STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245289	A. Building B. Wing	06/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Terrace at Crystal LLC	3245 Vera Cruz Avenue North Crystal, MN 55422

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to ensure a shared blood glucometer (device to test blood sugar levels) was cleaned and disinfected properly between resident use to prevent transmission of bloodborne pathogens for 2 of 2 residents (R33, R38,) and failed to properly disinfect a blood glucose monitor following use with R31 and prior to placing on shelf at nursing station for use with other residents reviewed for shared use of medical equipment. This practice resulted in an immediate jeopardy (IJ) situation for R38 due to the risk of potential transmission of blood borne pathogens from R33 to R38. In addition, the facility failed to implement appropriate precautions against clostridium difficile colitis (CDI) (a inflammation of the colon caused by the bacteria clostridium difficile) including use of appropriate personal protective equipment (PPE) and isolation precautions to prevent the spread of CDI for 1 of 1 residents (R31) reviewed for transmission-based precautions (TBP), failed to ensure appropriate hand hygiene and glove hygiene were implemented to prevent cross contamination during a bed bath for 1 of 1 resident's (R15) who were observed during personal cares, and failed to provide proper infection control measures during catheter care for 1 of 1 resident's (R23) reviewed for catheter care.The IJ began and was identified on 6/3/26 at 7:33 a.m. when R33 who had a diagnosis of HIV (human immunodeficiency virus; a virus that attacks the body's immune system, and without treatment, it can lead to AIDS (acquired immunodeficiency syndrome; which can be fatal) had his blood glucose (Bg) checked via a finger stick blood test (finger is pricked with a lancet to obtain a small quantity of capillary blood for testing). The shared glucometer was not properly cleaned or disinfected and was then brought into R38's room to check his Bg. Nursing staff were also not able to verbalize a consistent process to clean and disinfect shared glucometers. The administrator and director of nursing (DON) were notified of the immediate jeopardy on 6/3/26 at 1:10 p.m. The facility implemented corrective action, and the immediacy was removed on 6/4/26 at 3:05 p.m., however non-compliance remained at the lower scope and severity level of an E; a pattern which indicated no actual harm with the potential for more than minimal harm that is not immediate jeopardy. Findings include: Glucometer: R33 R33's quarterly Minimum Data Set (MDS) dated [DATE], identified moderately impaired cognition, no behaviors or rejection of care. Substantial/maximal assist from staff was required for hygiene and he was dependent on staff to get dressed. R33 had diagnoses of diabetes mellitus (DM) II, non-Alzheimer's dementia, hemiplegia or hemiparesis, anxiety, depression, psychotic disorder. R33's diagnosis list dated 9/13/24, included HIV. R33's care area assessment (CAA) dated 6/18/25, identified activities of daily living (ADLs) was (continued on next page)

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

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	triggered and R33 was at risk for further decline in physical function related in part to HIV. R33's physician orders included: 11/21/25, Freestyle Libre or substitution (a continuous glucose monitoring (CGM) system that provides real-time glucose readings) 14-day sensor kit. Apply one kit as directed every two weeks. 12/20/24, check Bg daily before a meal, alternate times. 12/20/24, Abacavir-Dolutegravir-Lamivud Oral Tablet 600-50-300 MG, one tablet by mouth every day related to HIV. R33's care plan for diabetes mellitus dated 9/19/24, identified to follow provider's order regarding Bg parameters. The care plan did not address interventions for blood borne pathogens such as cleaning and disinfecting shared Bg equipment. R38 R38's quarterly MDS dated [DATE], identified severely impaired cognition, no behaviors or rejection of care and was dependent on staff assistance for hygiene and dressing. Diagnoses included DMII with hyperglycemia, heart failure, kidney failure, non-Alzheimer's dementia, cataracts, glaucoma or macular degeneration, and cirrhosis of the liver. R38's CAA dated 3/1/26, identified ADLs triggered because the resident needed assistance with ADLs, transfers and mobility. Staff will continue to provide assistance to resident as needed. R38's diagnosis list dated 11/26/24, did not include any blood borne pathogens. R38's physician orders identified: 10/6/25, please check Bg three times a day. 8/22/25, start Freestyle Libre CGM 2 or 3 for diabetes management R38's care plan dated 11/29/24, identified a diagnosis of DM. Interventions included fasting Bg as ordered and to follow provider orders for Bg parameters. The care plan did not address interventions for blood borne pathogens such as cleaning and disinfecting shared Bg equipment. During an observation on 6/3/26 at 7:33 a.m., licensed practical nurse (LPN)-B entered R33's room with a red tote of Bg supplies (gauze, alcohol wipes, single use lancets, test strips and Bg meter). LPN-B scanned R33's CGM upper arm and no reading was obtained. LPN-B stated sometimes his CGM did not work. LPN-B use alcohol-based hand rub (ABHR), put on gloves, wiped R33's finger with an alcohol wipe and pricked the finger with a single use lancet to obtain a sample of blood. The test strip was inserted into the Bg meter and brought to R33's finger to absorb the blood resulting in a reading of 134. LPN-B placed the lancet and test strip in the garbage wrapped up in her gloves, washed her hands, put the Bg meter in the red tote and exited the room. The contaminated Bg meter was placed in the tote test strip side and on top of unused lancets. LPN-B did not disinfect the Bg meter nor the tote it was in and put the tote on the counter at the nurse's station. A continuous observation of the tote began at this time. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an observation and interview on 6/3/26 at 7:52 a.m., LPN-B entered R38's room, used ABHR and put on gloves. LPN-B scanned R38's CGM and no reading was obtained. LPN-B removed her gloves, used ABHR hand rub, exited the room and picked up the same red tote with Bg supplies, R38's door remained open and LPN-B did not clean or disinfect the meter and supplies prior to re-entering R38's room. Upon re-entry LPN-B used ABHR, put new gloves on and asked R38 which finger she should prick. LPN-B moved the lancet and Bg meter close to R38 and was stopped by surveyor and asked to step out of the room. LPN-B was asked what was used to disinfect Bg equipment between uses and she replied she would use an alcohol wipe from the tote. LPN-B verified verbally that was not done between residents. When asked if alcohol disinfects for blood borne pathogens, she replied no and went to the nurse's station to get Micro-Kill One EPA reg 88494-2-37459, the label identified it was effective against organisms including hepatitis B virus, hepatitis C virus and Human Immunodeficiency Virus (HIV-1) (AIDS). LPN-B stated said she should have used this type of wipe. LPN-B re-entered R38's room, cleaned the Bg meter and wrapped it in a Micro-Kill wipe for 1 minute as directed on the bottle and repeated the Bg check. After the Bg test was completed, LPN-B was asked if there was a risk of transmitting blood borne pathogens by not cleaning and disinfecting shared equipment to which she replied yes. R31 R31's annual MDS indicated intact cognition, a diagnosis of Type I Diabetes, and received insulin on a routine basis. R31's physician's orders dated 6/3/26, indicated R31 was on contact precautions for Clostridioides difficile (C-diff., highly contagious bacterium that infect the colon, causing severe diarrhea). It further indicated an order dated 7/4/25, indicated Accu checks with scheduled meals and bedtime four times a day for blood sugar. R31's care guide dated 3/27/26, indicated R31 was diabetic and was on enhanced barrier precautions (EBP). R31's care plan dated 2/21/24, indicated R31 had diabetes mellitus type I with an intervention to obtain blood sugars per medical doctor (MD) order. R31 has an order for Dexcom. Sensor to change every 10 days. R31's progress note dated 6/3/26, indicated R31 complained of generalized body pain. Lab result received; C- diff was detected in the stool sample and the provider was updated. New order received for Fidaxomicin 200 milligrams (mg) twice per day for 10 days and Maalox 20 mg four time per day (as needed) for epigastric pain. R31 to remain on contact precautions. During observation on 6/3/26 at 7:48 a.m., licensed practical nurse (LPN)-A put on gloves and entered R31's room in order to check her blood sugar. Once LPN-A was finished using the glucometer, she used a Sani-cloth disposable wipe, wiped the glucometer for a few seconds, and put it in a clear plastic cup in a bin filled with blood testing supplies, and placed it on a shelf at the nursing station. The back of the Sani-cloth wipe container indicated contact time-use second germicidal wipe to thoroughly wet surface. Allow to remain wet 2 minutes, let air dry. LPN-A did not thoroughly wet the surface or allow it to remain wet for 2 minutes when cleaning the glucometer. During an interview on 6/3/26 at 8:06 a.m., registered nurse (RN)-A stated she had already completed all of her blood sugar checks for the day. RN-A stated after completing a resident's blood sugar check, (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	she would use a Super Sani-Cloth wipe to clean the glucometer. RN-A stated she has five resident's requiring blood sugar checks. RN-A stated one glucometer was used for all residents on her unit. When asked how long the glucometer needed to remain wet, RN-A stated she would wrap the glucometer in the wipe and leave it in a plastic cup until it was needed again. During an interview on 6/3/26 at 8:10 a.m., trained medication aide (TMA)-A confirmed she was working on the first floor and stated no residents needed their blood sugars checked at this time. TMA-A stated they had one shared blood glucometer if residents did need their blood sugars checked on her unit. TMA-A stated that after completing a resident's blood sugar check, she would use a Micro-Kill bleach wipe to clean the glucometer and would wrap the glucometer in the wipe and leave it for three to four minutes. During an interview on 6/3/26 at 8:50 a.m., the infection preventionist (IP) stated cleaning and disinfecting wipes which were effective against blood borne pathogens should be used between uses of shared Bg meters per the disinfecting wipe package directions. The IP stated the Bg meter should be wiped until wet and allowed to remain wet for 2 minutes or as directed on the disinfecting wipes package directions. The IP stated alcohol wipes were not effective. The IP accompanied surveyor to observe the red tote. A Bg meter was wrapped up in a disinfecting wipe. The IP stated she changed out the red totes monthly, and agreed the tote was contaminated at this time, since the Bg meter was placed on top of the supplies in the tote after use and without being cleaned or disinfected. During an interview on 6/3/26 at 9:40 a.m., the director of nursing (DON) stated she expected shared Bg meters to be disinfected before, after, and in-between uses. The DON stated they would follow the manufacturer's recommendations on the bottle of disinfecting wipes and that alcohol wipes were not effective enough. The risks of not cleaning and disinfecting between uses included cross-contamination of resident infections which would include bloodborne pathogens. The DON stated the facility would not clean and disinfect according to the Bg meter instruction manual and would instead use the directions for the disinfecting wipes. The DON stated the Bg meters came with an instruction manual, and they could consult that for recommendations. During an interview on 6/3/26 at 11:32 a.m., the facility's Medical Director (MD) stated he would expect staff to clean and disinfect shared Bg meters with the proper disinfectants and per the infection control guidelines. Even if a drop of blood is present there was a risk of transmittal of blood borne pathogens from one resident to another. There was a risk of the transfer of blood borne pathogens with shared equipment, if the transfer occurred the potential for danger was high and the outcome of that transfer could be devastating. The facility policy Obtaining a Fingerstick Glucose Level, undated, identified to review the resident's care plan and provide for any special needs of the resident. Items needed included a disinfected Bg meter with sterile lancet or single resident use sprint loaded device or automatic or safety type lancet. Always ensure Bg meters intended for reuse are cleaned and disinfected between resident uses. Follow the instructions provided by the manufacturer of the Bg meter system to obtain a Bg reading. Clean and disinfect reusable equipment between uses according to the manufacturer's instructions and current infection control standards of practice. The undated user manual for EvenCare G3 Bg Meter, identified the Bg meter should be cleaned and disinfected between each patient. Wipe all external areas of the meter including both front and back surfaces until visibly wet. The following products have been validated for cleaning and disinfecting: (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 6/2/26 at 2:10 p.m., licensed practical nurse (LPN)-A stated the resident had been refusing stool specimen collection at times and staff had been attempting to obtain the specimen for an extended period. During an interview on 6/4/26 at 8:22 a.m., the Nurse Manager and LPN-C stated staff had difficulty obtaining stool specimens because the resident did not always allow collection. When asked about stool testing results, the Nurse Manager stated the facility had received results the previous day confirming R31 tested positive for C. difficile. During an interview on 6/4/26 at 10:36 a.m., the Infection Preventionist (IP) stated R31 tested positive for C. difficile and had been started on antibiotic treatment the previous day. The IP stated R31 had been placed on contact precautions on 6/3/26 and added to the symptom management and surveillance list at that time. The IP stated a C. difficile-specific enteric precautions sign was available for use; however, a generic contact precautions sign was mistakenly posted on R31's door instead. The IP stated the stool specimen documented as collected on 5/15/26 had been collected and sent to the laboratory, but she was unsure what happened to the specimen and planned to follow up with the laboratory. The IP stated R31 should have been placed on enteric precautions while C. difficile testing was pending. During an interview on 6/4/26 at 11:15 a.m., the Nurse Manager and LPN-C stated he contacted the laboratory and learned the laboratory had no record of receiving a stool specimen from 5/15/26 despite nursing documentation indicating the specimen had been collected and sent. During an interview on 6/4/26 at 11:40 a.m., R31 stated she had become progressively sicker over the previous several weeks and felt miserable. R31 stated she was afraid to leave her room because she needed to use the bathroom so frequently, particularly after eating. She stated her stomach hurt frequently. The TBP sign hung on R31's door indicated R31 was on contact precautions, not enteric precautions, which would direct staff to wash their hands versus use hand sanitizer as hand sanitizer is ineffective against C. difficile spores. During an interview on 6/4/26 at 2:16 p.m., the Director of Nursing (DON) stated staff should have followed up on pending stool testing, maintained infection control precautions while awaiting results, and notified the provider if the resident refused specimen collection to ensure timely diagnosis and treatment. An undated facility policy, titled Clinical Policy and Procedure: Implementation of Transmission-Based Precautions indicated nursing staff must initiate TBP immediately if a resident had new, unexplained diarrhea and/or suspected C. difficile. R15 R15's quarterly Minimum Data Set (MDS) dated [DATE], indicated intact cognition and diagnoses of chronic respiratory failure with hypoxia, morbid (severe) obesity, and muscle weakness. The MDS further included R15 had bilateral impairment on lower extremities and was dependent on staff for transfers. R15's Care Guide dated 3/27/26, lacked documentation R15 was on EBP. R15's Care Plan lacked documentation R15 was on EBP. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During observation and interview on 6/2/26 10:17 a.m., two NA's (NA-G, NA-H) donned a gown and gloves and entered R15's room to give him a bed bath and transfer him from his bed to his personal mobility device (PMD). The door to R15's room had a sign which indicated he was on EBP and there was an isolation cart in the hallway outside his room. NA-G filled up 2 basins of water in the bathroom sink and put soap in one. NA-H used washcloths to wash, rinse, and dry his upper body. R15 stated he had a bowel movement, so NA-G used wipes to clean his peri area. Once the area was clean, NA-G removed their gloves and applied new ones. NA-G did not perform hand hygiene in between glove changes. R15 rolled onto his right side and NA-G used wipes to clean his backside/bottom. Then NA-G rolled and tucked the pad underneath him and grabbed a clean washcloth from the wash basin and handed it to NA-H. NA-G did not change their gloves in between washing R15's bottom and then touching the clean washcloth. NA-G grabbed another clean washcloth and put it in the rinse bucket to get it wet and handed it to NA-H who then rinsed R15's front peri area. NA-G then picked up a clean towel and handed it to NA-H so they could dry the area. NA-G emptied the wash basin and filled it with clean water and handed a clean washcloth to NA-H to wash R15's back, picked up the barrier cream, applied it to R15's bottom, then applied the same cream to his back. Then NA-G grabbed a clean washcloth and washed the skin fold under his left arm all while wearing the same gloves. Then both NA's removed their gowns and gloves and washed their hands in the bathroom sink. NA-F entered the room to assist with transferring R15 into his PMD. All three NA's transferred R15 from his bed into his PMD. NA-F and NA-G were not wearing gowns while transferring R15 from his bed to his PMD. R23 R23 annual MDS dated [DATE], indicated moderately impaired cognition and diagnoses of multiple sclerosis (autoimmune disease that affects the central nervous system), spastic hemiplegia (a neuromuscular condition of spasticity that results in the muscles on one side of the body being in a constant state of contraction), affecting the right dominant side, and muscle weakness. It further indicated R23 was dependent on staff for toileting and had a catheter. R23's care guide dated 3/27/26, indicated R23 was on enhanced barrier precautions (EBP) and required catheter cares every shift. R23 's care plan dated 3/13/26, indicated R23 was on EBP related to a foley catheter with an intervention of staff will follow enhanced barrier precautions during high contact activities/activities of daily living (ADL). During observation on 6/2/26 at 11:09 a.m., nursing assistants (NA)-F and NA-G transferred R23 from her bed to her electric wheelchair using the Hoyer (mechanical) lift. Once R23 was in her wheelchair, NA-F was holding onto her catheter bag and bent over to guide R23's feet and the catheter drainage bag was rubbing against her shirt. NA-F and NA-G were not wearing gowns while transferring R23. During interview on 6/2/26 at 11:18 a.m., NA-F stated when cleaning a resident, they should go from clean to dirty and should change their gloves and perform hand hygiene after changing a resident's brief. NA-F further stated they were aware R15 and R23 were on EBP and should have been wearing a gown and gloves when performing cares. This would include transfers and catheter cares. During interview on 6/2/26 at 11:45 a.m., NA-G stated when cleaning a resident, they should go from clean to dirty. Changing their gloves and hand hygiene should be done following brief changes, and they are required to wear a gown and gloves when performing cares for residents who are on EBP. NA-G further stated they know the resident was on EBP precautions because they have a sign on (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	their door. During interview on 6/2/26 at 2:09 p.m., registered nurse (RN)-E stated when cleaning a resident, NA's should go from a clean area to a dirty area and they should be changing their gloves and performing hand hygiene following a brief change. RN-E further stated NA's should be wearing a gown and gloves while performing cares for a resident on EBP. During interview on 6/4/26 at 10:36 am, the infection preventionist (IP) stated nursing staff were only required to wear a gown when performing specific cares that related to the reason they were on EBP. For example, if a resident was on EBP due to a catheter, then staff were only required to wear a gown when performing catheter cares. The same would go for a wound, etc. Staff were not required to wear a gown if they were transferring the resident or changing their brief or any other high contact cares. The IP further stated nursing staff were expected to go from a clean area to a dirty area when bathing a resident or performing a brief change. They should also be changing their gloves and performing hand hygiene in between cares and after gloves were removed. The IP verified R15 was on EBP due to a wound and R23 was on EBP due to a catheter. The facility policy regarding hand hygiene and glove use (undated), indicated to use an alcohol-based hand rub containing at least 62% alcohol or alternatively soap and water for the following situations: -Before and after direct contact with residents -Before moving from a contaminated body site to a clean body site during resident care -After contact with blood or body fluids -After removing gloves. The facility policy regarding implementation of transmission-based precautions (undated), indicated long term care units must utilize EBP for residents with chronic, colonized Multidrug-Resistant Organisms (MDRO) or those with indwelling medical devices/chronic wounds without acute infection. EBP requires gown and glove use only during high contact care tasks.

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to assess, monitor, follow up, and implement physician-ordered care for ongoing gastrointestinal symptoms, failed to obtain and track diagnostic testing results, failed to ensure ordered specialty referrals were completed, and failed to develop a care plan to address persistent diarrhea for 1 of 3 residents (R31) reviewed for quality of care. The deficient practice resulted in actual harm for R31 through delayed identification and treatment of Clostridioides difficile (C. difficile) infection, prolonged unresolved gastrointestinal symptoms, abdominal pain, impaired nutritional status, social isolation, and skin discomfort. In addition, the facility failed to ensure a physician's order was implemented for 1 of 1 residents (R37) reviewed for diagnostic testing. Findings include: R31's annual Minimum Data Set (MDS) assessment dated [DATE] indicated R31 was cognitively intact with a Brief Interview for Mental Status (BIMS) score of 15. Diagnoses included diabetes mellitus, protein-calorie malnutrition, depression, and post-traumatic stress disorder (PTSD). R31 was identified as always continent of bladder and bowel, independent with toileting and transfers, and used a wheelchair for mobility. The MDS further indicated R31 did not exhibit any rejection of care behaviors. R31's care plan dated 6/4/26, identified R31 as continent of bowel, required supervision of one staff for toileting, and directed staff to ask resident about bowel movements daily. The care plan indicated R31 refused medication, showers, and non-pharmacological interventions, and often slept on the toilet. An intervention dated 5/11/25 indicated R31 declined to sign a risk/benefit [form] regarding sleeping on the toilet. A gastrointestinal (GI) care plan focus included R1 had an alteration in GI status related to peptic ulcer disease, pancreatitis, and chronic nausea with a goal of the resident will remain free from discomfort, complication, or signs/symptoms related to GI alterations revised 4/16/26. Interventions included obtaining and monitor lab/diagnostic work as ordered, and to report results to the provider and follow up as indicated. The care plan lacked a problem, goals, or interventions related to ongoing diarrhea, abdominal pain, stool testing or monitoring for infectious gastrointestinal illness related to frequent stools, or management of gastrointestinal symptoms. R31's provider orders included Oxycodone HCl tablet 5 milligrams (mg), give 2.5 mg every 24 hours as needed for pain rated 7-10 (on a 1-10 scale, where higher numbers equate to higher levels of pain) starting 1/14/26. A provider note from date of service 4/21/26 indicated the facility will schedule a follow up for R31 with a GI specialist. A social services progress note dated 4/21/26, indicated R31 stated concerns that documentation sometimes reflected refusal of care, and R31 wanted staff to understand there were times she may be asleep and not responding rather than refusing care. R31 stated they were a deep sleeper and sometimes did not respond when staff attempted to wake them. R31 reported concerns that documentation should reflect when sleeping vs. refusing. A provider note from date of service 5/12/26, included R31 was on the toilet during the visit, and reported worsening diarrhea, abdominal pain, and nausea and described it as constant and watery. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	The note indicated an enteric stool panel and c-diff sample was ordered, and the facility will schedule a follow up appointment for R31 with a GI specialist. A provider order dated 5/12/26 included c-diff A/B stool sample every shift for nausea, abdominal pain, watery diarrhea and to discontinue once collected. R31's May 2026 Treatment Administration Record (TAR) dated 5/1/26-5/31-26, identified an order for c-diff A/B stool sample every shift for nausea, abdominal pain, watery diarrhea and to discontinue once collected starting 5/12/26. The order was documented as refused once on 5/14/26 and completed/administered seven times between 5/12 and 5/15. The TAR also included an order to offer toileting assistance during night rounds and document any refusals in a progress note starting 2/5/26. Each night was documented as completed, and no refusals were documented in the progress notes. A nursing note dated 5/15/26 indicted a stool sample was collected and the order faxed to the lab for a STAT (high priority) order. R31's Medication administration Record dated 5/1/26-5/31-26 indicated R31 was given Imodium A-D Oral Tablet 4 mg for diarrhea on 5/24/26. A dietary note dated 5/25/26, identified R31 weighed 84.2 pounds, and a stool sample had been collected for norovirus and c. diff. The note did not include results of the testing. The medical record lacked documented laboratory results for the stool specimen reportedly collected and sent to the laboratory on 5/15/26. R31's Medication Administration Record (MAR) dated 5/1/26 – 5/31/26, indicated R31 had and order for Oxycodone (2.5 milligrams for pain rated 7-10/10) as needed and received 6 doses between 5/13-5/28 for generalized body pain. No other doses were given that month. A provider note from date of service 5/28/26, included R31 had worsening diarrhea and abdominal pain, and included: was stool sample collected as ordered on 5/12/26? If not, please re-order enteric stool panel and c diff A/B sample. The note also included ok to send to ED for evaluation if patient reports worsening abdominal pain. Staff were instructed to follow up when lab results were available. R31's provider order dated 5/29/26, included please re-order enteric stool panel and C. diff A/B sample every shift. Please discontinue this order when collected. R31's MAR dated 5/1/26-5/31/26, identified the order placed 5/29/26 for enteric stool panel and c. diff A/B sample as unable to be completed twice and was documented as completed five times. R31's MAR dated 6/1/26-6/3/26, identified the order for enteric stool panel and c. diff A/B sample as completed five times and not completed due to resident refusal or resident sleeping three times. The MAR also indicated R31 had received a dose of as needed Oxycodone (2.5 milligrams for pain rated 7-10/10) on 6/1, 6/2, and 6/3 for generalized body pain. The medical record lacked evidence that a second stool sample had been collected as ordered prior to the survey start. The order was discontinued on 6/3/26. Further review revealed no evidence the follow-up appointment with the GI specialist had been scheduled or completed. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	R31's progress note dated 6/3/26 indicated R31's lab result was received and c. difficile was detected on the stool sample. Provider was updated, and new orders were received for Fidaxomicin (an antibiotic) and Maalox (for epigastric pain). During interview and observation on 6/2/26 at 1:02 p.m., R31 stated she had not received any follow-up regarding the gastrointestinal appointment because they just don't make the appointments. R31 stated she had experienced diarrhea three to four times that day and it had been going on for weeks. She stated she believed staff collected a stool sample approximately one week earlier, but she had not received any information regarding the results. Observation revealed R31 appeared tired and lethargic. R31 stated she did not feel well and had no energy. During an interview on 6/2/26 at 2:10 p.m., licensed practical nurse (LPN)-A stated the health unit coordinator (HUC) was responsible for scheduling follow-up appointments. When asked whether R31's stool sample had been collected, LPN-A stated the resident had been refusing collection, and staff had been attempting to obtain the specimen for some time. During an interview on 6/3/26 at 10:50 a.m., a health unit coordinator (HUC) Assistant who helped with scheduling duties stated HUC staff were responsible for scheduling appointments when follow-up appointments had not already been arranged by outside providers. The HUC Assistant stated the actual HUC completed most appointment scheduling responsibilities. The HUC Assistant stated she highlighted orders requiring follow-up and provided them to the other HUC for action. When asked about R31's ordered GI specialist appointments, the HUC Assistant continued reviewing records to determine status, stating she would continue to look into it. During an interview on 6/4/26 at 8:22 a.m., LPN-C, who was also the nurse manager, stated staff had difficulty obtaining stool specimens because the resident would not always allow collection. When asked about stool testing results, LPN-C stated the facility had received results the previous day confirming R31 tested positive for C. difficile. When asked about the stool sample documented as collected and sent to the laboratory on 5/15/26 and the status of the GI referral, LPN-C stated he would investigate. During a follow-up interview on 6/4/26 at 11:15 a.m., LPN-C stated he contacted the laboratory and learned the laboratory had no record of receiving a stool specimen from 5/15/26, despite nursing documentation indicating the specimen had been collected and sent. LPN-C stated the HUC responsible for appointment scheduling was absent and he was unable to determine the status of the gastrointestinal referral but had not found any documentation of the appointment being scheduled or completed. During observation and interview on 6/4/26 at 11:40 a.m., R31 was observed lying in bed under a blanket with the hood of her sweatshirt pulled over her head. R31 appeared withdrawn, lethargic, and visibly ill. She remained in bed throughout the interview, spoke softly, and reported she felt horrible. R31 stated she had become progressively sicker over the previous several weeks and felt miserable. She stated she was afraid to leave her room because she needed to use the bathroom so frequently, particularly after eating. R31 stated her stomach hurt frequently and she was not eating as much as usual. She further stated her buttocks had become sore from repeated bowel movements, frequent wiping, and spending increased time in bed. R31 rated the pain at 6 out of 10. R31 stated she never refused to provide a stool sample for testing. She stated staff frequently asked her to provide a sample when she did not need to have a bowel movement or when she was asleep and later documented that she had refused. R31 stated this had occurred with other aspects of her care as (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	well, including medications and weight monitoring. R31 stated, I never refused. They would ask when I couldn't do it or when I was sleeping and then say I refused. R31 stated she believed the delay in obtaining the stool sample contributed to the length of time she remained ill without answers or treatment. During an interview on 6/4/26 at 2:16 p.m., the Director of Nursing (DON) stated nurses were expected to enter physician orders and referral information and the HUC was responsible for scheduling appointments as soon as possible. The DON stated staff should have followed up on pending stool testing, maintained infection control precautions while awaiting results, and notified the provider if the resident refused specimen collection to ensure quick diagnosis and treatment for R31. A call was placed to the provider on 6/5/26 at approximately 12:00 p.m., however a return call was not received. R37 R37's comprehensive Minimum Data Set (MDS) assessment dated [DATE] indicated R37 was cognitively intact, and diagnoses included end stage renal disease, pericardial effusion (fluid build-up in the sac around the heart), atrial flutter (a heart rhythm disorder), chronic heart failure, and dependence on renal dialysis. R37's care plan dated 1/6/26, indicated he was a vulnerable adult to complete treatments as ordered. A physician's order dated 4/30/26, directed staff to, Please ensure ECHO (echocardiogram - an ultrasound test to assess heart function) is scheduled for on or before June 1, 2026, for diagnosis of pericardial effusion. Review of R37's electronic medical record (EMR) lacked documentation that the ECHO had been scheduled, implemented, or completed. During an interview on 6/4/26 at 12:04 p.m., Director of Nursing (DON) and Administrator stated it was important to follow care plans because they reflected residents' needs and person-centered care. They stated it was important to follow physician orders because care was directed by the physician's orders. The DON and Administrator stated physician orders received through the fax system were entered by a floor nurse and verified by a second nurse. They stated medical records staff scheduled appointments and other items not related to medication administration. They further stated nurse managers were responsible for overseeing implementation of physician orders and updating care plans. The DON stated the order was not completed. A policy titled, Lab and Diagnostic Test Results - Clinical Protocol, undated, indicated physicians were to order testing based on resident needs. The policy indicated staff were to process test requisitions and arrange for ordered tests. The policy further indicated test results were to be reported to the facility and reviewed by a nurse.

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F 0680 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure the activities program is directed by a qualified professional. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, observation, and record review, the facility failed to provide direction and oversight of the activity program by ensuring a qualified professional directed the development, implementation, and coordination of resident activities. The facility failed to maintain leadership of the activity department after the Activities Director position became vacant, failed to ensure staff assigned activity responsibilities were trained and competent to perform the duties of the position, and failed to maintain basic components of the activity program including development and distribution of monthly activity calendars. This deficient practice had the potential to affect all 58 residents residing in the facility.Findings include: Record review of facility activity participation records and activity programming documents revealed the facility did not maintain a monthly activities calendar for May 2026. Record review further revealed residents residing on the third floor had limited opportunities to participate in organized activities and activity participation records reflected minimal documented activity attendance. (See F679)Observation conducted throughout the survey revealed no activities calendar was posted in common areas of the facility or in the elevator. Observation further revealed no organized activities occurring on the third floor during survey activities. (See F679)R3's quarterly Minimum Data Set (MDS), dated [DATE], indicated R3 was admitted to the facility on [DATE] and was cognitively intact with a Brief Interview for Mental Status (BIMS) score of 15. During an interview on 6/1/26 at 1:05 p.m., R3 stated she and another resident had attempted to organize activities themselves because no formal activities were occurring. R3 stated she never saw the Activities Assistant on the third floor, did not receive an activities calendar, and was not informed about activities occurring elsewhere in the facility. R3 stated residents on the third floor were bored because staff did not routinely provide activities or notify residents of scheduled events.During an interview on 6/2/26 at 2:10 p.m., Licensed Practical Nurse (LPN)-A stated activities primarily occurred on the second floor and acknowledged activities were often resident-run on third floor. LPN-A stated activities were mainly on second floor to be honest. During an interview on 6/4/26 at 8:22 a.m., the Nurse Manager and LPN-C stated activities occurred mostly on the second floor and reported they were unsure whether an activities calendar was available for residents.During an interview on 6/4/26 at 8:48 a.m., Activities Assistant (AA)-A stated the facility had not had an Activities Director since April 2026 and department heads had been assisting with activities. AA-A stated she primarily conducted activities on the second floor and acknowledged most organized activities occurred there. AA-A stated she did not have formal activities training and did not know many of the responsibilities previously performed by the Activities Director. AA-A stated there had not been an activities calendar during the previous month and, although a calendar had been developed for the current month, she had not printed or distributed it. AA-A stated she had not received training regarding the responsibilities of the Activities Director position and acknowledged she was relying on department heads for guidance regarding activity programming.During an interview on 6/4/26 at 2:16 p.m., the Director of Nursing (DON) stated she was aware the facility did not have an Activities Director and acknowledged activities had not been routinely occurring on the third floor. The DON stated the facility expected a monthly activities calendar to be available to inform residents of scheduled activities. The DON stated the facility was attempting to hire an Activities Director but was unaware of where in the hiring process the facility was. A facility policy on the Activity Program, dated 3/2025, did not address the need for an activities director.

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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 and interview, the facility failed to serve food in a sanitary manner by failing to ensure staff properly contained hair with a hairnet/beard net while serving food and preparing room trays. This had the potential to affect all residents residing on 2nd floor.Findings include:During a continual observation on 6/4/26 at 12:08 p.m. to 12:33 p.m., lunch was being served by a dietary aid from a warming table. The dietary aid was observed to be using resident menu tickets and preparing resident plates. The plates were either placed on top of the warming table and nursing staff picked up the plates and delivered them to residents in the dining room or placed them on plastic trays on the cart for delivery to resident rooms. The dietary aid was observed to be wearing gloves but not wearing a hairnet while serving and preparing food. Dietary aid was observed to have longer hair but was not pulled back or contained in any way. Dietary aid had a partial beard and a goatee that was approximately 1/2 inch to 1 1/2 inch long with the goatee being slightly longer. Dietary aid was not wearing a beard net on while serving and preparing food. During an interview 6/4/26 at 12:33 p.m., dietary aid (DA)-A stated they had just finished serving all the food for the floor. DA-A stated they had prepared all the room trays and served all the residents in the dining room. DA-A verified they did not have a hairnet on. DA-A stated, we typically wear one during serving. DA-A added, they took the hairnet off during break and forgot to put it back on. DA-A stated they did not have to wear a beard net. DA-A stated, they never said anything about it. DA-A stated their beard/goatee was about 2 inches long. During an interview 6/4/26 at 12:43 p.m., culinary district manager (CDM)-A stated all dietary staff were to wear hair nets, even if they were bald, and were to wear a beard net if they had more than a 5 o'clock shadow. CDM-A stated the expectation was anytime dietary staff were in the kitchen or serving/plating food on the floors; they were expected to wear hairnets and beard nets (if needed). CDM-A stated it's important to contain hair, so it doesn't drop into the food. During an interview on 6/4/26 at 12:53 p.m., director of nursing (DON) stated it would be expected that staff serving food would wear hairnets and beard nets so hair doesn't get into food as that would be an infection control concern.During an interview on 6/4/26 at 12:54 p.m., administrator stated it would be expected staff serving food would wear appropriate hair/beard nets to contain hair as that would be an infection control issue if hair got into the food. A facility policy titled Dietary Hair Restraints and Head Covering, dated 6/4/26, indicated all individuals entering food preparation, oof storage, warewashing, or plating areas must wear an approved, effective hair restraint that completely covers all head hair and, where applicable, facial hair. Furthermore, the document indicated the following under section III: Approved Hair Restraints: 1. Head Hair Restraints Hair Nets: Fine-mesh, commercial-grade hair nets that completely enclose thehair. Dietary Caps/Hats: Clean, facility-approved baseball-style caps or chef hats maybe worn only if they are paired with a mesh hair net to capture stray hairs alongthe nape of the neck and ears. Exclusions: Standard bandanas, visors, hair clips, or open-mesh caps without anunderlying fine hair net are strictly prohibited.2. Facial Hair Restraints (Beard Nets) Any individual with facial hair (including beards, long mustaches, or stubble)exceeding 1/4 inch in length must wear an approved beard restraint/snood thatcompletely covers the jawline, chin, and mouth.

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F 0944 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Conduct mandatory training, for all staff, on the facility?s Quality Assurance and Performance Improvement Program. Based on interview and document review, the facility failed to ensure staff completed mandatory quality assurance and performance improvement (QAPI) training for 1 of 10 staff members, nursing assistant (NA)-J, who was reviewed for training requirements. This had the potential to affect all 58 residents residing in the facility. Findings include: Review of personnel records indicated the NA-J had not completed education that included QAPI in the last year. During an interview on 6/5/26 at 8:33 a.m., the director of nursing (DON) was informed that QAPI training records for NA-J were not found in the records provided. The DON stated that she expected QAPI training to be completed annually, so NA-J should have completed the training. The DON stated she would provide any additional records if found. No additional records showing NA-J had completed QAPI training in the last year were received. The facility's undated Staff Development Program policy, indicated all personnel must participate in initial orientation and regularly scheduled in-service training classes. The policy indicated that QAPI training was a mandatory in-service training class but did not indicate how often this training should be completed.

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F 0946 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide training in compliance and ethics. Based on interview and document review, the facility failed to ensure staff completed mandatory compliance and ethics training for 1 of 10 staff members, nursing assistant (NA)-J, reviewed for training requirements. This had the potential to affect all 58 residents residing in the facility. Findings include: Review of personnel records indicated the NA-J had not completed education that included compliance and ethics in the last year. During an interview on 6/5/26 at 8:33 a.m., the director of nursing (DON) was informed that compliance and ethics training records for NA-J were not found in the records provided. The DON stated that she expected compliance and ethics training to be completed annually, so NA-J should have completed the training. The DON stated she would provide any additional records if found. No additional records showing NA-J had completed compliance and ethics training in the last year were received. The facility's undated Staff Development Program policy, indicated all personnel must participate in initial orientation and regularly scheduled in-service training classes. The policy indicated that ethics training was a mandatory in-service training class but did not indicate how often this training should be completed.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and document review, the facility failed to ensure 1 of 1 resident (R60) reviewed for wandering received adequate supervision per his plan of care to ensure safety and prevent elopement. Furthermore, the facility failed to check to ensure the correct sling size before transferring for 2 of 2 residents (R15, R23) using a mechanical lift and failed to ensure compatible lifts and slings were used for 1 of 2 residents (R54) who used a mechanical lift. The facility also failed to assess a bed in the high position for safety for 1 of 1 resident (R20) reviewed for bed height. In addition, the facility failed to ensure oxygen equipment and smoking materials were managed according to the resident's physician orders and care plan and failed to consistently supervise and monitor the resident's compliance with smoking safety requirements for 1 of 1 resident (R8) who required supplemental oxygen and was reviewed for smoking safety. Findings include: Adequate Supervision- Wandering R60's admission Minimum Data Set (MDS) dated [DATE], indicated R2 had intact cognition with behavioral symptoms not direct at others (e.g., physical symptoms such as hitting or scratching self, pacing, rummaging, public sexual acts, disrobing in public, throwing or smearing food or bodily wastes, or verbal/vocal symptoms like screaming, disruptive sounds), had no rejection of care behaviors, and had wandered one to three days during the lookback period (LBP). R2 required set-up help with eating, moderate assistance for hygiene needs, and required supervision for walking. R2 was diagnosed with dementia. R60's Elopement Risk Evaluation dated 4/25/26, indicated R60 was ambulatory, had a habit/history of wandering or attempting to leave the building, had asked to go home or to other specific locations, family had voiced concerns that the resident had the tendency to wander or elope, and was taking medication that may cause confusion. The evaluation indicated R60 was at risk for elopement. The evaluation indicated R60 would be placed on a secure unit, would have a check-in and out log, and staff were aware of his elopement risk. R60's care plan dated 4/28/26, indicated R60 had the potential for hearing impairment, so staff were to utilize the communication binder at the nurse's station as needed. The care plan indicated staff were to utilize an interpreting service and had the service's phone number, but the care plan did not include what language R60 spoke. R60's care plan indicated R60 was to receive close supervision while in the common area. The care plan indicated staff were to anticipate and meet R60's toileting needs. The care plan indicated staff were to distract the resident from wandering by offering pleasant diversions, structured activities, food, conversation, television, or a book. The care plan indicated staff were to identify patterns of wandering and intervene as appropriate. R60's provider progress note dated 5/1/26 at 1:54 p.m., indicated that R60 had flooded his room and staff had reported that he was fixated on turning on water sources. The note indicated that staff were to continue supportive care with R60 on the memory care unit. R60's order summary dated 5/28/26, included an order for 15-minute safety checks, to admit to the locked memory care unit, and close monitoring for safety. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 6/2/26 at 9:13 a.m., an unknown staff member left the memory care unit and did not look behind them as the door continued to close. R60 then followed the staff member out of the otherwise locked memory care doors, to the non-locked unit. Registered nurse (RN)-D, the nurse manager for the unit, appeared to witness this, ran to the memory care doors, exited, and then came back onto the memory care unit with R60. During continuous observation on 6/2/26 from 1:20 p.m. to 2:09 p.m., R60 was observed wandering in the non-locked second-floor common area before re-entering the locked unit at 2:09 p.m. RN-B was observed sitting at the second-floor nursing station desk. The facility was set up so the common area was in the front, then a hallway separating the common area from the nurses station that was placed perpendicular to the common area. The nurses station had a small wall on the common area side of the nurses station, so as RN-B sat at the left computer, she was not visible from all areas of the common area. - At 1:22 p.m., R60 was observed standing at the back side of the second floor common area, out of view of the nurse, inserting the prongs of a metal fork into the waistband of his pants, and then using the prongs in a pulling motion, as if trying to rip the pants fabric. - At 1:26 p.m., NA-I was observed standing in the second-floor common area before leaving out of view. R60 continued to walk around the common area picking up items, looking at windows, and talking to himself in a non-English language. - At 1:35 p.m., R60 was observed to continue to pull at his pants and wander around the edges of the room while talking to himself in a non-English language. - At 1:38 p.m., R60 was observed to find a corner of the room and urinate. RN-C was observed to enter the common area and ask the resident in English to go back to his room. R60 responded in a non-English language and did not follow RN-C as he re-entered the memory care unit. RN-C was not observed to use a translator or a communication binder to attempt communication with R60. During a second continuous observation on 6/2/26 from 2:13 to 2:48 p.m., R60 was observed wandering in the memory care dining room. R60 was again observed pulling at his pants and looking in various corners of the room. - At 2:33 p.m., R60 was observed out of view of RN-C, who was standing at a medication cart in the memory care hallway looking at a laptop. R60 was observed talking out loud in a non-English language as he pulled at his pants while walking along the wall of the dining room. R60 was observed to lower his pants and urinate on the wall. R60 then pulled his pants back up and continued to pace in the dining area. - At 2:40 p.m., R60 pulled out a chair and pointed at it, as if asking the surveyor to sit. The surveyor sat down. R60 was then observed to walk to the other side of the dining room, squat behind the far side of the steam table, with one hand on the steam table, and the other hand on the tall, metal, meal tray cart. R60 was then observed to pull a paper off of the wall behind him, appearing to use it to clean himself after having a bowel movement, and throw the paper to the side after use. R60 was then observed to pull pants back up and walk to the other side of the room. On further observation, stool was found on the far side of the steam table. RN-C continued standing in the hallway at the medication cart looking at the laptop and was unaware of the incident. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R60's progress note dated 6/2/26 at 3:30 p.m., indicated R60 was restless and agitated during the shift. The note indicated R60 took all of his medications. The note indicated R60 escaped through the door while the author was passing medications. The note indicated R60 was redirected several times, but most times he declined. R60's progress note dated 6/2/26 at 5:04 p.m., indicated R60 wanders sometimes and had followed staff through the door twice. The note indicated the second time, R60 had wanted to stay on the LTC [long term care] side and had then been successfully redirected to the memory care unit. The note indicated non-verbal cues had been used to communicate with the resident. The note indicated staff had attempted to use the interpreter service, but they had been unable to understand what R60 was saying. During a continuous observation on 6/3/26 at 1:26 p.m. to 2:16 p.m., R60's door was observed closed with what sounded like water running and R60's voice talking in a different language intermittently. R60's room's entrance was the room closest to the exit doors to the adjacent unit. - At 1:35 p.m., activities assistant (A)-A was observed to exit the memory care unit, not look back after she exited as she continued walking. The exit door stayed open for greater than four seconds. - At 2:08 p.m., A-A was observed to exit the memory care unit, not looking back after she exited as she continued walking. The exit door stayed open for approximately 15 seconds, as the door had been pushed farther open. - At 2:16 p.m., surveyor entered R60's room, observed R60 sitting on his bed with a privacy curtain from the middle of the room tied to a privacy curtain from the front of his room, now hanging over his bed. R60's sink was observed running with stool on the floor of the bathroom. - During this time period, no staff were observed to check on R60. During an interview on 6/3/26 at 2:17 p.m., licensed practical nurse (LPN)-B stated she was supposed to be completing 15-minute safety checks on R60, but she had gotten busy, and they were not completed. During an interview on 6/4/26 at 9:22 a.m., RN-D, the unit nurse manager, stated staff were supposed to ensure the memory care door closed before leaving the area to ensure no resident followed them out, as had happened with R60. RN-D stated staff were supposed to check on R60 every 15 minutes to ensure his safety. The facility's Elopement Prevention and Missing Resident policy dated 3/3/26, indicated residents would be assessed for their elopement risk on admission. The policy indicated high-risk residents would have an individualized care plan with specific interventions, environmental safeguards (secured exits), staff supervision tailored to risk level, and documented elopement precautions in the medical record. Mechanical Lift Sling Size Verification R15 R15's quarterly Minimum Data Set (MDS) dated [DATE], indicated intact cognition and diagnoses of (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	chronic respiratory failure with hypoxia, morbid (severe) obesity, and muscle weakness. If further included R15 had bilateral impairment on lower extremities and was dependent on staff for transfers. R15's care guide dated 3/27/26, indicated R15 required assistance of 2-3 staff with transfers using a Hoyer lift. The care guide lacked documentation of what sized sling R15 required. R15's care plan dated 3/3/26, indicated R15 required a mechanical lift (Hoyer) and the assistance of 3 staff members when transferring to his power mobility device (PMD) and the assistance of 2 staff when transferring back to bed. R15's care plan lacked documentation of what sized sling should be used when transferring R15 using the Hoyer lift until 6/2/26 (after survey started). During interview on 6/1/26 at 11:58 a.m., R15 stated the facility didn't label each resident's sling with their name, so there was no way to determine if each resident was getting the right sling back. Once they go to laundry to get washed, they are put in a bin, and the nursing assistants have to go down and get them. During observation on 6/2/26 at 10:17 a.m., three NA's (NA-F, NA-G, and NA-H), transferred R15 from his bed to his PMD, using the Hoyer lift and the sling that was already in R15's room located in the seat of his PMD. All three NA's failed to check the size of the sling before transferring R15. During interview on 6/2/26 at 10:30 a.m., NA-H stated each resident had their own sling that are kept in their room and that's how they know which sling to use for each resident. NA-H verified the tag on R15's sling had a small round hole punched in the tag next to where it said size medium but was unsure whether that hole indicated the sling was that size. During interview on 6/3/26 at 11:40 a.m., licensed practical nurse (LPN)-A stated NA's should be referring to the care plan or care sheets in order to determine what size sling each resident used. LPN-A verified R15's sling size was not in the care plan or on the care sheets, stating It should be right there!. LPN-A further stated if the NA's were unsure as to what size sling a resident was supposed to use, they should ask a nurse or manager. LPN-A also verified the care sheets/guide dated 3/27/26 were the most current. R23 R23 annual Minimum Data Set (MDS) dated [DATE], indicated moderately impaired cognition and diagnoses of multiple sclerosis (autoimmune disease that affects the central nervous system), spastic hemiplegia (a neuromuscular condition of spasticity that results in the muscles on one side of the body being in a constant state of contraction), affecting the right dominant side, and muscle weakness. It further indicated R23 had bilateral lower extremity impairment and was dependent on staff for transfers. R23's care guide dated 3/27/26, indicated R23 should be transferred with a Hoyer lift and assist of 2 staff using a medium sling. R23 's care plan dated 3/13/26, indicated R23 had an activity of daily living (ADL) self-care deficit related to multiple sclerosis and spastic hemiplegia. It further included an intervention R23's required total assist of two staff for transfers using the Joerns HPL 700 lift with full body medium size sling. During observation on 6/2/26 at 11:09 a.m., two nursing assistants (NA)-F and NA-G transferred R23 (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	measurements. TMA-A was not sure if there was a documented assessment for sling sizes. During an observation on 6/2/26 at 8:27 a.m., NA-E and NA-B were beginning to transfer R54 from her bed to her Broda chair. They placed the same sling with the faded label Joerns brand underneath R54. NA-B brought an Invacare lift model MDS450EL in the room and they began to connect the sling to the mechanical lift. NA-E stated they could not use this lift and disconnected the sling and took the lift out of the room. NA-B asked if the battery was dead but NA-E was already out of the room. When NA-E entered she said a Joerns brand mechanical lift was required since the sling brand was Joerns. They could not use Invacare brand and Joerns brand together. When asked what size sling R54 used NA-E stated the label was too worn to read but hers should probably be large. During a phone call on 6/2/26 at 10:40 a.m., Joerns health care representative (JR)-A stated they do not recommend using different brands of slings with their lifts, such as Invacare, because the other brands have not been tested with Joerns lifts, they might make the transfer unsteady or the sling would not fasten correctly to the lift and the transfer might be unsteady. Using different brands would be unsafe. Invacare customer service: Invacare:40 AM phone interview - Shakia - did not give last name, US customer service rep- we do not recommend using different brands of slings with our lifts, such as Invacare- only Joerns. that is because other brands haven't been tested with our lifts and so they might be unsteady or wouldn't fasten the correct way, it would be potentially unsafe. During an interview on 6/2/26 at 9:20 a.m., registered nurse (RN)-C stated he would know the correct sling and lift to use on a resident by the physician's order. Orders were reviewed and the sling and lift specifications were not found. RN-C stated he was not sure where that information would be and to talk to the manager. During an interview on 6/2/26 at 9:16 a.m., RN-D stated sling and lift specifications would be found in the NA care guide, not necessarily in the care plan in the electronic medical record. RN-D reviewed the NA care guide and stated R54 should have a medium sling and if the label was worn, staff could go by the color-coded edges of the Joerns sling which identified the size base on the colors. RN-D stated they had several different lifts in the facility, and they could be used with different slings, unless the resident had a bariatric bed and equipment, that was specialized equipment and could not be used for all residents. During an observation on 6/2/26 at 11:35 a.m., NA-E brought R54 to her room. NA-B brought in the Invacare lift MDS450EL. R54 had the same Joerns sling underneath her in the Broda chair. NA-E stated we cannot use this lift because the brands are different and exited the room with the lift. During an interview on 6/2/26 at11:45 a.m., NA-E returned with a mechanical lift brand Joern's model number HPL700 and stated this was the one they used with her sling. The infection preventionist (IP) was nearby and verified this was the lift that should be used and was compatible with the sling. The sling label could not be read; however, the sling had a yellow border on it, and on the lift the yellow sling size was identified as a medium. During a follow up interview on 6/4/26 at 9:38 a.m., RN-D stated the lift, and sling should match in brands before using and size should be verified. She would expect staff to reference the NA care guides prior to providing care to ensure the correct transfer equipment was used. RN-D stated therapy did the assessment to determine sling and lift compatibility. During an interview on 6/4/26 at 9:56 a.m., the director of therapy services (DTS) stated therapy did not do assessments for sling and lift compatibility or sizes and was not sure who did. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 6/4/26 at 2:03 p.m., the director of nursing (DON) stated sling and lift specifications were on the NA care guide for staff to reference. She would expect the guides to be referenced prior to providing care to ensure a safe environment was provided. R20: Bed Height R20's quarterly Minimum Data Set (MDS) dated [DATE], identified moderately impaired cognition. No behaviors or rejection of care were identified. R20 was independent with bed mobility and needed partial/moderate assistance to stand from a seated position and for transfers. R20 had one fall since the prior assessment with injury. Diagnoses included epileptic seizures, aphasia (difficulty speaking), and non-Alzheimer's dementia. R20's Care Area Assessment (CAA) dated 7/11/25, identified he was at risk for falls due to body weakness and decrease in muscle weakness. See care plans for safety interventions and fall prevention efforts. R20's nursing assistant Care Guide dated 6/1/26, identified he refuses care and refuses housekeeping. The care guide did not mention bed height. R20's behavior care plan dated 1/9/26, identified no behaviors of raising his bed to a high level. R20's communication care plan dated 1/5/25, identified an intervention dated 4/23/24, to keep the bed in the lowest position. R20's falls care plan dated 7/6/25, identified an intervention dated 2/20/24, to keep the bed in a low position at night. R20's care guide dated 6/1/26, identified to notify the nurse if cares were refused. The care guide lacked description of bed height. R20's nursing progress note dated 1/19/26 at 23:55 (11:55 p.m.), identified he had fallen out of bed in the low position, after attempting to transfer to his wheelchair, and had not used his call light to alert staff even thought it was in reach. R20's nursing progress note dated 3/1/26 at 22:51 (10:51 p.m.), identified resident had a generalized seizure lasting about three minutes and used his call light to alert staff. R20's quarterly rehabilitation screening tool dated 4/15/26, addressed bed mobility as independent, to walk with therapy only, and lacked a bed safety assessment. R20's nursing Fall Risk assessment dated [DATE], identified he was at high risk for falls due to disorientation, chair bound status and psychotropic medication use. R20's nursing Lift/Mobility Status assessment dated [DATE], identified he could not stand, pivot or walk without physical assistance, he was not cooperative or non-combative and was independent with bed mobility. During an observation on 6/1/26 at 2:01p.m., R20 was in bed with his bed in a high position at about 4.25 feet off the ground. His bed remote was on his bed. R20 was asked if he was going to lower his (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident safety measures that are identified as having a higher than usual risk for injury would be identified. Safe Smoking R8 R8's Quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated R8 was admitted to the facility on [DATE] and had a Brief Interview for Mental Status (BIMS) score of 13, indicating the resident was cognitively intact for daily decision making and able to participate in care planning. A physician order, dated 8/12/25, directed that R8's cigarettes and lighter were to be secured in the medication cart. The order instructed staff to provide the resident with one cigarette and one lighter at a time, document the date and time the items were issued, and ensure the lighter was returned and signed back in by nursing staff upon the resident's return. R8's care plan, revised 8/12/25, identified the resident as a smoker of cigarettes and marijuana and included an intervention directing staff to provide one cigarette and one lighter at a time and require return of the lighter when the resident returned to the unit. An additional intervention dated 7/26/25, directed staff to encourage the resident to leave lighters at the nursing station; however, the resident refused. During an interview on 6/1/26 at 12:47 p.m., R8 stated she smoked outside and took her oxygen tank and nasal cannula to the smoking patio. R8 stated she removed the nasal cannula from her nose and turned the oxygen off while smoking but kept the oxygen tank and tubing with he

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The Terrace at Crystal LLC	3245 Vera Cruz Avenue North Crystal, MN 55422

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. Based on observation, interview, and document review, the facility failed to ensure a resident room was maintained in a clean, sanitary manner for 1 of 1 resident (R5) whose room was in a state of disrepair. In addition, the facility failed to ensure the memory care dining room floor was kept in a clean and sanitary condition, which had the potential to affect all 10 residents residing on the memory care unit. Findings include: During an observation on 6/1/26 at 2:16 p.m., R5 was observed lying in bed which was positioned parallel to the wall. The wall was noted to have an area that was not painted the same color as the rest of the wall below the tv mounted on the wall (appeared as though plastic covering had been moved and area had not been re-painted). The wall across from the bed, by the closets, was noted to have multiple black marks on the wall which were approximately 8 inches long. The wall appeared to be dirty and was discolored with light brown marks in some areas. The ceiling above the window was observed to be discolored a yellowish color and was approximately the size of a basketball. It extended along the ceiling/wall another 8 inches or so each way with discoloration. The door frame, entering the room, was noted to have multiple scuff marks on along with areas of missing paint. During a follow up observation on 6/2/26 at 2:33 p.m., the observations above remained the same. During an interview on 6/2/26 at 2:24 p.m., R5's family member (FM)-C stated they have concerns with the environment at the facility. FM-C stated the facility was always disgusting. FM-C stated the facility was not clean, and smells bad. FM-C stated they have reported concerns with R5's room to the staff about the smell, the paint missing, the ceiling and they just brush it off. During an observation on 6/4/26 at 8:29 a.m., R5's wall was noted to have an area that was not painted the same color as the rest of the wall below the TV mounted on the wall (appeared as though plastic covering had been moved and area had not been re-painted). The wall across from the bed, by the closets, was noted to have multiple black marks on the wall which were approximately eight inches long. The wall appeared to be dirty and was discolored with light brown marks in some areas. The ceiling above the window was observed to be discolored a yellowish color and was approximately the size of a basketball. It extended along the ceiling/wall another 8 inches or so each way with discoloration. The door frame, entering the room, was noted to have multiple scuff marks along with areas of missing paint. During an observation on 6/3/26 at 7:29 a.m., the memory care dining room floor was observed with what appeared to be light-colored food crumbs, brown-colored crumbs of food, pieces of a white meat-looking substance, as well as what appeared to be spaghetti noodles under multiple dining tables. During an interview on 6/3/26 at 7:32 a.m., licensed practical nurse (LPN)-B stated it looked like the floors were not cleaned after last night's meal. LPN-B stated housekeeping was supposed to clean the floors after meals were served. During an interview on 6/3/26 at 7:39 a.m., the administrator confirmed she also observed the food under the dining tables and stated any staff member who observed the food under the tables should (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	help clean it up, not just housekeeping. During an interview on 6/4/26 at 8:29 a.m., the director of maintenance (DOM) stated he had been planning on picking paint colors and buying new paint to condense the colors used for residents' rooms down significantly. The DOM stated that although he had been planning this, he had not yet bought any paint for this project or planned a date for this. The DOM stated he had not been notified the wall/ceiling disrepair in R5's room, and although he couldn't say for sure, there appeared to be some water damage on R5's ceiling that would need to be repaired. A facility policy titled Maintenance Service, revised 3/5/25, indicated the maintence department is responsible for maintaining the buildings, grounds, and equipment in a safe and operable manner at all times.

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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 dignity was maintained for 1 of 1 resident (R6) reviewed for catheters.R6's quarterly Minimum Data Set (MDS) dated [DATE], identified moderately impaired cognition, rejection of care one to three days, and was dependent on staff assistance with dressing, bed mobility and toileting. R6 was always incontinent of bowel and bladder and had intermittent catheterization. Diagnoses included infective bursitis of the left elbow. R6's care plan dated 4/27/26, identified R6 had a catheter for neurogenic bladder. An intervention dated 5/12/26, identified to position catheter bag and tubing below the level of the bladder and away from entrance room door.During an observation on 6/1/26 at 12:52 p.m., R6 was in the commons area near the elevator and hallways. He was seated in his wheelchair with clear yellow urine showing in his urinary catheter drainage (CDB), which was hung under his wheelchair. Nursing assistant (NA)- D brought R6 to his room, assisted him to transfer to bed. emptied out the CDB and hung it on the side of the bed facing out to the room entrance.R6's nursing progress note dated 6/1/26 at 16:16 (4:16 p.m.), identified he went to the hospital for urinary retention. R6's nurse practitioner (NP) progress note dated 6/2/26, identified R6 went to the emergency department (ED) yesterday (6/1/26) for foley catheter malfunction and returned with a functioning catheter. R6 was started on Macrobid (an antibiotic medication specifically designed to treat uncomplicated urinary tract infections. During an observation on 6/2/26 at 9:35 a.m., R6 was in the commons area with one other unidentified resident. R6's CDB was uncovered, however, there was a blue flap on one side of the catheter. The other side was clear and clear yellow urine was observed from the hallway. The blue side was facing toward the commons area, and the clear side out to the hallway and elevator space. Unidentified therapy staff came by and adjusted the wheelchair foot rest of the unidentified resident who was seated near R6 in the commons area and did not arrange for privacy of R6's CDB. The infection preventionist (IP) also came to talk to R6 and did not arrange for privacy of R6's CDB. R6's nurse RN-B was at her medication cart intermittently, within eyesight of R6 and did not arrange for privacy of R6's CDB.During an observation on 6/3/26 at 10:49 a.m., nursing assistant (NA)-F adjusted R6's CDB which was now in a pillowcase under his wheelchair.During an interview on 6/3/26 at 10:50 a.m., NA-J stated R6's CDB was possibly in the pillowcase for privacy reasons.During an interview on 6/3/26 at 11:02 a.m., registered nurse (RN)-A stated R6's CDB was in a pillowcase for privacy.During an interview on 6/4/26 at 8:48 a.m., trained medication assistant (TMA)-A stated R6's catheter should have the blue side of the new catheter bag facing out toward the public for privacy. TMA-A stated she was not sure if the facility had privacy bags that covered the entire catheter drainage bag.During an interview on 6/4/26 at 9:37 a.m., registered nurse (RN)-D stated catheter drainage bags should be covered to maintain dignity and to avoid bodily fluid display to the public.During an interview on 6/4/26 at 2:04 p.m., the director of nursing (DON) stated the facility had CDB with a blue cover on one side. Staff were expected to keep the blue side facing the public to cover the CDB to maintain dignity.The facility's Dignity policy dated 6/4/26, identified to keep catheter drainage bags and colostomy pouches covered with commercial covers or tucked out of plain sight. The purpose of the policy was to ensure employees maintain and enhance each resident's dignity, individuality and privacy.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review, the facility failed to ensure a call light was within reach for a resident who had a history of seizure and fall and relied on staff assistance for 1 of 1 resident (R20) reviewed whose call light was not within reach.Findings include:R20's quarterly Minimum Data Set (MDS) dated [DATE], identified moderately impaired cognition. No behaviors or rejection of care were identified. R20 was independent with bed mobility and needed partial/moderate assistance to stand from a seated position and for transfers. R20 had one fall since the prior assessment with injury. Diagnoses included epileptic seizures, aphasia (difficulty speaking), and non-Alzheimer's dementia.R20's Care Area Assessment (CAA) dated 7/11/25, identified he was at risk for falls due to body weakness and decrease in muscle weakness. See care plans for safety interventions and fall prevention efforts.R20's communication care plan dated 1/5/25, identified an intervention dated 4/23/24, to Ensure/provide a safe environment: resident is able to use call light, make sure that call light in reach when resident is in his room.R20's activities of daily living (ADL) care plan dated 3/20/18, identified an intervention dated 2/20/24, to encourage resident to use bell to call for assistance.R20's behavior tracking dated 5/7/26 through 6/6/26, identified no behaviors were observed. Options included physical aggression, verbal aggression, threatening, reject care, wander, self-transfer, cry, withdrawn, neg statements, sleepy, awake at night, restless, short temper, socially inappropriate, hallucinate, or delusions. R20's nursing progress note dated 1/19/26 at 23:55 (11:55 p.m.), identified he had fallen out of bed in the low position after attempting to transfer to his wheelchair, and had not used his call light to alert staff even thought it was in reach.R20's nursing progress note dated 3/1/26 at 22:51 (10:51 p.m.), identified resident had a generalized seizure lasting about three minutes and used his call light to alert staff.During an observation on 6/1/26 at 2:01 p.m., R20 was in bed, his call light was on the wall wrapped around the call light switch box which was located above his head of bed and off to his left. During a follow up observation and interview on 6/1/26 at 4:54 p.m., R20's call light was still on the wall in the same position. R20 stated he would like his call light and nursing assistant (NA)-A was brought into the room and verified verbally he would not have been able to reach his call light, and it should have been within reach.During an interview on 6/2/26 at 1:25 p.m., NA-B stated all residents should have a call light within reach. The purpose of having assessments and care plan interventions was resident safety.During an interview on 6/4/26 at 2:01 p.m., the director of nursing (DON) stated call lights should always be within reach for safety reasons.The facility's undated Answering the Call Light policy identified when the resident was in bed or confined to the chair be sure the call light was within easy reach of the resident in order to respond to the resident's requests and needs.

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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 assess for potential side effects of antipsychotic medication for 1 of 5 residents reviewed (R6) who was reviewed for unnecessary medications.Findings include:R6's quarterly Minimum Data Set (MDS) dated [DATE], identified moderately impaired cognition, rejection of care one to 3 days, and was dependent on staff assistance with dressing, bed mobility and toileting. R6 took an antipsychotic medication.R6's care plan dated 2/7/26, identified antipsychotic medication was used for Parkinson's. R6 was to be monitored for potential adverse effects and nursing staff were directed to document and record any findings. Potential adverse effects included: unsteady gait, tardive dyskinesia, EPS (shuffling gait, rigid muscles, shaking), frequent falls, refusal to eat, difficulty swallowing, dry mouth, depression, suicidal ideations, social isolation, blurred vision, diarrhea, fatigue, insomnia, loss of appetite, weight loss, muscle cramps nausea, vomiting, and unusual behavior symptoms. R6's physician order dated 4/25/25, identified to give quetiapine fumarate (an antipsychotic medication) 25 milligrams (mg) by mouth one time a day for Parkinson's disease (PD) and behavioral disturbance with agitation. Also give 50 mg by mouth one time a day for Parkinson disease and behavioral disturbance with agitation.R6's nursing order dated 4/26/26, identified to Complete AIMS - Abnormal Involuntary Movement Scale one time a day every 3 month(s) starting on the 20th for 3 day(s).R6's treatment administration records (TAR) identified:4/21/26 through 4/23/26, the order to complete the AIMS assessment was signed off as having been done daily for these three days, however, there were no assessment results documented in R6's record.5/19/26, the order sign off to complete the AIMS assessment was blank, and there were no assessment results documented in R6's record.6/1/26 through 6/4/26, no AIMS assessment had been signed off or documented in R6's record.During an observation on 6/1/26 at 12:52 p.m., R6 was seated in his wheelchair with a flat affect and a mild tremor in his fingers.During an interview on 6/4/26 at 9:44 a.m., registered nurse (RN)-D stated upon admission the nurse would enter the AIMS assessment into the medical record so nursing could complete it. RN-D stated AIMS was important to check for side effects, and the purpose of the assessments were for residents safety. During an interview on 6/4/26 at 2:01 p.m., the director of nursing (DON) when a resident was on an antipsychotic either the nurse working on the floor or the manager would place the order on the TAR to signal nursing to complete the AIMS assessment. Completed AIMS assessments would be documented in R6's medical record under assessments The purpose completing an AIMS assessment is mainly for the purpose of medication adjustments and so the pharmacy could review to see if any changes or side effects which may require medication adjustment. The facility's AIMS Assessment policy dated 6/4/26, identified an AIMS assessment was required for residents prescribed a second-generation antipsychotic such as quetiapine. A baseline assessment should be completed prior to starting an antipsychotic and every 3 months or sooner if changes for the elderly.

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to ensure an adequate discharge planning process was maintained to ensure resident preference for discharge was met for 1 of 1 residents (R7) reviewed for discharge planning.Findings include:R7's quarterly Minimum Data Set (MDS) assessment, dated 5/13/26, identified R7 had short term and long-term memory problems and cognitive skills for daily decision making were severely impaired. Section Q indicated there was no active discharge planning occurring for resident to return to the community.During an interview on 6/1/26 at 2:11 p.m., R7's legal guardian (FM)-A stated they have expressed numerous times the desire for R7 to move closer to them. FM-A stated they would like to have R7 in St [NAME] as getting back and forth to the facility had become difficult. FM-A stated the facility had previously been looking for a facility closer but no longer was. FM-A stated they still wanted R7 to live in St [NAME] but have grown tired of asking all the time about moving and being told no. R7's care plan, printed 6/2/26, indicated R7's currently discharge plan was resident wishes to discharge to a facility closer to family with an initiation date of 8/8/25. The intervention to meet this goal was social service will coordinate services for necessary for discharge with an initiation of 8/8/25.The care plan lacked information on any referrals sent, updated or outcomes of any referrals made.R7's progress notes, dated 12/1/25 to 6/2/26, were reviewed and included the following:-2/10/26 indicated R7 had a legal guardian who made all decisions for him.The progress notes lacked information or updates if any referrals were sent, any follow up being done regarding R7's desire to move to a facility closer to family, or communication of coordination or updates to guardian.R7's Social Service Care Conference, dated 12/31/25, identified social services, staff nurse, and nurse manager were present during care conference. The document identified discharge planning needed as family would like him moved to a facility closer to them. Social services summary further indicated, resident's family would like him to discharge to a facility closer to them in Shoreview MN. Resident has been denied at many SNFs. Currently on [name] hospice as of 10/08.R7's Social Service Care Conference, dated 5/29/26, identified R7, family, nurse manager and social services were present for care conferences. The document identified no discharge planning needed as resident LTC hospice. During an interview on 6/3/26 at 12:59 p.m., registered nurse (RN)-A stated they did not participate in planning a resident discharge unless there was a specific assessment that was needed. RN-A stated the nurse manager, or social worker would assist in planning a resident discharge. RN-A was not sure if R7 or his family was interested in finding another facility.During an interview on 6/3/26 at 1:22 p.m., registered nurse manager (RN)-D stated social services takes the lead if a resident or their representative had requested the resident to move to another facility. RN-D stated the previous social worker was working on finding R7 another facility per the family request and thought R7 may have been denied at one facility but was unsure. RN-D stated they were unsure where the process was currently at.During an interview on 6/3/26 at 1:41 p.m., social services (SS)-A stated social services was responsible for coordinating discharge planning. SS-A stated R7 was on hospice when asked about any discharge plans. SS-A reviewed R7 medical records and verified R7's care plan indicated the desire to move closer to family. SS-A stated R7 had a recent care conference, and it was indicated that resident received long term care (LTC) and hospice services. SS-A stated she assumed the family was ok with R7 staying at the facility as it was not brought up or discussed during the most recent care conference. During a follow up interview on 6/3/26 at 2:18 p.m., SS-A stated she followed up with FM-A who indicated they wanted R7 to move to St [NAME] or closer to the rest of the family. SS-A stated discharge for R7 was not discussed during the care conference and should have been. SS-A stated she would follow up now as she was now aware that R7's guardian wants R7 to move to a facility closer. During an interview on 6/4/26 at 11:22 a.m., director of nursing (DON) stated that (continued on next page)

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	social services facilitates the process of a resident or their family has expressed a desire to discharge. DON stated nursing would assisting with the nursing part meaning any assessments needed or coordination with another facility for health-related needs.A facility policy on discharge planning was requested and not received.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to ensure a written transfer notice (including information such as the ombudsman information and the resident's appeal rights) and a written bed hold notice (including information such as the duration of the state bed-hold policy, the reserve bed payment policy, and the nursing facility's policies regarding bed-hold periods) was given as soon as practicable for 2 of 2 residents (R17, R63) reviewed for hospitalization.Findings include:R17's quarterly Minimum Data Set (MDS) assessment dated [DATE], indicated R17 had moderate cognitive impairment with no hallucinations, delusions, or behaviors.R17's census listing dated 5/28/26, indicated R17 had a status of hospital unpaid leave starting on 5/26/26 and a status of active on 5/28/26.R17's progress note dated 5/26/26 at 2:02 p.m., indicated R17 was transferred to the hospital, and the power of attorney (POA) was contacted.An email correspondence dated 5/26/26 at 6:21 p.m., indicated the facility had asked R17's POA if she wanted a bed hold. The email did not include information such as the duration of the state bed-hold policy, the reserve bed payment policy, or the nursing facility's policy regarding bed-hold periods.R63's admission MDS dated [DATE], indicated R63 had intact cognition with no hallucinations, delusions, or behaviors.R63's Census dated 4/2/26, indicated R63 was coded as active on 3/16/26 and stop billing on 4/2/26.R63's progress note dated 4/2/26 at 9:23 a.m., indicated R63 had an order to send to the emergency department, and the significant other was notified and had declined a bed hold.R17 and R63's medical records were reviewed, and an indication that a written transfer notice, which included information such as the ombudsman information and the resident's rights, was given on transfer to the hospital was not found. Indication that R17, R63, or their resident representatives had been given a written bed-hold notice that included information such as the duration of the state bed-hold policy, the reserve bed payment policy, or the nursing facility's policy regarding bed-hold periods, on transfer to the hospital was not found. During an interview on 6/3/26 at 12:51 p.m., licensed practical nurse (LPN)-B stated that she sent documents such as the order summary, medication administration record, etc., but was unsure if a written transfer notice, which included information like ombudsman information and appeal rights, or a written bed hold notice was given on transfer to the hospital. RN-E stated she would have to follow up with the registered nurse (RN)-D, the nurse manager for the unit.During an interview on 6/4/26 at 9:29 a.m., RN-D stated she did not believe they had a process to give residents a written notice of transfer, which included information like ombudsman information and appeal rights. RN-D stated she would email the resident representative to see if they wanted a bed hold, but the email did not include information such as the duration of the state bed-hold policy, the reserve bed payment policy, or the nursing facility's policy regarding bed-hold periods.The facility's undated Emergency Transfer or Discharge policy, indicated that if an emergency transfer or discharge to the hospital occurred, staff should prepare a transfer form. The policy did not indicate what was included in this transfer form.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on interviews and document review, the facility failed to provide the opportunity to attend and participate in a care conference for 1 of 1 residents (R10) reviewed for care conferences.Findings include: R10's quarterly Minimum Data Set (MDS) assessment, dated 5/25/26, identified R10 had intact cognition with no hallucinations, delusions, rejection of care, or behaviors present. During an interview on 6/1/26 at 1:55 p.m., R10 was observed lying in bed with the television on. R10 stated she has not had a care conference recently, and indicated the last one was more than 3 months ago. R10's Social Service Conference form, dated 1/16/26, indicated a care conference was held with R10, R10's family member, nurse manager and social services. R10's progress notes dated 1/30/26 to 6/3/26 were reviewed and lacked indication of any care conference held or scheduled. During an interview on 6/3/26 at 1:29 p.m., registered nurse manager (RN)-D stated care conferences were arranged by social services and should be held quarterly, with any significant changes, and as needed. RN-D stated care conferences should follow the MDS assessment. During an interview on 6/3/26 at 1:46 p.m., social services (SS)-A stated they were responsible for care conferences and have been having their assistant help schedule care conferences. SS-A stated the expectation would be care conferences are held upon admission, quarterly, with significant changes, at discharge, or when requested. SS-A stated the facility was behind on care conferences when she started but the care conferences had been caught up. SS-A reviewed R10's medical record and verified R10's last care conference was 1/16/26. SS-A verified R10 had the following MDS assessments: quarterly 1/21/26, significant change in status 2/3/26 and 2/22/26, and a quarterly on 5/25/26. SS-A verified her assistant had not scheduled the care conferences and put it on the calendar. SS-A stated R10 should have had a care conference. During an interview on 6/3/26 at 1:53 p.m., R10's family member (FM)-B stated they typically attended care conferences either in person or via phone for R10. R10 stated they believed the last care conference was in January. R10 stated the next care conference was not scheduled, however R10 received a call from the facility to schedule during interview with the surveyor. During a follow up interview on 6/3/26 at 2:17 p.m., SS-A stated she thought she had the care conferences caught up and R10's must have been missed. SS-A stated R10's care conference had just been scheduled. During an interview on 6/4/26 at 11:21 a.m., director of nursing (DON) stated social services was responsible for coordinating care conferences. DON stated care conferences followed the MDS schedule. DON stated a resident should have a care conference every time a MDS assessment was completed such as a significant change, quarterly, annual, or admission assessment. DON stated it was important to have care conferences with family and their representatives to discuss resident care, any issues so they can be addressed and to help ensure family involvement. A facility policy titled Care Conference Policy reviewed 12/9/25, indicated care conferences will be held at all required intervals, promptly after significant changes, and at any time upon request.

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	245289	A. Building B. Wing	06/05/2026

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to implement interventions for 1 of 1 residents (R60) who required alternate means of communication due to hearing loss and being non-English speaking. Findings include:R60's admission Minimum Data Set (MDS) dated [DATE], indicated R2 had intact cognition with behavioral symptoms not direct at others (e.g., physical symptoms such as hitting or scratching self, pacing, rummaging, public sexual acts, disrobing in public, throwing or smearing food or bodily wastes, or verbal/vocal symptoms like screaming, disruptive sounds), had no rejection of care behaviors, and had wandered one to three days during the lookback period (LBP). R2 required set-up help with eating, moderate assistance for hygiene needs, and required supervision for walking. The MDS indicated R2 had highly impaired hearing with no hearing aid or other hearing appliance.R60's care plan dated 4/28/26, indicated R60 had the potential for hearing impairment, so staff were to utilize the communication binder at the nurse's station as needed. The care plan indicated staff were to utilize an interpreting service and had the service's phone number, but the care plan did not include what language R60 spoke. The care plan indicated staff were to anticipate and meet R60's toileting needs.R60's order summary dated 5/28/26, included an order for 15-minute safety checks, admit to the locked memory care unit, and close monitoring for safety.R60's banner dated 6/1/26, indicated R60 had the special instructions to use an interpreting service during patient care, but it did not include what language R60 spoke.R60's progress note dated 6/2/26 at 5:04 p.m., indicated R60 wanders sometimes and had followed staff through the door twice. The note indicated the second time, R60 had wanted to stay on the LTC [long term care] side and had then been successfully redirected to the memory care unit. The note indicated non-verbal cues had been used to communicate with the resident. The note indicated staff had attempted to use the interpreter service, but they had been unable to understand what R60 was saying.During an interview on 6/2/26 at 11:55 a.m., registered nurse (RN)-C confirmed he was R60's nurse for the shift and stated he was unsure what language R60 spoke or what the expected process was to communicate with him.During an interview on 6/2/26 at 12:05 p.m., a Hmong interpreting service was utilized, and the interpreter was able to translate R60's words to English, although it was unclear how well R60 was able to hear the translator/his understanding, as he did not respond to some of the questions asked by the surveyor.During an interview on 6/2/26 at 12:07 p.m., nursing assistant (NA)-I stated she has worked with R60 and the translator was be used sometimes when they completed R60's morning cares. NA-I stated she would use the translator when the nurse manager would bring the phone with the translator on the line, as she was unsure what language R60 spoke.During an interview on 6/2/26 at 12:09 p.m., registered nurse (RN)-D, the nurse manager for the unit, stated R60 spoke Hmong and staff were supposed to use the translator when they did cares with him. RN-D stated the facility has a cordless phone and staff should be calling the interpreter line themselves when cares were going to be completed. RN-D stated staff occasionally asked for help with calling the translator but had not this morning. RN-D stated that R60 didn't always understand the interpreter, so she would expect staff to then attempt to use the communication binder to assess R60's needs.During continuous observation on 6/2/26 from 1:20 p.m. to 2:09 p.m., R60 was observed wandering in the non-locked second-floor common area before re-entering the locked unit at 2:09 p.m. RN-B was observed sitting at the second-floor nursing station desk. The facility was set up so the common area was in the front, and a hallway separating the common area from the nurses' station that was placed perpendicular to the common area. The nurses' station had a small wall on the common area side of the nurses' station, so as RN-B sat at the left computer, she was not visible from all areas of the common area.- At 1:22 p.m., R60 was observed standing at the back side of the second-floor common area, out of view of the nurse, inserting the prongs of a metal fork into the (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	waistband of his pants, and then using the prongs in a pulling motion, as if trying to rip the pants fabric.- At 1:26 p.m., NA-I was observed standing in the second-floor common area before leaving out of view. R60 continued to walk around the common area picking up items, looking at windows, and talking to himself in a non-English language.- At 1:35 p.m., R60 was observed to continue to pull at his pants and wander around the edges of the room while talking to himself in a non-English language.- At 1:38 p.m., R60 was observed to find a corner of the room and urinate. RN-C was observed to enter the common area and ask the resident in English to go back to his room. R60 responded in a non-English language and did not follow RN-C as he re-entered the memory care unit. RN-C was not observed to use a translator or a communication binder to attempt communication with R60.- During this continuous observation, staff were not observed to use an interpreting service or the communication binder to attempt to speak with or assess R60's needs.During continuous observation from 2:13 to 2:48 a.m., R60 was observed wandering in the memory care dining room. R60 was again observed pulling at his pants and looking in various corners of the room.- At 2:13 p.m., RN-C was observed giving R60 two beverages to drink and setting them at a dining table. RN-C was again not observed using the communication binder or a translator to assess R60's needs.- At 2:33 p.m., R60 was observed out of view of RN-C, who was standing at a medication cart in the memory care hallway looking at a laptop. R60 was observed talking out loud in a non-English language as he pulled at his pants while walking along the wall of the dining room. R60 was observed to lower his pants and urinate on the wall. R60 then pulled his pants back up and continued to pace in the dining area.- At 2:40 p.m., R60 pulled out a chair and pointed at it, as if asking the surveyor to sit. The surveyor sat down. R60 was then observed to walk to the other side of the dining room, squat behind the far side of the steam table, with one hand on the steam table, and the other hand on the tall, metal, meal tray cart. R60 was then observed to pull a paper off of the wall behind him, appearing to use it to clean himself after having a bowel movement, and throw the paper to the side after use. R60 was then observed to pull pants back up and walk to the other side of the room. On further observation, stool was found on the far side of the steam table.- During this continuous observation, staff were not observed to use an interpreting service or the communication binder to attempt to speak with or assess R60's needs.The facility's Communication and Language Access Services policy dated 6/4/26, indicated the resident's primary language should be placed prominently in the electronic health record.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on observation, interview, and document review, the facility failed to ensure routine personal hygiene (i.e., shaving) were completed for 1 of 1 resident (R51) reviewed for activities of daily living (ADLs) and who were dependent on staff for their care.Findings include: R51's quarterly Minimum Data Set (MDS) assessment, dated 5/11/26, indicated R51 had intact cognition with no hallucinations, delusions, no behaviors, or rejection of care. MDS indicated R51 was dependent on staff for personal hygiene (i.e., shaving, combing hair, washing/drying hands), toileting, showering, dressing and mobility needs. R51's care plan, printed 6/4/26, indicated R5 had an ADL self-care performance deficit related to fatigue and morbid obesity which included the following interventions: - prefers no facial hair, provide grooming on shower days and as needed which was initiated on 6/26/25- BATHING/SHOWERING: The resident is totally dependent on 2-3 staff to provide bath/shower weekly on Tues and Fri PM and as needed. Resident prefers bed bath- PERSONAL HYGIENE/ORAL CARE: The resident is totally dependent on 2 staff for personal hygiene and oral care. R51's progress notes, dated 5/1/26 to 6/3/26, were reviewed and lacked evidence of refusals of shaving or completion of shaving.R51's Weekly Skin/bath assessment, dated 5/29/26 was reviewed and identified R51 received a bed bath. The audit form lacked evidence of facial shaving being offered or completed.R51's Weekly Skin/bath assessment, dated 5/22/26 was reviewed and identified R51 received a bed bath. The audit form lacked evidence of facial shaving being offered or completed.R51's Weekly Bath Audit, dated 5/27/26 was reviewed and identified R51 received a shower. The audit form lacked evidence of facial shaving being offered or completed.During an interview and observation on 6/1/26 at 11:59 a.m., R51 was observed with facial hair that was approximately 1/4 inch long. R51 stated the staff do not ask her if she wants to be shaved. R51 stated if she asked staff to shave her facial hair, the staff would but she found it embarrassing to have to ask to be shaved.On 6/3/26 at 12:33 p.m. R51 was observed to continue to have approximately 50 or so 1/4 inch long facial hairs on her chin and lower cheeks. R51 stated no staff had asked her if she wanted her facial hair removed and felt they should ask her daily or when they saw it. R51 stated, I don't wanna look like a man. On 6/3/26 at 1:00 p.m., registered nurse (RN)-A stated R51 required total staff assistance. RN-A stated nursing and aids should be asking if residents want to be shaved when they notice any facial hair. RN-A went and observed R51 facial hair. R51 was observed stating to RN-A she would like the facial hair removed and so she doesn't like looking like a man. RN-A stated R51's facial hair should have been and needed to be removed.On 6/3/26 at 1:25 p.m., registered nurse manager (RN)-D stated shaving was considered part of daily grooming. RN-D stated based on resident preferences, staff should be offering to shave or assist to shave resident anytime they provided cares. RN-D requested to review R51's medical record and provide additional information. No additional information was provided.On 6/4/26 at 11:21 a.m., director of nursing (DON) stated residents should be groomed per their preference. DON stated shaving should be offered with showers and as needed and documented if refused. A facility policy titled Activities of Daily Living (ADLs) Supporting, reviewed 11/2022, indicated Appropriate care and services will be provided for residents who are unable to carry out ADLs independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with:a. hygiene (bathing, dressing, grooming, and oral care);b. mobility (transfer and ambulation, including walking);c. elimination (toileting);d. dining (meals and snacks); ande. communication (speech, language, and any functional communication systems).

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, observation, and record review, the facility failed to provide an ongoing program of activities designed to meet the interests and well-being of a resident(s) and failed to ensure residents were informed of available activities for 2 of 2 resident (R3 and R37) reviewed who identified group activities and participation in favorite activities as important (R3, R37). Findings include: R3's quarterly Minimum Data Set (MDS), dated [DATE], indicated R3 was admitted to the facility on [DATE] and was cognitively intact with a Brief Interview for Mental Status (BIMS) score of 15. R3's Activity Interview for Daily and Activity Preferences, dated 3/28/25, indicated the facility completed a resident preference assessment designed to identify the importance of various daily routines, social interactions, and leisure activities. The assessment instructed residents to identify each preference as very important, somewhat important, not very important, not important at all, or important, but can't do or no choice. The assessment included questions regarding participation in group activities, involvement in favorite activities, choosing how to spend free time, and opportunities for social engagement. R3 identified doing things with groups of people and participating in favorite activities as somewhat important, indicating these activities were meaningful to her quality of life and personal preferences. R3's activity care plan, dated 10/5/24, identified preferences for meeting emotional, intellectual, physical, and social needs. Interventions directed staff to provide R3 with an activities calendar and notify her of any changes. Record review of facility activity participation sign-in sheets indicated R3 had no documented participation in activities between 5/1/26 and 5/16/26. The records further indicated the facility held an ice cream social on 5/15/26; however, R3 did not attend. Participation sign in sheets were not available for 5/17/26 - 5/31/26. Observation conducted throughout the survey revealed no activities calendar was posted in any public area on the third floor. Observation further revealed no activities calendar was posted in the facility elevator. During an interview on 6/1/26 at 1:05 p.m., R3 stated she and another resident had attempted to organize activities themselves by collecting money and prizes from other residents for a resident auction because no formal activities were occurring. R3 stated the facility had hired an activities aide, but she never saw the aide on the third floor. R3 stated she did not have an activities calendar, and no calendar was posted in the hallway. R3 stated she did not know what activities were occurring because activities, if held, occurred on the second floor and staff did not notify residents on the third floor. R3 stated, We are all bored up here on third floor. During an interview on 6/2/26 at 2:10 p.m., Licensed Practical Nurse (LPN)-A stated activities primarily occurred on the second floor and acknowledged that activities were often resident-run on third floor. LPN-A stated activities were mainly on second floor to be honest. During an interview on 6/4/26 at 8:22 a.m., the Nurse Manager and LPN-C stated they were unsure (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	whether an activities calendar was available and reported activities occurred mostly on the second floor. During an interview on 6/4/26, Activities Assistant (AA)-A stated the facility had not had an Activities Director since April 2026 and department heads had been assisting with activities. AA-A stated most activities occurred on the second floor because the memory care unit was located there. AA-A stated she documented attendance on paper sign-in sheets. AA-A stated there had been no activities calendar during the previous month and although a calendar existed for the current month, she had not yet printed it for resident viewing. AA-A stated calendars would be distributed to residents if enough paper was available; otherwise, they would be posted in the elevator. AA-A stated R3 only attended larger social events such as monthly birthday parties and one ice cream social held during the year. Attendance records indicated R3 did not attend the ice cream social. During an interview on 6/4/26 at 2:16 p.m., the Director of Nursing (DON) stated she was aware the facility did not have an Activities Director and acknowledged activities had not been routinely occurring, especially on the third floor. The DON stated the facility expectation was for a monthly activities calendar to be available so residents would be aware of scheduled activities. The DON stated the facility was in the process of hiring an Activities Director. R37's comprehensive Minimum Data Set (MDS) assessment dated [DATE], indicated R37 was cognitively intact, and dependent on mechanical device and assist of 2 for transfers. R37 indicated it was very important to attend activities. R37's care plan dated 1/6/26, indicated he was to be encouraged to participate in activities that promote exercise, and improved mobility. During an interview on 6/1/26 at 4:16 p.m., R37 stated the facility did not have an Activities Director and reported there were no activities available. R37 stated he would have liked to participate in activities if they had been offered. During an interview on 6/2/26 at 2:09 p.m., Activities Assistant (A)-B stated he had worked at the facility for approximately one month and confirmed the facility did not have an Activities Director. A-B stated activities staff attempted to engage residents through trivia, word games, board games, and bingo. A-B confirmed there was no activities calendar posted on the community board on the third floor. During a follow-up interview on 6/4/26 at 8:32 a.m., R37 stated there was no activities calendar posted on the third floor and no information regarding available activities. R37 stated the resident had informed staff of a desire to attend an auction activity on Monday; however, no staff assisted the resident to attend. R37 stated the resident relied on staff assistance and a mechanical lift for transfers. The resident further stated staff did not invite the resident to activities and there was no communication regarding what activities were available or when they occurred. R37 stated the resident enjoyed television programs, previously attended bingo, and remained interested in participating in facility activities. R37 stated activities were important because they helped break up the day and expressed that the facility needed a full-time Activities Director. During an interview on 6/4/26 at 8:43 a.m., Licensed Practical Nurse (LPN)-C stated the facility previously had an Activities Director, but the individual had resigned. LPN-C stated the facility was interviewing candidates for the position and acknowledged activities were important for residents' (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	mood and well-being. He confirmed there wasn't an activities calendar posted. During an interview on 6/4/26 at 12:04 p.m., the Director of Nursing (DON) and Administrator stated activities were important for meeting residents' individual needs and preferences. The Administrator stated the facility was actively interviewing candidates for the Activities Director position because of the unique needs of the resident population. A policy dated 3/6/25 titled, Activity Programs, indicated activity programs were designed to meet the interests of and support the physical, mental and psychosocial well-being. Activities were to be scheduled 7 days a week, and residents were given an opportunity to contribute to the planning. Activities offered were based on the comprehensive resident-centered assessments.

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. Based on interview and document review, the facility failed to ensure physician-ordered vision services were arranged and provided by failing to schedule and follow through with a routine referral to a retinal specialist for 1 of 1 resident (R31) reviewed for vision services. This failure had the potential for more than minimal harm by delaying evaluation and treatment of reported vision symptoms and potential diabetes-related eye conditions. Findings include: R31's annual Minimum Data Set (MDS) assessment, dated 4/1/26, indicated R31 was cognitively intact with a Brief Interview for Mental Status (BIMS) score of 15. Diagnoses included diabetes mellitus, protein-calorie malnutrition, depression, and post-traumatic stress disorder (PTSD). R31's physician orders revealed a routine referral to a retinal specialist dated 1/19/26.R31's electronic medical record (EMR) lacked evidence the retinal specialist appointment had been scheduled or completed. The EMR also lacked documentation of follow-up regarding the referral or any consultation report from a retinal specialist.During an interview on 6/1/26 at 12:02 p.m., R31 stated she needed to see the eye doctor because her eyes were fuzzy and burned. R31 stated she had previously been told there was some edema behind my eyes or something and that she needed follow-up with a specialist. R31 stated the facility was supposed to make the referral but she had never heard anything further. R31 stated her last eye appointment had been over a year ago. During a follow up interview on 6/2/26 at 1:02 p.m., R31 stated she had not heard anything further about the eye doctor appointment. When asked why she thought the appointment had not occurred, R31 stated, Cause they just don't make the appointments.During an interview on 6/2/26 at 2:10 p.m., Licensed Practical Nurse (LPN)-A stated when there was an order in the EMR for a follow-up appointment, the health unit coordinator (HUC) downstairs was responsible for scheduling the appointment.During an interview on 6/3/26 at 10:50 a.m., a health unit coordinator (HUC) assistant stated HUC staff were responsible for scheduling appointments when outside providers had not already arranged follow-up. The HUC assistant stated she highlighted physician orders requiring follow-up appointments and provided them to the HUC responsible for scheduling. When asked about R31's retinal specialist referral, the HUC assistant reviewed the medical record but was unable to determine whether the appointment had been scheduled or completed and stated she would continue looking into it.During an interview on 6/4/26 at 8:22 a.m., Licensed Practical Nurse (LPN)-C, the nurse manager, stated he was unsure whether R31's retinal specialist appointment had been scheduled or completed and stated he would investigate.During a follow-up interview on 6/4/26 at 11:15 a.m., LPN-C stated the HUC was out sick and he had been unable to obtain additional information. LPN-C stated he did not find any documentation in the EMR indicating the appointment had been scheduled or that R31 had been seen by the retinal specialist.During an interview on 6/4/26 at 2:16 p.m., the Director of Nursing (DON) stated the expectation was that nurses entered physician orders and needed appointments into the EMR and the HUC scheduled follow-up appointments as soon as possible.An undated facility policy titled Clinical and Operational Policy: Vision Appointment Management stated the facility would ensure all residents had access to comprehensive vision care and would coordinate with external providers to deliver vision services safely and efficiently.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review the facility failed to ensure a catheter drainage bag (CDB) remained below the level of the bladder for 1 of 2 residents (R6) reviewed for catheter care.Findings include:R6's quarterly Minimum Data Set (MDS) dated [DATE], identified moderately impaired cognition, rejection of care one to 3 days, and was dependent on staff assistance with dressing, bed mobility and toileting. R6 was always incontinent of bowel and bladder and had intermittent catheterization. Diagnoses included infective bursitis of the left elbow. R6's care plan dated 4/27/26, identified R6 had a catheter for neurogenic bladder. An intervention dated 5/12/26, identified to position catheter bag and tubing below the level of the bladder. During an observation and interview on 6/3/26 at 10:44 a.m., activities assistant (A)-A brought R6 in his wheelchair to the commons area by hallways and elevator. R6's CDB was hooked on his wheelchair arm rest above the level of the bladder. The catheter tubing contained urine that had not drained down. R6 stated he was moving the catheter tubing to try and get the urine to drain down into the CDB. During an interview on 6/3/26 at 10:46 a.m., nursing assistant (NA)-J stated R6's catheter should be positioned below the level of the bladder for drainage. During a follow up interview on 6/3/26 at 10:46 a.m., A-A stated R6 was at an activity for 1 and 1/2 hours. Activities staff did not touch catheters, so his remained on his wheelchair arm rest for the past 1 and 1/2 hours, and no one from nursing did anything with his catheter while he was at the activity. During a follow up observation on 6/3/26 at 10:49 a.m., NA-J put R6's CDB in a pillowcase and was attempting to connect the pillowcase to the stability bars under the wheelchair During an interview on 6/3/26 at 10:50 a.m., NA-F stated CDB should be placed below the level of the bladder. she wasn't sure who placed R6's catheter bag above the level of the bladder.During an interview on 6/3/26 at 10:54 a.m., registered nurse (RN)-A stated CDB should be below the level of the bladder for drainage. RN-A stated R6 was currently on antibiotics for a bladder infection.During an observation and interview on 6/3/26 at 10:52 a.m., RN-D was adjusting R6's catheter tubing so it would drain. RN-D confirmed verbally there was urine in the tubing, and it needed manual drainage. During a follow up interview on 6/3/26 at 11:02 a.m., RN-D stated CDB should be below the level of the bladder so the bladder can empty.During another observation on 6/4/26 at 8:43 a.m., R6 was seated in the dining room with his CDB hooked on his wheelchair arm rest above the level of the bladder. The catheter tubing contained urine that had not drained down. Several unidentified nursing staff were in the area and did not intervene to place the CDB below the level of the bladder. During an interview on 6/4/26 at 8:48 a.m., trained medication assistant (TMA)-A confirmed verbally R6's CDB was incorrectly placed above the level of the bladder and needed to be below the bladder to ensure drainage.During an interview on 6/4/26 at 2:04 p.m., the director of nursing (DON) stated CDB should be positioned below the level of the bladder to ensure urine drains and does not backflow.The facility's undated Urinary Catheter Care policy identified the CDB should be held or positioned lower than the level of the bladder to prevent the urine in the tubing and CDB from backflowing into the bladder.

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F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that the resident and his/her doctor meet face-to-face at all required visits. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to ensure a resident's physician completed the initial comprehensive 30-day visit for 1 of 3 (R50) newly admitted residents reviewed. Findings include:R50's admission Minimum Data Set (MDS) dated [DATE], indicated R50 was diagnosed with cancer, kidney disease, malnutrition, and a seizure disorder.R50's census report dated 4/23/26, indicated R50 remained an active resident at the facility, had a primary payer source of Medicare A, and admitted to the facility on [DATE].R50's medical record was reviewed, and a progress note indicating a visit had been completed by a physician was not found.During an interview on 6/5/26 at 8:52 a.m., the director of nursing (DON) stated that the physician should see the resident within the first 30 days of their stay. The DON stated she would look for a note indicating that a physician had seen R50 during her stay and would provide the records. Records indicating R50 had been seen by a physician were not received.The facility's Physician Visits policy dated 4/2013, indicated the attending physician will visit residents in a timely fashion, consistent with applicable State and Federal requirements. The policy indicated that the attending physician must visit the resident once every thirty days for the first 90 days.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review, the facility failed to follow up on two pharmacy recommendations for 1 of 5 residents (R6) reviewed for unnecessary medications.Findings include:R6's quarterly Minimum Data Set (MDS) dated [DATE], identified moderately impaired cognition, rejection of care one to 3 days, and was dependent on staff assistance with dressing, bed mobility and toileting. R6 took an antipsychotic medication.R6's care plan dated 2/7/26, identified antipsychotic medication was used for Parkinson's. R6 was to be monitored for potential adverse effects and nursing staff were directed to document and record any findings. Potential adverse effects included: unsteady gait, tardive dyskinesia, EPS (shuffling gait, rigid muscles, shaking), frequent falls, refusal to eat, difficulty swallowing, dry mouth, depression, suicidal ideations, social isolation, blurred vision, diarrhea, fatigue, insomnia, loss of appetite, weight loss, muscle cramps nausea, vomiting, and unusual behavior symptoms. R6's physician order dated 4/25/25, identified to give quetiapine fumarate (an antipsychotic medication) 25 milligrams (mg) by mouth one time a day for Parkinson's disease (PD) and behavioral disturbance with agitation. Also give 50 mg by mouth one time a day for Parkinson disease and behavioral disturbance with agitation.R6's consultant pharmacist (CP) Medication Regimen Review (MRR) dated 4/23/26, identified due to quetiapine use to add AIMS monitoring baseline and at least every six months unless already ordered and to report any significant changes to prescriber as soon as possible.R6's CP MRR dated 5/18/26, identified there was an order placed on 4/26/26, for an AIMS assessment for R6, however, documentation was not found that it was completed. R6's nursing order dated 4/26/26, identified to Complete AIMS - Abnormal Involuntary Movement Scale one time a day every 3 month(s) starting on the 20th for 3 day(s).R6's treatment administration records (TAR) identified:4/21/26 through 4/23/26, the order to complete the AIMS assessment was signed off as having been done daily for these three days, however, there were no assessment results documented in R6's record.5/19/26, the order sign off to complete the AIMS assessment was blank, and there were no assessment results documented in R6's record.6/1/26 through 6/4/26, no AIMS assessment had been signed off or documented in R6's record.During an observation on 6/1/26 at 12:52 p.m., R6 was seated in his wheelchair with a flat affect and a mild tremor in his fingers.During an interview on 6/4/26 at 9:44 a.m., registered nurse (RN)-D stated upon admission the nurse would enter the AIMS assessment into the medical record so nursing could complete it. RN-D stated AIMS was important to check for side effects, and the purpose of the assessments was for residents safety. During an interview on 6/4/26 at 2:01 p.m., the director of nursing (DON) stated when a resident was on an antipsychotic either the nurse working on the floor or the manager would place the order on the TAR to signal nursing to complete the AIMS assessment. Completed AIMS assessments would be documented in R6's medical record under assessments The purpose of completing an AIMS assessment is mainly for the purpose of medication adjustments and so the pharmacy could review to see if there were any adverse effects.The facility's AIMS Assessment policy dated 6/4/26, identified an AIMS assessment was required for residents prescribed a second-generation antipsychotic such as quetiapine. A baseline assessment should be completed prior to starting an antipsychotic and every 3 months or sooner if changes for the elderly.

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep all essential equipment working safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review the facility failed to ensure patient care equipment was maintained in safe operating condition for 1 of 1 resident (R15) who used a Hoyer lift for transfers. Findings include: R15's quarterly Minimum Data Set (MDS) dated [DATE], indicated intact cognition and diagnoses of chronic respiratory failure with hypoxia, morbid (severe) obesity, and muscle weakness. If further indicated R15 had bilateral impairment of his lower extremities and was dependent on staff for transfers.R15's care guide dated 3/27/26, indicated R15 required the assistance of 2-3 staff (using a Hoyer lift) with transfers. R15's care plan dated 3/3/26, indicated R15 required a mechanical lift (Hoyer) and the assistance of 3 staff members when transferring to his power mobility device (PMD) and the assistance of 2 staff when transferring back to bed. During interview on 6/1/26 at 11:58 a.m., R15 stated almost every time he was transferred using the Hoyer lift, the battery would run out in the middle of the transfer. Sometimes they would put him back in bed and manually lower him down using the emergency release button and sometimes they would leave him hanging in the sling while one of the nursing assistants went to get another battery. They've had these lifts for years and they just keep recharging the batteries instead of getting new ones. Last night (5/31/26) they needed to use two different batteries to get me into bed. During observation and interview on 6/2/26 10:17 a.m., 3 nursing assistants (NA-F, NA-G, and NA-H) were transferring R15 from his bed to his PMD using the Joerns Hoyer lift (HPL700). As NA-F was using the remote to lower him down into his PMD, the lift stopped working. NA-F stated it was due to a low battery, stating How hard is it to charge a battery? R23 used the manual release button to lower himself down into his PMD. During interview on 6/2/26 at 11:18 a.m., nursing assistant (NA)-F stated NA's who worked the overnight shift were responsible for charging the batteries for the Hoyer lifts, but they were never charged. If the lift was to stop working in the middle of a transfer, they would manually lower the resident using the emergency manual release button. NA-F further stated they usually tried to see if the lift would go up/down before they entered the resident's room because they knew there was a good chance the battery would be dead. During interview on 6/2/26 at 11:45 a.m., NA-G stated everybody was responsible for ensuring the batteries for the lifts were charged and they should be checking it before they enter the resident's room. If the lift was to stop working during a transfer, they would use the emergency manual release button (as they did with R15) to lower the resident back down into bed. NA-G further verified, the batteries for the lifts weren't always charged and the lift occasionally stopped working during transfers (due to low battery).During interview on 6/4/26 at 8:47 a.m., licensed practical nurse (LPN)-A stated everyone was responsible for ensuring the batteries for the lifts were charged, but mainly the overnight staff were supposed to ensure they were charged for the morning, If the battery were to run out during a transfer, the NAs should lower them back down in bed using the emergency manual release button and then go and get a new battery. During interview on 6/4/26 at 9:15 a.m., LPN-D stated nursing staff who work the overnight shift were responsible for ensuring the batteries for the Hoyer lifts were charged, but everyone should be checking. LPN-D further stated NAs should also be checking the battery was charged before entering the resident's room when transferring them. If the lift were to stop working during a transfer, the NAs should lower them back down in bed and one of them, should go and get another battery. During interview on 6/4/26 at 1:31 p.m. the director of nursing (DON), stated NAs were responsible for ensuring the batteries for the lifts were charged. If the lift ran out of battery during a transfer, the NAs should push the emergency release, lower the resident back down to the bed or chair, and then go and get another battery. The DON further stated the NAs should be checking to make sure the battery was charged before entering the resident's room to transfer the resident. During interview on 6/4/26 at 2:16 p.m., the maintenance supervisor stated they replace the batteries on the lifts here and there or if they get a complaint about a lift not working properly. They've only replaced the battery on one lift. (continued on next page)

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The surveyor requested invoices for any batteries that had been purchased for the lifts, but the maintenance supervisor stated he didn't know if he had any. No invoices were received. The Manufacturer Guidelines for the Joern's Hoyer lift (HPL700) dated 2024, indicated Always Check the Following Before Operation:Push the up and down buttons on the hand control and confirm the boom raises and lowers. It further indicated: Warning- keep the batteries fully charged. Place the battery on charge whenever it is not in use. If it is more convenient to do so, place on charge every night. The charger will not allow the batteries to overcharge. Never run the batteries completely flat. As soon as the audible warning sounds, complete the lifting operation in hand and place on charge. To avoid possible permanent damage to the battery, the battery should be placed on charge as soon as the display indicates the half empty battery symbol. Never store the battery for long periods without regular charging throughout the storage period. The facility policy titled Safe Patient Handling and Mechanical Lifts (undated), maintenance staff or floor nurses must verify that lift batteries are charged and emergency stop buttons are functional at the start of each shift.

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F 0917 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure each resident has 1) at least one window to the outside in a room; 2) a room at or above ground level; 3) adequate bedding; 4) furniture that meets the resident's needs; or 5) adequate closet space. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review the facility failed to ensure residents had a fitted sheet on their bed for 2 of 2 residents (R15, R53) with bariatric beds.Findings include: R15 R15's quarterly Minimum Data Set (MDS) dated [DATE], indicated intact cognition and diagnoses of chronic respiratory failure with hypoxia, morbid obesity, and chronic pain. It further included R15 had bilateral impairment of his lower extremities, was dependent on staff for toileting and transfers. During observation and interview on 6/1/26 at 11:58 a.m., R15 was in bed (bariatric) on top of a blanket that had been laid across the bed where large areas of the bare mattress were exposed. R15 stated the facility never put a fitted sheet on his bed because they didn't have any sheets that fit. During observation on 6/2/26 at 10:17 a.m., nursing assistants (NA)-G and NA-H went into R15's room to transfer him from his bed to personal mobility device (PMD). R15 was in bed on top of a blanket that had been laid across the bed and large areas of the bare mattress were exposed. NA-H verified there wasn't a fitted sheet on R15's bed and wasn't sure why. During interview on 6/2/26 at 1:50 p.m., NA-F stated NAs were responsible for making the residents beds stating We've been asking for bariatric sheets for months. We only have maybe 3 or 4 sets of bariatric sheets and they are always in room [ROOM NUMBER] because she makes laundry give them back to her. NA-F further stated they had reported not having enough bariatric sheets to the previous administrator and maintenance supervisor. During interview on 6/3/26 at 11:23 a.m., NA-E stated NAs were responsible for putting sheets on the residents' beds and the reason some of the bariatric beds didn't have sheets was because the facility didn't have enough. NA-E further stated This is not a new thing, it's been a problem since January, There are not enough sheets that fit the bariatric beds. We keep telling management they need to buy a bigger size. If there aren't any sheets available to make the bed, we just use a blanket.R53R53's quarterly Minimum Data Set (MDS) dated [DATE], indicated intact cognition and diagnoses of anxiety, morbid (severe) obesity, and sleep deprivation. It further indicated R53 required substantial assistance with toileting and partial assistance with transfers. During observation and interview on 6/1/26 at 11:19 a.m., R53 was lying in bed on top of a blanket with parts of the bare mattress exposed. R53 stated the facility didn't have any sheets that fit her bed and she would prefer to lay on a fitted sheet (as opposed to a blanket) that fit the bed properly and didn't fall off all the time. During observation on 6/3/26 7:40 a.m., R53 was lying in bed on top of a blanket with parts of the bare mattress exposed. There wasn't a fitted sheet R53's bed. During observation and interview on 6/4/26 at 8:37 a.m., NA-B brought R53's breakfast tray to her room. R53 was lying in bed on top of a blanket and there were parts of the bare mattress exposed. NA-B verified there wasn't a sheet on R53 beds and should have been. During interview on 6/4/26 at 1:31 p.m., the director of nursing (DON), stated she would expect all residents to have sheets on their beds.The facility policy titled Making an Unoccupied Bed (undated), indicated the purpose of the policy was to provide a resident who gets out of bed a clean, comfortable bed. If further indicated the following procedure for equipment/supplies needed to make a bed:-1 pillowcase-2 sheets-1 blanket (if necessary)-1 bedspread (if necessary)-1 plastic drawsheet (per facility policy)-1 cotton drawsheet (if necessary)-disposable bed liner (if necessary)-laundry bag, soap and water, paper towels, and personal protective equipment (gloves, gowns, etc.)

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. Based on observation and interview, the facility failed to ensure required nurse staffing information was posted to reflect accurate total number and actual hours worked per shift for licensed and registered staff for each shift on a daily basis. This had potential to affect all 58 residents, staff, and visitors who could want to review this information. Findings include:Review of the daily staff postings and staff schedules for the past month on 6/4/26, revealed the postings did not accurately reflect the actual staffing levels during each day.During interview with the director of nursing (DON) and the administrator on 6/4/26 at 12:29 p.m., DON stated the daily staff postings were filled out by the receptionist and did not reflect any changes throughout the day such as call-ins, no-shows, or staff picking up shifts. The administrator stated expectation of the daily staff postings to reflect accurate shift numbers.During interview with receptionist (RC) on 6/4/26 at 12:54 p.m., RC stated when she arrives in the morning, she was expected to review the daily staff schedule that was sent to her from the staffing coordinator (SC) and to fill out the staff posting form. RC stated no one updated the daily posting with changes involving call-ins, no-shows, or picked up shifts.During review and interview with SC on 6/4/26 at 1:03p.m., SC stated she was responsible for the staff schedule and forwarding daily information to the receptionist and DON, But not the staff posting. SC stated she was not aware of anyone updating the daily staff postings to reflect call-ins, no-shows, or picked up shifts. Review of May and June 2026 staff schedules and daily staff postings were reviewed with SC who verified they did not match.Facility policy on daily staff postings was requested and not received.