STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245285	A. Building B. Wing	02/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Good Samaritan Society Inver Grove Heights	1301 50th Street East Inver Grove Heights, MN 55077

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to ensure a resident's advance directives were accurately and consistently documented in the resident's electronic health record (EHR) banner, Provider Order for Life-Sustaining Treatment (POLST), and physician orders to ensure the resident's wishes would be followed in the event of a cardiac arrest for 3 of 35 residents (R8, R36, R40) reviewed for code status.Findings include:R8R8's quarterly Minimum Data Set (MDS) dated [DATE], indicated R8 had severely impaired cognition and was receiving hospice care. The MDS indicated R8 was admitted to the facility on [DATE] and was diagnosed with a stroke, a seizure disorder, and respiratory failure. R8's POLST dated [DATE], indicated attempt resuscitation/full treatment and was signed by family member (FM)-B, prepared on [DATE], and signed by the provider on [DATE]. This POLST was found in the orange Resident Advance Directives binder at the nursing station on [DATE] at 11:14 a.m. along with an additional undated POLST for R8. This additional POLST indicated to attempt resuscitation/full treatment, was signed by a provider, and indicated a verbal discussion was had with the FM-B. R8's progress note dated:-[DATE] at 2:54 p.m., indicated R8 had signed onto hospice with the assistance of FM-B as of this date. -[DATE] at 3:43 p.m., indicated R8's Advance Directive was resuscitation (CPR) and had been admitted to hospice care due to a persistent decline in health status.R8's Hospice IDG Comprehensive Assessment and Plan of Care Update Report dated [DATE], indicated R8's code status was a full code and could be found on the POLST.R8's order summary dated [DATE], included an advanced directive do not resuscitate (DNR) order that was dated [DATE].R8's Hospice IDG Comprehensive Assessment and Plan of Care Update Report dated [DATE], indicated R8's code status was a full code and could be found on the POLST.R8's POLST signed by a provider on [DATE], and prepared [DATE], indicated DNR/allow natural death with comfort-focused treatment and was signed by FM-B.R8's Hospice IDG Comprehensive Assessment and Plan of Care Update Report dated [DATE] and [DATE], indicated R8's code status was DNR with comfort measures only and could be found on the POLST.R8's progress note dated [DATE] at 12:05 p.m., indicated R8's DNR code status remained accurate.R8's Hospice IDG Comprehensive Assessment and Plan of Care Update Report dated [DATE], indicated R8's code status was DNR with comfort measures only and could be found on the POLST.R8's progress note dated [DATE] at 11:47 a.m., indicated FM-B had attended the care conference. The note indicated a POLST as not on file, so the social work department would follow up with the hospice team regarding the POLST. The note did not include a preferred code status. R8's Hospice IDG Comprehensive Assessment and Plan of Care Update Report dated [DATE], [DATE], [DATE], and [DATE], indicated R8's code status was DNR with comfort measures only and could be found on the POLST.R8's Hospice IDG Comprehensive Assessment and Plan of Care Update Report dated [DATE], indicated the hospice start of care date was [DATE]. The plan of care indicated R8's code status was DNR with comfort measures only and could be found on the POLST. The note indicated R8 had terminal decline at the facility due to a stroke. The report indicated R8 was dependent for all needs and decisions and had a prognosis of six months or less to live. -R8's progress notes dated (continued on next page)

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

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	[DATE] to [DATE] were reviewed with no further code status wishes noted.R8's EHR banner, printed on [DATE], indicated R8's code status was DNR. R8's care plan dated [DATE], indicated code status as ordered. The care plan indicated R8 was receiving hospice services for a terminal prognosis related to a stroke. R36R36's quarterly MDS assessments dated [DATE] and [DATE], indicated R36 had intact cognition and was admitted to the facility on [DATE].R36's POLST dated [DATE], indicated DNR/allow natural death with selective treatment with a verbal consent from FM-C, prepared on [DATE], and signed by a provider on [DATE]. This POLST was found during a surveyor audit of the orange Resident Advance Directives binder from the nursing station on [DATE] at 2:46 p.m.R36's care plan dated [DATE], indicated R36 was forgetful/confused at times and had a difficult time making decisions related to disease process. The care plan indicated R36 required assistance from his daughter with all decision-making. The care plan did not reference code status. R36's Medical Diagnosis report dated [DATE], indicated R36 had a history of a stroke, a heart attack, end-stage kidney disease dependent on dialysis (a machine filters wastes, salts, and fluid from the blood when the kidneys are no longer healthy enough to do so), diabetes, and heart disease.R36's progress note dated:-[DATE] at 3:36 p.m., indicated facility staff received a call from the R36's daughter, indicating she and R36 wanted R36's code status to be full code. -[DATE] at 4:12 p.m., indicated facility staff discussed code status with R36 and R36 affirmed that what his daughter said was correct and R36 wished to be full code. The note indicated a message was sent to the provider to obtain an order to change the code status. R36's POLST dated [DATE], indicated attempt resuscitation/CPR with full treatment such as intubation and signed by R36 and indicated patient has capacity. This POLST was signed by a provider on [DATE], and the section indicating who prepared the document and when was left blank. -[DATE] at 9:32 a.m., indicated code status had been discussed with R36, and code status remained accurate as CPR. -[DATE] at 12:33 p.m., indicated a care conference was held, but did not indicate if the resident had attended the care conference or if code status was discussed.-R36's progress notes dated [DATE] to [DATE] were reviewed with no further code status wishes noted.R36's Order Summary Report dated [DATE], included an order for MN POLST (A): an advance directive order to attempt resuscitation/CPR dated [DATE]. An additional order dated [DATE], MN POLST (B) dated [DATE], indicated R36 wanted selective treatment that included no intubation, advanced airway interventions, or mechanical ventilation. R36's EHR banner, printed on [DATE], indicated R36's code status was to attempt resuscitation/CPR and, if not in cardiopulmonary arrest, to follow orders in POLST part B.R40R40's comprehensive MDS dated [DATE], indicated R40 was admitted to the facility on [DATE] and had moderate cognitive impairment. The MDS indicated R40 was receiving hospice services. The MDS indicated R40 was diagnosed with heart failure, kidney disease, and respiratory failure.R40's POLST dated [DATE], indicated attempt resuscitation/full treatment and was signed by R40, prepared on [DATE], and signed by the provider on [DATE]. This POLST was found during a surveyor audit of the orange Resident Advance Directives binder from the nursing station on [DATE] at 2:46 p.m.R40's POLST dated [DATE], indicated attempt resuscitation and was signed by R40, and signed by the provider on [DATE]. The POLST did not indicate who prepared the POLST or when it was completed. R40's Order Summary Report dated [DATE], included an advanced directive do not resuscitate (DNR) order that was dated [DATE].R40's progress note dated: -[DATE] at 1:32 p.m., indicated R40 had returned from the hospital and wanted to elect hospice services and not pursue therapy. The note indicated R40 wanted DNR status with comfort-focused care. -[DATE] at 8:59 p.m., indicated a care conference was held for R40, and her DNR status was confirmed. The note indicated the facility needed an updated POLST, so social work would complete this with the resident. This POLST was requested and not received. --R40's progress notes dated [DATE] to [DATE] were reviewed with no further code status wishes noted.R40's care plan dated [DATE], indicated R40 had impaired cognitive function or impaired thought processes related to a terminal illness. The care plan dated [DATE] indicated code status as ordered.R40's Hospice IDG Comprehensive Assessment and Plan of Care (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Update Report dated-[DATE], indicated R40 was eligible for hospice admission related to respiratory failure with comorbidities such as heart failure, obstructive sleep apnea, and insomnia contributing to terminal decline. The plan of care indicated R40's code status was DNR with comfort measures only and could be found on the POLST. -[DATE], indicated the hospice start of care date was [DATE]. The plan of care indicated R40's code status was DNR with comfort measures only and could be found on the POLST. During an interview and observation on [DATE] at 11:17 a.m., registered nurse (RN)-A confirmed that he was the only RN working during this shift and was the nurse assigned to R8. RN-A stated that to determine if he needed to start CPR on a resident found not breathing and without a pulse, he would look at the POLST. RN-A stated his process was to look in the advanced directive binder at the nursing station at the POLST to determine if the resident was to be resuscitated. RN-A was observed to grab an orange binder titled Resident Advanced Directives POLST that was observed with other various binders on the nursing station counter. The orange binder was reviewed with approximately 100 POLSTs dated [DATE] to [DATE]. A report of all residents' advance directives was not found in the binder. RN-A was observed to find R8's POLST, indicating attempt resuscitation/full treatment, and stated that he would perform CPR on R8 as this was what the POLST indicated. When asked if this was the code status source he would review if R8 or any resident was found with no pulse and not breathing, RN-A confirmed that it was and then stated that although he knew R8 was on hospice, the family must still want him resuscitated, so after looking at the POLST in the binder, he would start CPR. RN-A confirmed that R8 was unable to make his own decisions due to his cognition, so the family assisted with this. During a follow-up interview on [DATE] at 11:35 a.m., RN-A confirmed he worked at the facility full-time. During an interview on [DATE] at 11:22 a.m., licensed practical nurse (LPN)-A stated she was pool staff and did not work at the facility full-time. LPN-A stated that if a resident was found not breathing and with no pulse, she would reference the EHR banner because this was the easiest place to find the code status in an emergency. During an interview on [DATE] at 11:36 a.m., the director of nursing (DON) stated that if a resident were to be found not breathing and without a pulse, she would expect staff to look at the resident's banner in the EHR, as this was the fastest way to find the resident's most up-to-date code status. The DON stated that the banner pulled the code status from the order summary, so these two sources always matched. When the DON was asked about the orange advanced directive binder at the nurse's station, she stated she did not realize the binder was at the nurse's station and was unable to provide a date for when it was last updated. The DON stated she thought the health information manager (HIM) may have accidentally placed the binder at the nurse's station. The DON stated she would have expected staff to look at R8's order to not be resuscitated on the banner in the EHR and not perform CPR for R8.During an interview on [DATE] at 11:37 a.m., FM-B confirmed he was the primary decision maker for R8. FM-B stated that at a care conference a couple of months ago, he had a discussion with facility staff about code status, and he had decided to switch R8's code status from a full code to DNR at that time. FM-B stated this DNR code status remained accurate for his wishes for R8. During an interview on [DATE] at 12:24 p.m., the HIM stated that on resident admission, she assisted with putting code status orders in the EHR, but she did not assist past that with entering or updating the resident's code status. The HIM stated she was unaware there was a POLST binder at the nurse's station and was unsure how it got there or who updated it. During an interview on [DATE] at 12:30 p.m., the social services director (SSD) stated that she assisted with resident care conferences. The SSD stated code statuses were reviewed at care conferences, and this should be documented in a progress note. The SSD stated that after reviewing the medical record, it appeared she needed to reach back out to hospice to get R8's most up-to-date POLST. The SSD stated she had reached out to the hospice company in January, but it did not appear they had received the updated POLST yet. The SSD confirmed she was unable to find the code status that FM-B preferred in the care conference notes, although the latest note mentioned the POLST. The SSD stated she was unsure when R8's code status changed from full code to DNR.During an interview on [DATE] at 2:17 (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	p.m. with the DON and administrator, the DON stated code status was reviewed on admission, at care conferences, and with any resident or family requests. The DON stated she would expect this to be documented in the progress notes. The DON stated it was not always their process to use a POLST, so if a resident wanted a code status change, the nurse or social worker would call the provider, get a verbal order to change the code status, and update the order in the order summary. The DON stated this was why it was important that facility staff referenced the EHR order summary and not the POLST to determine the most up-to-date code status for the residents, as a new POLST was not always completed. The DON stated she believed hospice had the conversation with R8 regarding code status and was waiting for an updated POLST from them regarding his DNR code status.During an interview on [DATE] at 3:34 p.m., family member (FM)-A stated R40 was started on hospice at the end of [DATE] due to heart failure. FM-A stated R40 has continued to decline and has not gotten out of bed since she came back from the hospital in December of 2025. FM-A stated that R40 does not wish to have CPR performed if she stops breathing or her heart stops beating, as they have been told by doctors that the trauma from CPR would be damaging to her heart. FM-A stated that resuscitation would be detrimental for R40 and would not follow her wishes.During an interview on [DATE] at 3:44 p.m., when asked about his wishes if his heart stopped beating and he stopped breathing, R36 stated he wanted staff to perform full resuscitate measures.During an interview on [DATE] at 4:35 p.m., RN-C, R8's hospice nurse, stated hospice would review the resident's code status with the resident and family at the start of care and as needed. RN-C stated she expected the facility to review the code status with the resident and family at care conferences, and, if any changes were requested. RN-C stated a different nurse had previously been assigned to work with R8, so would have to review R8's hospice notes and plan of care to determine when his code status changed from a full code TO DNR. RN-C stated that if R8 was resuscitated, this would lead to a sad outcome for him and sounded like the facility should be completing audits to ensure code statuses matched across sources. During an interview on [DATE] at 8:47 a.m., the administrator stated staff were supposed to be running a daily advanced directive report per their policy and then using that to audit the POLSTs in the advanced directive binder. The administrator stated this was not occurring before the state agency issued an immediate jeopardy on [DATE]. During an interview on [DATE] at 10:48 a.m., the medical director (MD) stated that he felt that a mismatch between code status sources that facility staff could reference during an emergency was concerning and he expected facility staff to follow their policy to ensure these sources were updated as changes occur. The MD stated it was important that these sources matched to ensure the resident's code status wishes were honored.The facility's Advanced Directive, including Cardiopulmonary Resuscitation (CPR) and Automated External Defibrillator (AED) policy dated [DATE], indicated the purpose of the policy was to provide the resident with the opportunity to make decisions about their medical care and define a process to make the resident's decisions known. The policy indicated that if a resident's wishes differed from the resident's orders, the staff member was to immediately document the resident's wishes in the medical record and contact the provider to obtain an order via a fax communication form. The policy indicated CPR should be initiated unless the resident had a valid DNR order on file or a valid advanced directive on file. The policy indicated that social services (or a designated staff member) would meet with the resident/decision maker on admission and readmission to determine if the resident had an advanced directive and/or if this was something they wished to develop or amend. The policy indicated that each day, nursing staff would print a report of all advanced directive orders and keep them in a three-ring binder easily accessible to nursing staff, along with advanced directive forms. The policy indicated this was important to complete to ensure important information was available if there was a power outage or other disruption in access to the EHR. The policy indicated that at care conferences, advance directive orders were to be reviewed with the resident/decision maker to ensure no changes are needed, and this discussion is to be documented in the progress note.

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to provide the Skilled Nursing Facility Advanced Beneficiary Notice (SNFABN; CMS-10055) to 2 of 3 residents (R14 and R38) reviewed whose Medicare Part A coverage ended and then remained in the facility. The facility further failed to ensure an appropriate 48-hour notice was given for 1 of 3 residents (R51) who discharged from the facility. Findings include:R14R14's admission Minimum Data Set (MDS), dated [DATE], indicated R14 was admitted to the care facility on 12/5/25.R14's Notice of Medicare Non-Coverage (NOMNC; CMS 10123), signed on 1/26/26, indicated R14's Medicare A coverage ended on 1/29/26 and they would assume cost for their care at the care facility.R14's electronic medical record (EMR) lacked evidence R14 and/or their representative had received a Skilled Nursing Facility Advanced Beneficiary Notice (SNFABN; CMS-10055) despite the fact he remained in the facility when his Medicare A coverage ended.R38R38's admission MDS, dated [DATE], indicated R38 was admitted to the care facility on 1/12/26.R38's EMR lacked evidence R38 and/or their representative had received a SNFABN; CMS-10055 despite Medicare A coverage ending on 2/11/26 and R38 remaining in the facility and assuming cost for their care at the care facility.R51R51's admission MDS, dated [DATE], indicated R51 was admitted to the care facility on 12/12/25.R51's NOMNC; CMS 10123, signed 1/22/26, indicated R51's Medicare A coverage ended 1/23/26, failing to provide R51 and/or their representative a 48-hour notice.During an interview on 2/18/26 at 11:40 a.m., director of social services (DSS) stated R38 transitioned to hospice on 2/11/26, within hours of their Medicare A coverage ending and did not have time to complete a SNFABN; CMS-10055. The DSS further stated R14 transitioned to hospice services within days of their Medicare A services ending and had Medicaid pending for his stay at the care facility. During a follow up interview on 2/19/26 at 10:15 a.m., the DSS confirmed R51 was not given an appropriate 48-hour notice for the NOMNC; CMS 10123 prior to his discharge from Medicare A and the care facility. The DSS also confirmed if a resident is remaining in the care facility, a SNFABN; CMS-10055 is always needed. The DSS stated the process is for her to stay in contact with the therapy department and issue the appropriate notices (i.e., a SNFABN; CMS-10055 and a NOMNC; CMS 10123) as soon as she is made aware Medicare A coverage is ending.A policy on beneficiary notices was requested and not received.

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 observation, interview and document review the facility failed to monitor for resident specific target behaviors related to psychotropic medications use for 1 of 5 residents (R50) and failed to ensure appropriate medication side effect monitoring for potential daytime sleepiness/drowsiness was completed for 1 of 5 residents (R4) reviewed for unnecessary medication use. Findings include: R18's admission Minimum Data Set (MDS) assessment, dated 2/1/26, identified R18 had moderately impaired cognition with no hallucinations, delusions, behaviors or rejections of cares with an admission of 1/26/26. Diagnoses included: anxiety, depression, periprosthetic fracture around internal prosthetic right hip joint (a break in the thigh bone adjacent to the artificial hip stem), hypertension (high blood pressure) and diabetes (body can't manage blood sugars properly). R50's Order Summary Report, printed 2/19/26, included the following orders: -bupropion HCL ER (antidepressant medication) 150 milligram (mg) tablet: give 150 mg by mouth in the morning for DM2 starting 1/27/26 -escitalopram oxalate (antidepressant medication) 10 mg tablet: give 10 mg by mouth one time a day for major depressive disorder starting 1/27/26 The Physician Order Report lacked documentation of any direction to monitor target behaviors or identification of target behaviors. R50's care plan, printed 2/17/26, identified R50 was on medications with FDA Boxed warning related to major depressive disorder and included the following interventions: -WARNINGS #1 : Refer to boxed warnings in eMAR for use of escitalopram and LPN notify provider if side effects/adverse reactions are observed. - WARNINGS #2: Refer to boxed warnings in eMAR for use of bupropion and notify provider if side effects/adverse reactions are observed. - Monitor resident condition based on clinical practice guidelines or clinical standards RN of practice r/t use of escitalopram, bupropion, oxycodone. The care plan lacked documentation of any direction to monitor target behaviors or identification of target behaviors. R50's Medications Administration Record (MAR/TAR) for February was reviewed. The document indicated R50 received bupropion and escitalopram as ordered. The document lacked evidence of target behavior monitoring. During an interview on 2/19/26 at 12:15p.m., registered nurse (RN)-B stated any psychotropic medication has target behavior monitoring. RN-B stated when a resident admits to the facility, nursing put the orders in along with side effect monitoring. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/19/26 at 12:25 p.m., RN-A reports target behaviors are identified on the care plan and documented under treatments. RN-A verified R50 did not have any target behavior monitoring in place. During an interview on 2/19/26 at 1:35 p.m., director of nursing (DON) stated target behaviors are documented on the MAR. DON stated the expectation was all psychotropic medications have target behavior monitoring to help ensure the medication is appropriate for the residents. DON verified R50 did not have any target behavior monitoring in place. R4's quarterly Minimum Data Set (MDS) dated [DATE], indicated R4 had moderately impaired cognition and was dependent on staff for completing toileting hygiene, lower body dressing, and transferring. R4's Medical Diagnosis list dated 6/11/25, indicated R4 had a diagnosis of dementia, paranoid personality disorder, depression, and kidney failure. R4's care plan dated 11/18/25, indicated R4 was taking quetiapine and staff were to refer to the boxed warnings in the orders, eMAR, or medication reference of choice. The care plan indicated R4 was on hypnotic therapy related to sleepiness, an antipsychotic related to agitation and paranoia, and an antidepressant related to depression. The care plan indicated the resident's condition would be monitored based on clinical practice guidelines or standards. The care plan indicated R4 received hemodialysis (use of a machine that filters wastes, salts, and fluid from the blood when the kidneys are no longer healthy enough to do so) on Mondays and Fridays. R4's Order Summary dated 1/30/26, included an order:-dated 6/11/25, for six milligrams (mg) of melatonin (a supplement used for sleep with possible side effects of daytime drowsiness, headache, etc.) daily at bedtime. -dated 6/11/25, for 7.5 mg of Mirtazapine (an antidepressant with a possible side effect of drowsiness) daily at bedtime.-dated 11/13/25, for 25 milligrams of quetiapine (an antipsychotic with a common side effect of drowsiness) twice a day.-dated 1/30/26, for 25 milligrams of quetiapine once a day. R4's Medication Administration Record dated 2/1/26 to 2/17/26, included an order for:-antidepressant side effect monitoring, including sleep problems, -antipsychotic side effect monitoring, including sedation,-hypnotic side effect monitoring, including daytime drowsiness, -an order to document hours of sleep every shift. The orders had a space for check marks that were checked as completed, but did not include whether sleep problems, sedation, or daytime drowsiness were observed. The MAR also did not include documented hours that R4 slept every shift; instead, it included check marks. R4's quarterly review progress note dated 2/4/26 at 6:13 a.m., indicated R4 was often out of the facility at dialysis appointments and was often tired when he was at the facility. R4's progress notes dated 2/1/26 to 2/17/26 were reviewed with no further assessment of R4's drowsiness/fatigue found. R4's nutrition progress note dated 2/5/26 at 9:36 a.m., indicated R4 appears fatigued most often. During an observation on 2/17/26 at 9:06 a.m., R4 was observed lying in bed with the lights on. R4 was addressed and responded by saying hi, and then started snoring. During an observation on 2/18/26 at 12:16 p.m., R4 was observed lying in bed with the lights on, (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	snoring. During an observation on 2/18/26 at 12:38 p.m., R4 was observed lying in bed with the lights on, snoring. During an observation and interview on 2/18/26 at 12:42 p.m., R4 was observed lying in bed with the lights on, snoring. Nursing assistant (NA)-B confirmed she was R4's aide today. NA-B stated she had worked with R4 in the past and thought he normally sleeps a lot. NA-B stated she had attempted to assist him with getting ready for the day and getting out of bed, but he was too drowsy, so she would attempt again later. During an interview on 2/18/26 (a Wednesday) at 12:43 p.m., NA-C stated she had worked with R4 often and noticed that R4 was often tired the day he got dialysis and would sleep longer. NA-C stated she had noticed that R4 had been really sleepy lately, but still sometimes got up to go to activities. During an interview on 2/19/26 at 11:25 a.m., registered nurse (RN)-A stated R4 had a history of intermittent sleepiness and thought it was possible he was awake more at nighttime. RN-A stated he thought facility staff were supposed to track hours that R4 slept to see if there were any changes in his status, but this was not something he was completing. RN-A stated that when R4 got back from dialysis, he was very tired, but his melatonin or antipsychotic could also be causing this drowsiness. During an interview on 2/19/26 at 11:30 a.m., the director of nursing (DON) stated R4 had a history of delusional behaviors and paranoia and thought the resident was awake at night but was not aware how often. The DON stated she would have to review R4's medical record to see if sleep monitoring was being tracked but would expect this to be completed if medications were used to assist with sleep. At 12:09 p.m., the DON confirmed she had reviewed R4's medical record and stated that the order for sleep monitoring had been entered incorrectly, so the hours R4 was sleeping were not being monitored. The DON stated she had updated the order and would complete an audit to ensure no other residents had this problem. A policy regarding medication side effect monitoring was requested but not received. A facility policy on psychotropic medication related to target behaviors was requested and not received.

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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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to ensure proper cleaning and maintenance of a non-invasive ventilation machine to reduce the risk of complications (i.e., respiratory infection) for 1 of 1 resident (R1) observed for a continuous positive airway pressure (CPAP) machine.Findings include:The [NAME] Dream Station 2 User Manual dated 2021, indicated cleaning the CPAP machine daily. The manual indicated to use a lint-free cloth dampened with a liquid soap solution to clean the exterior of the machine, heater plate and the air inlet/outlet seal. The manual indicated daily hand wash of the humidifier water tank with warm water and mild soap. Furthermore, the manual indicated the humidifier water tank should be disinfected once a week with 70% isopropyl alcohol, and the tube should be washed once a week with warm water and mild soap. The filter and tube should be replaced once a month. The American Thoracic Society information series dated 2020 indicated the CPAP mask should be cleaned every day with a damp cloth and mild detergent to remove any body oil, sweat, or debris that may have built up while wearing the mask. R1's quarterly Minimum Date Set dated 1/23/26, indicated R1 had severe cognitive impairment, needed maximal assistance with bathing, upper body dressing, and needed moderate assistance with personal hygiene. MDS indicated diagnoses of Parkinson's disease and depression.R1's medication administration record (MAR) dated 2/2026, indicated a diagnosis of obstructive sleep apnea. The MAR included an order dated 1/15/25, for CPAP EO6010 machine for home use at pressure 7-20. Use home settings at bedtime.R1's care plan did not include a respiratory care plan related to his CPAP machine. R1's electronic medical record (EMR) lacked documentation about cleaning and maintaining R1's CPAP machine. During observation on 2/17/26 at 12:05 p.m. a [NAME] Dream Station 2, CPAP machine was observed on R1's nightstand. The tube was connected to the CPAP, and the mask was attached to the tube. The mask was placed on top of the CPAP machine with the cushion down. During observation on 2/18/26 at 11:56 a.m., the CPAP's mask was on top of the machine, and the tube was attached to the mask and machine. During interview on 2/18/26 at 3:11 p.m., registered nurse (RN)-A stated this morning he removed R1's CPAP mask, checked oxygen level and R1's skin. RN-A stated he did not wash the mask, he placed the mask down on the CPAP Machine. RN-A was not sure when the mask was cleaned. RN-A stated the overnight nurse changed the CPAP's tube on Saturday or Sunday and washed the machine using vinegar. During interview on 2/18/26 at 3:37 p.m., family member (FM)-D stated R1's machine was about 2 years old. FM-D used to take care of the CPAP machine when R1 lived at home. FM-D stated the nursing staff never asked her about what kind of supplies were needed to maintain the CPAP machine. FM-D stated she had supplies at home including masks, mask straps, tubing and filters. FM-D stated she visited R1 three times a week. Every time she visited, she cleaned the mask and wiped the machine. Once a week she washed the tubing, and changed the mask as needed. Since R1's admission to the facility, FM-D had taken the CPAP to the sleep clinic once to have the machine checked.During interview on 2/19/26 at 1:09 p.m., director of nursing (DON) stated a resident admitted with a CPAP machine needed orders including the settings, which were preprogramed. The order also needed to indicate when to put it on and when to remove it. DON stated on Fridays the overnight nurse washed the machine water reservoir, changed the tubing, filter and mask. This nurse also ordered supplies as needed. DON stated the facility obtained orders about cleaning and maintenance of the CPAP machine. DON verified R1's orders, MAR and treatment administration record (TAR) did not include orders to clean the mask every morning, change the filter, wash the water reservoir, or wash and change the tubing. DON stated she expected the staff to clarify the orders and clarify on the care plan what FM-D role on the maintenance of the CPAP machine, supplies and mask was. DON stated the facility needed to make sure R1's CPAP machine was properly taken care of as there will be a risk of a less than desirable outcome. The facility's policy titled Non-Invasive Respiratory Support dated 10/31/25 indicated the policy provided (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	guidance to location staff members when caring for residents using non-invasive respiratory support technology. The policy directed staff to follow the manufacturer's recommendations for cleaning and maintaining the equipment.

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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 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to implement or maintain an appropriate communication and collaboration system with an outside dialysis clinic to promote continuity of care and reduce the risk of complications (i.e., missed orders, insufficient preparation for treatment) for 1 of 1 residents (R4) reviewed for dialysis care. Findings include: R4's quarterly Minimum Data Set (MDS), dated [DATE], identified that R4 had moderate cognitive impairment along with several medical conditions, including anemia, diabetes, and kidney failure. R4's order summary dated 10/31/25, included an order for staff to send a dialysis communication sheet with R4, and it was to be checked upon return for new orders.R4's care plan dated 11/18/25, indicated R4 received hemodialysis (use of a machine that filters wastes, salts, and fluid from the blood when the kidneys are no longer healthy enough to do so) on Mondays and Fridays. The care plan included information such as monitoring related to dialysis, contact information for the dialysis center and transportation, as well as instructions related to the dialysis access port. R4's progress notes dated 1/22/26 through 2/19/26 were reviewed and included:-dated 1/30/26 at 11:10 p.m., indicated R4 did not bring any paper from dialysis but did not indicate if the facility had followed up with the dialysis center when communication was not received on the resident's return. -dated 2/13/26 at 11:54 p.m., indicated R4 had returned from dialysis at 6:40 p.m., and R4 did not bring any paper from dialysis. The note did not indicate if the facility had followed up with the dialysis center when communication was not received on the resident's return. -No further progress notes were found regarding communication with the dialysis center during this time period. Dialysis communication forms from 1/22/26 through 2/19/26 were requested, with this period containing eight dialysis appointments.R4's Dialysis Communication/Referral dated 2/6/26, included information such as a resident assessment of vital signs, status, and dialysis access site completed by the facility. The form had a space at the bottom titled Dialysis to Complete the Following Section that was not completed. R4's Dialysis Communication/Referral dated 2/9/26, included information such as a resident assessment of vital signs, status, and dialysis access site completed by the facility. The form had a space at the bottom titled Dialysis to Complete the Following Section that was not completed. A Dialysis Communication/Referral dated 2/16/26 and included information such as a resident assessment of vital signs, status, and dialysis access site completed by the facility. A Hemodialysis Patient Communication Sheet dated 2/16/26 included information such as vital signs, resident weight before and after treatment, medications given, and a space for recommendations to the long-term care facility that stated no complications. No further dialysis communication forms were received. During an interview on 2/19/26 at 11:04 a.m., the health information manager (HIM) stated she had reviewed R4's medical record and could only find the above-mentioned dialysis communication forms. During an interview on 2/19/26 at 11:23 a.m., registered nurse (RN)-A stated he was not normally working when the resident returned from dialysis, so he was unsure if facility staff was having a problem receiving communication back from the dialysis center after R4's appointments. RN-A stated that he would expect staff to call dialysis to ask them to fax the dialysis form if R4 was not coming back from his appointment with the communication form filled out. RN-A stated he would then expect nursing staff to enter a progress note that this had been completed. RN-A stated it was important that this was completed to ensure that if R4 had any changes in dialysis or if there was anything they needed to follow up on, facility staff were aware of it. During an interview on 2/19/26 at 11:29 a.m., the director of nursing (DON) stated that if nursing staff were not receiving the dialysis forms back from dialysis, she would expect the facility to call dialysis and request an update and document that this was completed in the progress notes. During an interview on 2/19/26 at 12:05 p.m., registered nurse (RN)-E, the charge nurse from the dialysis center, stated their practice was to fill out their own post-dialysis form that included an assessment, medications given, any recommendations, etc., that (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	they send with the resident after dialysis. RN-E stated that if the facility was not receiving them, the facility could request a copy, and they could fax it to them.A policy regarding dialysis was requested but not received.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident?s drug regimen must be free from unnecessary drugs. Based on observation, interview, and document review, the facility failed to ensure non-pharmacological interventions were attempted and recorded prior to the administration of as-needed (PRN) pain medication to help facilitate person-centered care planning and reduce the risk of complication (i.e., constipation, sedation) for 1 of 5 residents (R50) reviewed for unnecessary medication use. Findings include:R18's admission Minimum Data Set (MDS) assessment, dated 2/1/26, identified R18 had moderately impaired cognition with no hallucinations, delusions, behaviors or rejections of cares with an admission of 1/26/26. Diagnoses included: periprosthetic fracture around internal prosthetic right hip joint (a break in the thigh bone adjacent to the artificial hip stem), hypertension (high blood pressure) and diabetes (body can't manage blood sugars properly). In addition, the MDS outlined R50 did not receive scheduled pain medication but did receive PRN pain medication during the review along with non-medication interventions for pain. R50 indicated she frequently experienced pain which frequently made it hard to sleep at night, limited participation in rehabilitation therapies and limited day to day activities. Further, R50 indicated they had occasional pain which they rated at six (6) out of 10 (10 being the worst possible). R18's care plan, printed 2/17/26, identified R50 had acute pain related to right hip fracture. The care plan listed interventions to help R50 meet this goal which included, Attempt non-pharmacological intervention (SPECIFY), and provide resident with reassurance that pain is time limited. Encourage resident to try different pain-relieving methods i.e. position, relation therapy, progressive relaxation, bathing, heath and cold application, muscle stimulation, ultra-sound, etc.R50's February Medication Administration Record (MAR) included the following:-acetaminophen (pain medication) 325 milligrams (mg) tablet-give 650 mg by mouth every 6 hours as needed for pain, must chart effectiveness started 1/26/26 which had been administered five (5) times. Four of five (4 of 5) administration documented with an e indicating effective along with a pain scale prior to administration with one (1) administration being documented with a u indicating unknown. There was no documentation on the MAR of nonpharmacological interventions offered, administered or declined prior to administration. -oxycodone (narcotic pain medication) 5 mg tablet- give 1 tablet by mouth every four hours as needed for pain 3-7, must chart effectiveness started 1/26/26 which had been administered ten (10) times. Eight of ten (8 of 10) administration documented with an e along with a pain scale prior to administration with two (2) documented with an u. There was no documentation on the MAR of nonpharmacological interventions offered, administered or declined prior to administration.-oxycodone 5 mg tablet-give two (2) tablet by mouth every four (4) hours as needed for4 pain 8-10, must chart effectiveness started 1/26/26 which had been administered three (3) times. Administration had been documented with e along with a pain scale prior to administration. There was no documentation on the MAR of nonpharmacological intervention offered, administered or declined prior to administration.The MAR lacked any documentation of any nonpharmacological interventions offered, administered or declined to R50. R50's progress notes, dated 1/26/26 to 2/19/26, reviewed and lacked evidence of nonpharmacological interventions offered or attempted prior to administrations of PRN pain medications.R1's medical record was reviewed and lacked evidence of what, if any, non-pharmacological interventions were offered or attempted prior to the administration of the PRN narcotic medication all the administered doses from 2/1/26 to 2/19/26.During an interview on 2/19/26 at 12:07 p.m., registered nurse (RN)-B stated if a resident reports pain, they would assess the resident to determine and have the resident rate the pain if they are able or use the nonverbal pain scale. RN-B stated they would determine the next steps after their assessment. RN-B stated if a nonpharmacological intervention was offered for pain, it would be documented in the progress notes.During an interview on 2/19/26 at 12:22 p.m., RN-A stated they would offer nonpharmacological interventions for pain prior to administering as needed pain medications for pain. RN-A stated they would document any nonpharmacological interventions offered in the progress notes. RN-A stated any (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	nonpharmacological interventions offered whether accepted, helpful or declined, they would document in the progress notes. During an interview on 2/19/26 at 12:33 p.m., R50 stated she has not been offered any alternatives to pain medications. R50 stated would like to be offered ice for her pain as she previously used ice on her back when it was sore and it felt very nice.During an interview on 2/19/26 at 1:30 p.m., director of nursing (DON) stated the expectation would be that prior to administration to PRN medications, nonpharmacological interventions are offered. DON stated nonpharmacological interventions are used in conjunction with pain medication to address pain appropriately. DON stated nonpharmacological interventions would be documented on the MAR/TAR or in a progress note. DON requested to follow up to look further into if nonpharmacological interventions were provided as upon review could not identify they were being completed. No additional information was provided.A policy on nonpharmacological interventions for pain management was requested and not received.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** During observation, interview, and record review the facility failed to ensure a safe, sanitary, and comfortable environment for 1 of 1 residents (R40) observed whose headboard and footboard of their bed was not maintained in good repair and whose personal fan was not clean.Findings include: R40R40's Significant change in status assessment (SCSA) Minimum Data Set (MDS) dated [DATE] identified R40 had impaired cognition, required assistance of two for all personal cares and transfers, was on oxygen and hospice, and had diagnoses of heart failure, kidney disease, hip fracture, respiratory failure, obesity and lymphedema (swelling caused by accumulation of protein-rich fluid in the body's tissues).During observation and interview on 2/17/26 at 8:18 a.m., R40 was lying in bed on her back with cracked, splintered particle board running along top of the footboard and headboard of her bed. The edge banding on top of them was not adhered. In addition, her personal fan with visible matter attached to the front of the fan and blades was operating on high speed, blowing air across R40's head while R40 was using Oxygen on 2 liters via nasal canula. The nightstand the fan was on also had visible dust on all surfaces. R40 stated she recalled the footboard and headboard were in disrepair as long as I have been here and it does not look good. R40 also stated she could not recall if her personal fan or nightstand had ever been wiped down or cleaned when housekeeping came into her room.During observation and interview with R40's primary emergency contact and significant other (SO) on 2/17/26 at 9:38 a.m., SO stated he visited R40 daily and, fan is usually on all the time. No one has cleaned it. Looks dirty. In addition, SO stated R40's footboard and headboard, had been broke since last September and indicated facility staff were aware but did nothing about it. SO stated he was concerned with the fan blowing dirty air across R40s face while she was on oxygen. SO stated he had never seen housekeeping or other facility staff clean or wipe down R40s fan.During observation and interview with R40 and SO on 2/18/26 at 9:52 a.m., R40's personal fan with visible matter attached to the front of the fan and the blades was operating on high blowing air across R40's head while they were using Oxygen on 2 liters via nasal canula. R40 looked at the chipped and broken particle board of the footboard of her bed and stated, it does not look good to me. It is something I have gotten used to. Looks like it is falling apart.During observation and interview with nursing assistant (NA)-A on 2/18/26 at 10:01 a.m., NA-A stated R40's fan looks very dirty. It should not be blowing across her face due to respiratory concerns. NA-A stated he was unaware of who was responsible for managing and cleaning personal fans. NA-A observed R40's headboard and footboard and stated expectation of staff to notify maintenance through an email portal or verbally of any repairs that were identified, including the footboard and headboard of R40. NA-A stated he was unaware of any staff member submitting a maintenance request. NA-A stated he had not notified maintenance of the issue either. NA-A stated it was important for safety to get it fixed and indicated he would hate to have his bed frame look like that.During observation and interview with registered nurse (RN)-A on 2/19/26 at 10:27 a.m., RN-A looked at R40's personal fan and stated, it needs to be cleaned. RN-A stated aide should clean it because it could be causing issues with her breathing due to her respiratory status. RN-A stated they didn't know when personal fans should be cleaned and wiped down, but it was dirty and could cause infection, however indicated the aide should wipe the nightstands and tables daily. RN-A stated R40's footboard was not in good repair and needed to be fixed, and they would not like it in their home. RN-A stated maintenance should be notified through online portal, however she was unaware of any requests for maintenance for repair or replacement of R40s headboard and footboard. RN-A stated she did not notify maintenance of any repairs needed for R40's room.During interview with RN-B on 2/18/26 at 10:35 a.m., RN-B stated expectations of all staff to notify maintenance of any repair request to use the online portalDuring interview with maintenance director (MNC) on 2/18/26 at 10:40 a.m., MNC stated expectation of staff to use online portal to (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	request repairs. MNC verified there were no requests to repair or replace R40's headboard and footboard. MNC agreed that R40's headboard and footboard needed to be replaced.During observation and interview with director of nursing (DON) on 2/18/26 at 10:54 a.m., DON looked at R40's personal fan and stated, I appreciate it being cleaned. DON stated housekeeping staff were responsible for cleaning the personal fans and did not know how often the surfaces were wiped down. DON verified R40's fan had visible dust and matter on them while it was blowing air across R40's face.During interview with interim administrator on 2/18/26 at 11:24 a.m., interim administrator stated expectation of staff to utilize the online portal to document and submit work order requests. The staff have been trained but they are not consistent with doing that.During observation and interview with housekeeper (HK)-A on 2/18/26 at 11:24 a.m., HK-A stated expectation of housekeeping is to pick up garbage, clean toilets, and mop the floors in each resident room daily. HK-A observed the dust on R40's nightstands and personal fan and stated, I have never been told to wipe down the personal fans. HK-A verified, it looks like it has not been done in over a week. HK-A also stated expectation of staff to submit an online maintenance request for repairs of facility equipment including headboards and footboards. HK-A observed R40's headboard and footboard and stated they had not noticed that before and stated it did not look good and maintenance should fix it or replace it.During interview with infection control preventionist (IP) on 2/18/26 at 1:25 p.m., IP stated they did not know who was responsible for cleaning the personal fans. IP stated it is a potential issue with dirty fan blades blowing air across [R40] in her bed. She is vulnerable respiratory wise and cardiac wise.During interview with MNC on 2/19/26 at 7:15 a.m., MNC stated facility did not have a schedule to clean personal fans, but indicated dirty fans are not appealing and should be clean with no visible dirt or matter on them.Policies on maintaining facility equipment and personal fans was requested and not received.