 6/4/26 at 9:27 a.m., nursing assistant (NA)-E stated R111 was on hospice services and confirmed care plans were primarily updated by the nurse manager.During interview on 6/4/26 at 9:33 a.m., licensed practical nurse (LPN)-B stated R111 had been on hospice services and had graduated from hospice. LPN-B stated the facility had held a care conference regarding the possibility of restarting hospice services; however, R111 did not meet hospice criteria.During interview on 6/4/26 at 12:32 p.m., registered nurse case manager (CM)-C stated R111 was discharged from hospice after a hospitalization on 5/10/26 and was scheduled to be discharged from hospice on 5/11/26. CM-C reviewed the EHR and confirmed it continued to identify R111 as receiving hospice services. CM-C stated the record should have been updated to accurately reflect the resident's current status. CM-C further stated she completed the Significant Change in Status Assessment on 6/3/26 after the surveyor requested information regarding the resident's hospice discharge.During interview on 6/4/26 at 12:59 p.m., Director of Nursing (DON) stated hospice discharges generated notifications to administration staff and required updates to the resident's care plan and clinical record. The DON stated documentation was typically received from the hospice agency at discharge and confirmed a Significant Change in Status Assessment should have been completed following the hospice discharge. The DON stated it was important for the record to accurately reflect the resident's current status and care needs in real time.During interview on 6/4/26 at 1:29 p.m., MDS nurse (RN)-E reviewed the resident's assessment history and stated the Significant Change in Status Assessment was completed on 6/3/26.Review of the facility's MDS assessment history confirmed a Significant Change in Status Assessment was not completed until 6/3/26, approximately three weeks after R111's discharge from hospice services on 5/11/26.Review of the facility's MDS 3.0 (Minimum Data Set) RAI policy, revised 10/27/25, identified when a significant change in a resident's status was identified, staff were to notify the social worker, RN coordinator, or designated employee so a timeline could be established and communicated to interdisciplinary team members. The policy further required documentation of the significant change in the PN-MDS, notification of the interdisciplinary team through the MDS/Care Plan Notification process, and completion of the Significant Change MDS in accordance with the Resident Assessment Instrument (RAI) Manual requirements and timelines.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to ensure professional standards of practice were followed during administration of crushed medications for 1 of 2 residents (R68) observed during medication administration.Findings include: R68's Annual Minimum Data Set (MDS) dated [DATE], identified R68 as exhibiting severe cognitive deficit and was identified as requiring assist with all aspects of activities of daily living (ADLs-dressing, grooming, bathing, and toileting). R6's medical diagnoses included aphasia (difficulty with speaking), anemia (a low blood count of red blood cells or hemoglobin), hypertension (high blood pressure) and non-Alzheimer's dementia (a condition which may cause alteration in thoughts, cognition, and behavior).R68's admission Profile printed 6/4/26, indicated R68 had diagnoses of generalized muscle weakness.R68's Care Plan revised 2/23/26, indicated R68 had limited physical mobility related to history of a stroke with right side weakness and received antiplatelet therapy. R68's care plan identified an order in place for a texture modified diet. The care plan lacked indication prior to 6/3/26. R28 was okay to have crushed meds.During a medication observation on 6/3/26 at 7:31 a.m. R68 was given the following medications were crushed together and mixed with applesauce and given orally: Clopidgrel 75 mg one tablet; Senexon S 500 mg/8.6 mg one tablet; and Amlodipine 10 mg one tablet. Registered nurse (RN)-B stated R68's medications were crushed and mixed together with applesauce for R68. RN-B stated this was able to be completed as it was ordered by the provider.On 6/3/26 at approximately 10:00 a.m., DON stated all medications which required crushing were to have an order in place. DON stated this was important to assure medications were able to be crushed based on timed release status, protective coating, etc. DON stated she was unaware if there were orders in place for R68, however, affirmed medications were not to be crushed without provider orders.R68's progress notes were reviewed and identified on 6/3/26 at 12:46 p.m., an order was received from the provider that it was okay to crush meds due to history of stroke and seizure.A review of R68's cumulative orders lacked indication of authorization to crush medications prior to 6/3/26.The facility policy, Medications: Crushing-AL, R/S, LTC, date reviewed/revised 1/29/26 identified the attending provider must be aware of the need to crush medications so that the appropriate form of the medication can be ordered. The policy further states best practice would be to separately crush each medication and separately administer each medication with food.

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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 interview and record review, the facility failed to ensure physician-ordered parameters were monitored prior to administration of an antihypertensive medication, including failure to obtain blood pressure readings to determine whether a PRN dose of metoprolol was indicated, for 1 of 1 resident (R91) reviewed for medication administration parameters.Findings include:R91's quarterly Minimum Data Set (MDS) dated [DATE] identified R91 had severe cognitive impairment and required assistance with activities of daily living (ADL)'s. R91's diagnoses included schizophrenia (a chronic mental health disorder that affects a person's ability to think clearly, perceive reality, manage emotions, and interact with others). The MDS further identified R91 received antipsychotic medications.R91's physician orders identified an order for Metoprolol Tartrate 12.5 mg (milligram) by mouth every 24 hours as needed for blood pressure greater than 150 related to paranoid schizophrenia. The order was initiated on 3/30/26.R91's electronic health record (EHR) identified the PRN metoprolol order remained active. Review of the EHR identified the facility obtained R91's blood pressure on a weekly basis; however, the record failed to identify blood pressure monitoring was completed to determine whether R91's blood pressure exceeded the ordered parameter of greater than 150 and whether administration of the PRN medication was indicated. The record further failed to identify documentation the facility evaluated the ongoing need for the medication or whether the ordered blood pressure parameter was ever met.During an interview on 6/4/26 at 9:41 a.m., licensed practical nurse (LPN)-B reviewed R91's physician orders and stated R91 had an order for PRN metoprolol. LPN-B stated he believed the medication was intended for symptoms that occurred during aggressive episodes.During an interview on 6/4/26 at 12:32 p.m., registered nurse case manager (CM)-C stated R91's family did not want R91 routinely receiving metoprolol and a decision had been made during a care conference to change the medication to PRN use. CM-C reviewed the physician order and stated the facility should have obtained clarification from the provider regarding blood pressure monitoring parameters. CM-C further stated the order should have included instructions regarding how often blood pressure readings were to be obtained and acknowledged staff should have been monitoring R91's blood pressure to determine whether the medication was indicated.During an interview on 6/4/26 at 12:59 p.m., director of nursing (DON) reviewed the physician order and stated R91's blood pressure should have been monitored and there should have been an order identifying how frequently blood pressure readings were to be obtained. DON stated staff should have followed up with the physician for clarification regarding blood pressure monitoring expectations related to the PRN metoprolol order.A facility policy regarding monitoring and administration of PRN antihypertensive medications, including blood pressure monitoring expectations and physician order clarification requirements, was requested and was not received.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** During interview and record review, the facility failed to ensure all residents were offered and up to date on immunizations for 1 of 5 residents (R29) reviewed for immunizations.Findings include:Information on the CDC website: Pneumococcal Disease link, outlined on the CDC website and dated 2/25/26, identified various tables when each (or all) of the pneumococcal vaccinations should be obtained. This site identified recommendations for those who had never been vaccinated for pneumococcal disease, as well as those who had started the pneumococcal process. Additionally, the link to Influenza (Flu) site dated 9/18/25, identified everyone six months and older should get a flu vaccine every season with rare exceptions.R29's admission minimum data set (MDS) dated [DATE], included an admission date of 4/29/26, and R29 was identified as being [AGE] years of age. R29's medical diagnoses included coronary artery disease (the narrowing of arteries which decreases blood flow to the heart), hypertension (high blood pressure), and non-Alzheimer's dementia (loss of memory and other intellectual functions, affecting the ability to perform activities of daily living ADL's). R29's electronic medical record (EMR) lacked a review of current immunizations, including those which would have been received prior to admission. This review would have included the current status on pneumococcal immunizations, as well as influenza vaccinations.Additionally, a review was completed to identify if vaccinations had been declined as evidenced by presence of a vaccine consent marked refused. The EMR was lacking any consent for vaccination reviewed with R29 or his responsible party.During interview on 6/3/26 at 2:07 p.m., infection preventionist (IP) stated every resident's immunization status was reviewed by the admission nurse within the first 24 hours following admission. IP stated resident's immunization status was then verified via MIIC (Minnesota Immunization Information Connection-a web-based system to allowing tracking of immunizations given) by IP to assure the vaccine had not been previously given. Once verified, the necessary immunizations were offered. Upon review of R29's immunization tab in the EMR, IP stated R29's immunization status had not been reviewed, and the record lacked a vaccination history, or offering of vaccinations. IP stated this should have been completed at the time of admission.The facility policy, Immunizations/Vaccinations for Residents, Pneumococcal, Influenza, Covid-19, reviewed/revised 11/8/25 identified the purpose of the immunization program was to promote the health and safety of residents/patients, employees, and visitors through protection against vaccine-preventable diseases. The policy identified Skilled nursing facilities (SNFs) are federally required to provide education and offer any influenza, COVID-19, or pneumococcal vaccine a resident is eligible to receive. The process identified resident were to be screened for eligibility and any contraindications to a vaccine following CDC recommendations. The SNF was then to provide the resident and/or their legal medical decision-maker with a vaccine information sheet to educate on the risks and benefits of a vaccine the resident is eligible to receive, and document education provided in the medical record. Once the education was provided, staff were then to obtain consent or declination for the vaccine and document in the medical record. The facility was then to follow up with the provider for orders for vaccination and proceed with vaccination, monitoring, and documentation.

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on document review and interview, the facility failed to ensure COVID-19 immunization was offered and/or administered in accordance with current standard of practice for 1 of 5 residents (R29) reviewed for immunizations.Findings include:A Centers for Disease Control and Prevention (CDC) COVID-19 Vaccination Guidance updated 11/4/25, indicated individuals should receive recommended COVID-19 vaccinations, including booster doses, when eligible, unless medically contraindicated or refused. Long-term care facilities were responsible for assessing vaccination status and ensuring residents were offered recommended vaccines.R29's admission minimum data set (MDS) dated [DATE], included an admission date of 4/29/26, and R29 was identified as being [AGE] years of age. R29's medical diagnoses included coronary artery disease (the narrowing of arteries which decreases blood flow to the heart), hypertension (high blood pressure), and non-Alzheimer's dementia (loss of memory and other intellectual functions, affecting the ability to perform activities of daily living ADL's). R29's electronic medical record (EMR) lacked a review of current immunizations, including those which would have been received prior to admission. This review would have included the current status on Covid-19 vaccinations.Additionally, a review was completed to identify if vaccinations had been declined as evidenced by presence of a vaccine consent marked refused. The EMR lacked any consent for vaccination reviewed with R29 or his responsible party.During interview on 6/3/26 at 2:07 p.m., infection preventionist (IP) stated every resident's immunization status was reviewed by the admission nurse within the first 24 hours following admission. IP stated resident's immunization status was then verified via MIIC (Minnesota Immunization Information Connection-a web-based system to allowing tracking of immunizations given) by IP to assure the vaccine had not been previously given. Once verified, the necessary immunizations were offered. Upon review of R29's immunization tab in the EMR, IP stated R29's immunization status had not been reviewed, and the record lacked a vaccination history, or offering of vaccinations. IP stated this should have been completed at the time of admission.The facility policy, Immunizations/Vaccinations for Residents, Pneumococcal, Influenza, Covid-19, reviewed/revised 11/8/25 identified the purpose of the immunization program was to promote the health and safety of residents/patients, employees, and visitors through protection against vaccine-preventable diseases. The policy identified Skilled nursing facilities (SNFs) are federally required to provide education and offer any influenza, COVID-19, or pneumococcal vaccine a resident is eligible to receive. The process identified resident were to be screened for eligibility and any contraindications to a vaccine following CDC recommendations. The SNF was then to provide the resident and/or their legal medical decision-maker with a vaccine information sheet to educate on the risks and benefits of a vaccine the resident is eligible to receive, and document education provided in the medical record. Once the education was provided, staff were then to obtain consent or declination for the vaccine and document in the medical record. The facility was then to follow up with the provider for orders for vaccination and proceed with vaccination, monitoring, and documentation.

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F 0574 Level of Harm - Potential for minimal harm Residents Affected - Many	The resident has the right to receive notices in a format and a language he or she understands. Based on observation, interview, and record review, the facility failed to ensure the most up to date Nursing Home Resident [NAME] of Rights (RBOR) was displayed for residents, visitors, and staff to review. This had the potential to affect all 88 residents currently residing in the facility, as well as all staff and visitors.Findings include: On 6/2/26 at 10:13 a.m., it was observed that RBOR poster was displayed in a locked glass case right off the main entrance, near the elevators, which lacked the date of print. A facility combined RBOR was posted next to the entrance of the therapy room, just off the main lobby, which was dated 11/16. On 6/2/26 at 2:15 p.m. the administrator stated she was unaware any changes made to the RBOR form and was unaware of the need to obtain and post the updated version. The facility policy, Posting Information, Social Services-Rehab/Skilled, revised 12/23/25, identified all residents residing in the facility had the right to be aware of a certain location where information concerning it's [the facility] operation, as well as their [the residents] right of appeal and advocacy. The policy indicated it was the responsibility of the location [facility] to keep this information posted in a visible place, accessible to all residents, whether ambulatory or in a wheelchair, and to keep it updated at all times. A listing of the required information to be posted in this location included the Resident's Rights for Skilled Nursing Facilities.

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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. Based on observation, interview, and record review, the facility failed to ensure all recent facility survey results were posted in an accessible location for residents, staff, and visitors. This had the potential to affect all 88 residents residing in the facility as well as staff and visitors.Findings include: On 6/2/26 at 10:13 a.m., a review was completed of the facility survey binder, located on a table on the side wall of the lobby. A review of the binder was completed to ensure all surveys from the last recertification, completed 2/14/25, and subsequent follow up surveys (including complaint investigations and their findings) were available for review. Upon review of the documentation, it was noted that the binder lacked information from the following complaint investigations surveys completed on 12/31/25, 4/2/26, 4/8/26 and 5/15/26.On 6/2/26 at 2:16 p.m. the administrator reviewed the survey binder and acknowledged the above listed survey results were lacking in the binder. Administrator stated the survey results in the binder were to reflect the survey results of the past three years. Administrator stated this was important, so the results were available for residents, visitors, and family members to review if they wished to do so. The facility policy, Posting Information, Social Services-Rehab/Skilled, revised 12/23/25, identified all residents residing in the facility had the right to be aware of certain location information concerning its [facility's] operation, as well as their [the residents] right of appeal and advocacy. The policy indicated it was the responsibility of the location to keep this information posted in a visible place, accessible to all residents, whether ambulatory or in a wheelchair, and to keep it updated at all times. A list of the required information to be posted included the most recent federal or state survey (CMS Form #2567) and, if applicable, plans of correction.