STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245312	A. Building B. Wing	03/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Flagstone	12500 Castlemoor Drive Eden Prairie, MN 55344

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to obtain and document informed consent, including an explanation of risks and benefits, for 1 of 5 residents (R43) reviewed for the use of psychotropic medications.Findings include: R43's quarterly Minimum Data Set (MDS) dated [DATE], indicated R43 had both long-term and short-term memory impairment and severely impaired cognitive decision-making skills. The MDS indicated R43 had Alzheimer's disease, anxiety, depression, and a psychotic disorder.R43's order summary dated 3/18/26, indicated R43 had an order for 50 milligrams (mg) of Seroquel (an antipsychotic medication) twice a day for psychosis with a start date of 3/12/26. The order summary also included an order for 25 mg of Seroquel daily for psychosis with a start date of 3/12/26. R43's medical record was reviewed and lacked evidence that consent for the use of the Seroquel at the current dose and frequency was obtained prior to the medication being administered. During an interview on 3/19/26 at 9:39 a.m., licensed practical nurse (LPN)-A stated he worked with R43 frequently and was her nurse today. LPN-A stated he had reviewed R43's medical record and was unable to find documentation that consent had been obtained for R43's Seroquel, but did believe he had talked with resident representative (RR)-A and obtained verbal consent. During an interview on 3/19/26 at 12:05 p.m., RR-A confirmed he was R43's power of attorney. RR-A stated he had been informed of R43's medication changes in the past, but did not believe he had been informed of the most recent March updates to R43's antipsychotic medications, including the Seroquel that was started on 3/12/26. During an interview on 3/19/26 at 11:58 a.m., the nurse manager for the unit, registered nurse (RN)-B, stated that when psychotropic medication updates were made, the floor nurses were in charge of contacting family, discussing the risks and benefits of the medications, and obtaining consent for the medication. RN-B stated they had a form that included the risks of psychotropic medications that RR's would sign and would be uploaded to the medical record.The facility's Psychotropic Medication Use policy dated 3/2025, indicated informed consent was to be obtained for the use of psychotropic medications used for behavior management.

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

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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 interview and document review, the facility failed to ensure instructions for use of multiple as-needed (PRN) psychotropic medications were included, to ensure appropriate administration and minimize the risk of unnecessary medication usage for 1 of 5 residents (R43) reviewed for unnecessary medications. Findings include:R43's quarterly MDS dated [DATE], indicated R43 had both long-term and short-term memory impairment and severely impaired cognitive decision-making skills. The MDS indicated R43 had Alzheimer's disease, anxiety, depression, and a psychotic disorder. The MDS indicated R43 did not have hallucinations, delusions, or rejection of care during the look-back period.R43's care plan dated 2/5/26, indicated R43 had an alteration in mood or behavioral expression as well as dementia with psychotic features. The care plan indicated R43's target behaviors were paranoia, beliefs that weren't real, anger at caregivers and family, physical aggression, and wandering/yelling in the hall at others or things that aren't there. The care plan indicated R43 used anticonvulsant medication, including gabapentin and Depakote, with the target behaviors of complaints of pain with completion of activities of daily living (ADLs) and refusal to complete ADLs. The care plan did not give instructions regarding PRN psychotropic medication use, such as the order of administration.R43's Order Summary Report dated 3/4/26 included:- An order dated 3/12/26 for .5 milligrams (mg) of lorazepam (an anti-anxiety medication) twice daily as needed for agitation and psychosis.- An order dated 3/4/26 for 125 mg of delayed-release Depakote sprinkles (an anticonvulsant medication sometimes used for mood stabilization) daily as needed for agitation. - The order summary included no further instructions on which medication should be given first, for what symptoms these symptoms should be given, etc. R43's medication administration record (MAR) dated 3/1/26 to 3/19/26 at 9:17 a.m., indicated R43 had received the PRN Depakote eight times and the PRN lorazepam documented as administered four times and once on 3/15/26 at 8:33 p.m., with an administration code of 9 meaning other/see nursing notes. R43's administration progress note dated 3/15/26 at 8:33 p.m., included a note, agitation. During an interview on 3/19/26 at 9:49 a.m., LPN-A confirmed he was R43's nurse and had worked with her previously. LPN-A stated R43 had a lot of restlessness and agitation, and that is when he would administer the PRN lorazepam or Depakote. LPN-A stated he had used both the PRN lorazepam and Depakote and had found the lorazepam more helpful. LPN-A stated he was unsure what medication he was supposed to try first if the resident had agitation, so he would just pick one of them.During an interview on 3/19/26 at 11:58 a.m., RN-B confirmed she had reviewed the orders and did not see any instructions for administration for the PRN psychotropic medications, such as which medication staff should administer first if agitation was observed. During an interview on 3/20/26 at 7:52 a.m., the director of nursing (DON) stated she would expect the pharmacist to review antipsychotic medications during their monthly reviews to ensure they had an appropriate diagnosis. The DON stated that if a resident had multiple PRN medications written for agitation, the interdisciplinary team (IDT) would need to meet, and they would need to come up with a plan with further instructions for when each medication should be administered. The facility's Psychotropic Medication Use policy dated 3/2025, indicated psychotropic medications were only to be used when the medication was appropriate to treat a resident's specific, diagnosed, and documented condition. The policy did not include instructions for management of multiple (non-antipsychotic) PRN psychotropic medications.

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to ensure complete and comprehensive Minimum Data Set(s) (MDS) were completed for 1 of 5 residents (R4) reviewed for assessment accuracy. Findings include: The Centers for Medicare and Medicaid (CMS) Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual, dated 10/2025, identified the MDS as an assessment tool that facilities are required to use. The manual directed comprehensive assessments, include the completion of both the MDS and the CAA process, as well as care planning. The CMS RAI manual also identified that the RAI process (i.e., MDS) was completed to help evaluate residents' strengths and areas for care planning. R4's annual MDS dated [DATE], included the following information:-Section B- Hearing, Speech, and Vision: indicated B0100 (Persistent vegetative state/no discernible consciousness) was answered as no, so staff were to continue to B0200, Hearing. B0200-B1000, fields regarding R4's hearing, speech, his ability to understand and make himself understood, and vision, were dashed.-Section C- Cognitive Patterns: indicated C0100 (Should Brief Interview for Mental Status (C0200-C0500) be Conducted?) was answered as yes, so staff were to continue to C0200. Sections C0200 through C1310, fields regarding mental status, memory, cognitive skills, and signs of delirium were dashed.-Section D- Mood: indicated D0100 (Should Resident Mood Interview be Conducted?) was answered yes, so staff were to continue to D0150. D0150 questions A-I, an interview assessing the resident's mood, were dashed, and D0160 had a score entered of 99, which indicated that the interview was unable to be completed. D0500-D0600, the section for staff assessment of resident mood was left blank.-Section F-Preferences for Customary Routine and Activities: indicated F0300 (Should Interview for Daily and Activity Preferences be Conducted?) was coded as yes, continue to F0400. Section F0400 A-H, an interview for daily preferences, was all dashed. Section F0800, the staff assessment of daily and activity preferences was left blank. During an interview on 3/19/26 at 10:28 a.m., registered nurse (RN)-C, the MDS coordinator, stated she had received an email from the nursing team that they had missed completing parts of the MDS assessment for R4, such as mood, cognition, and social assessment, before the assessment reference date (ARD). RN-C stated that by the time she looked for the assessments to use to complete the MDS, it was past the ARD. RN-C stated she hadn't noticed until it was too late to complete the assessments, so she had dashed the areas for which she could not find an assessment. During an interview on 3/20/26 at 7:49 a.m., the director of nursing (DON) stated that the floor nurses completed the MDS assessments, and then the unit managers were in charge of ensuring MDS assessments were completed and completed accurately.The facility's Resident Assessment Instrument (RAI) Process: MDS 3.0, Care Area Assessments, Care planning, and Submission policy dated 3/2025, indicated the facility's multidisciplinary team would work together to complete the MDS assessment according to the RAI manual.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to ensure routine personal hygiene care (i.e., facial hair removal) was provided for 1 of 1 resident (R39) reviewed who was dependent of staff for activities of daily living (ADLs).Findings included:R39's quarterly Minimum Data Set (MDS) dated [DATE], indicated R39 had severe cognitive impairment, did not refuse personal cares, and needed setup/cleaning assistance with oral hygiene and personal hygiene. MDS also indicated R39 needed moderate assistance with bathing, dressing, and toileting hygiene.R39's Medical Diagnoses report dated 3/20/26, indicated diagnoses of chronic diastolic heart failure, amnesia, essential hypertension, muscle weakness, and bilateral shoulder pain.R39's care plan dated 3/20/26 indicated R39 was cognitively impaired and was had difficulty in communicating. This care plan indicated the staff will anticipate and meet her needs. R39's care plan also indicated she had self-care performance deficits and needed assistance of one staff member with dressing, grooming and hygiene.During observation on 3/17/26 at 12:33 p.m., R39 had facial hair on her chin. R39 had about 12 beard strands, each measuring approximately 4 to 5 centimeters long. During the interview, R39 raised her shoulders in response to multiple questions including how she felt about the strands on her chin.During interview on 3/18/26 at 9:10 a.m., registered nurse (RN)-D verified R39 facial hair strands. RN-D stated the nursing assistants needed to help her shave.During interview on 3/18/26 at 1:45 p.m., RN-B stated resident needed to be shaved on shower day or during morning cares. RN-B stated, sometimes R39 got agitated during personal cares and wondered if R39 would let the staff shave her. RN-B verified there was nothing documented on R39's care plan about refusing shaving.During interview on 3/19/26 at 11:33 a.m., nursing assistant (NA)-B stated she will shave female residents' facial hair, unless their care plan indicated the female resident didn't want to be shaved. NA-B stated, It's not okay for a woman to have facial hair.During interview on 3/23/26 at 9:54 a.m., resident representative (RR)-B returned call placed on 3/18/26 at 9:45 am. RR-B indicated on 3/22/26, the previous day, he saw a razor in R39's room and the staff shaved R39 and she looked nicer. RR-B stated it would be important for his mother to not have long facial hair.During interview on 3/20/26 at 8:10 a.m., the director of nursing (DON) stated female facial hair needed to be shaved and added It's a dignity issue.Facility policy titled Resident Care Policy dated 7/2024, indicated every resident will have morning and bedtime cares done daily and shave residents per planned individual preferences.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to comprehensively assess and, if needed, determine or develop proactive interventions to help address pressure injury risk and prevent skin alteration worsening, after a pressure-induced skin alteration was identified for 1 of 3 residents (R19) reviewed for pressure injuries. Findings include: R19's annual Minimum Data Set (MDS) dated [DATE], indicated R19 had intact cognition, no rejection of care behaviors, and was diagnosed with heart failure, kidney failure, and diabetes. The MDS indicated R19 had a functional limitation in range of motion to both upper extremities, needed moderate assistance with toileting hygiene, was dependent for bathing, and needed moderate assistance for bed mobility. The MDS indicated R19 was at risk for pressure ulcers and had no current pressure ulcers.R19's order summary dated 6/9/25, included an order dated 6/9/25 to place R19's CPAP or BiPAP on at bedtime, check overnight, remove in the morning, clean the tubing, and fill the chamber with water before use. R19's care plan dated 12/22/25, indicated staff were to inspect R19's skin for redness, open areas, scratches, cuts, or bruises while providing care and report changes. The care plan indicated R19 was at risk for skin impairment, and the nurse was to be notified immediately of any new areas of skin breakdown. The care plan indicated R19 required assistance from staff with repositioning and toileting, and staff were to wash his skin with mild soap, rinse, and dry thoroughly while providing care. The care plan indicated that staff were to assist R19 in applying his CPAP machine per MD/NP orders. R19's medication/treatment administration record dated 3/1/26 to 3/18/26 at 8:00 a.m., indicated R19's CPAP/BiPAP had been applied every night and removed every morning during the period. R19's progress note dated 3/6/26 at 1:51 p.m., indicated that R19's body audit indicated his skin was clean, dry, and intact.R19's progress note dated 3/16/26 at 4:50 p.m., indicated a bowel, bladder, skin risk summary and analysis were completed, and that his skin remained intact. R19's progress notes dated 3/6/26 to 3/16/26 were reviewed with no note of the redness or scabbing under R19's eyes. During an interview and observation on 3/17/26 at 10:52 a.m., R19 was observed in his room in his wheelchair. Under R19's right eye, a skin alteration was observed in the wrinkle that ran from his undereye diagonally down, following the curve of the nose to his mouth. In this wrinkle, R19 had redness that was about 2.5 centimeters (cm) long by one cm wide, with a dark red scab about the length and thinness of the end of the nail of an adult thumb. R19 stated he had some drainage from the scab and thought the drainage started about a week ago. R19 was unable to further describe the drainage. R19 stated he thought the skin alteration was from the CPAP machine he wore at nighttime. R19 stated the redness caused slight pain, but not enough to stop using the machine. On 3/18/26 at 10:44 a.m., he thought he had had the skin redness and scab under his right eye for about three weeks to a month. R19 was observed with the same skin alteration on the right side as described above, although the skin redness was now about one cm by one cm. R19 also had new redness in the mirrored wrinkle on the left side of the face, which extended approximately 4 cm long with a width of approximately one cm. During an interview and observation on 3/18/26 at 10:58 a.m., registered nurse (RN)-A stated he was the nurse in charge of R19's care today, but normally worked on a different unit, so he was not that familiar with R19's care. RN-A was observed to assess R19's skin and confirmed the above measurements from 3/18/26. RN-A was observed to press on the redness, the skin turning white, and then turning red again. RN-A stated he thought R19's CPAP mask might be too tight, causing the facial redness and scabbing. R19 stated he was unsure how long R19 had had the scab and redness on his face, but thought it was caused by pressure from his CPAP mask. RN-A was observed to apply a CPAP mask to R19. The mask was observed to sit on top of the skin alterations. RN-A stated the aides should report when the resident has skin alterations like this one, but it had not been reported to him, and he was unsure if it had been in the past. RN-A stated he was going to notify the provider of the skin alteration to determine what treatments or methods needed to be utilized to (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	prevent the skin alteration from worsening. During an interview on 3/18/26 at 11:06 a.m., nursing assistant (NA)-A stated R19 had a pattern of redness and scabbing under his eyes from his CPAP machine that would heal and then recur, and this the redness and scabbing under his right eye had been there for about a week to a week and a half. NA-A stated she had noticed that the scab under his right eye had been bleeding slightly when she took the machine off him at around 8 a.m. this morning. NA-A stated she thought she had told licensed practical nurse (LPN)-A about the wound previously, but thought he should know about it anyway because anyone going into his room could see it. During an interview on 3/19/26 at 9:42 a.m., LPN-A stated he had worked with R19 in the last week, but did not recall if he had scabbing or redness under his eyes, but did not think that was something he noticed. LPN-A stated he was unsure if any NAs had notified him of any skin alterations for R19 in the last couple of weeks, but thought he would have added a progress note about the skin alteration if he had. During an interview on 3/19/26 at 11:49 a.m., the nurse manager for the unit, RN-B, stated she had not been notified of the redness and scabbing on R19's face prior to the surveyor questioning the staff about the skin alteration, but she would have expected the staff to. RN-B stated that now that she had been made aware of the issue, she had assessed the CPAP mask, and it appeared as if staff had been unvelcroing the straps that adhere the mask to the face instead of using the clips that allow the mask to be detached from the face without altering the strap length. RN-B stated she had refitted the mask to R19, as it was previously too tight, and was completing education with her staff to ensure the clips were used instead of the straps to prevent worsening of R19's skin alterations that were caused by the pressure of R19's CPAP mask. During an interview on 3/20/26 at 7:56 a.m., the director of nursing (DON) stated that if an aide noticed a skin alteration, they should notify the nurse, who should document this occurrence so it can be fully assessed, and a treatment plan can be developed. The facility's Skin Integrity Management policy dated 10/2025, indicated a pressure ulcer/injury referred to a localized damage to the skin or underlying soft tissue usually over a bony prominence or related to a medical or other device. The policy indicated that staff were to inspect the skin for signs or symptoms of breakdown and inspect the skin under medical devices every shift. The policy indicated that body audits were to be performed weekly, and the findings were to be documented.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to ensure safety measure were put in place to prevent accidents for one of two resident (R25) reviewed for accidents who had known fainting episodes, often while on the toilet. Findings include:R25's quarterly minimum data set (MDS), dated [DATE], indicated R25 was admitted to the care facility on 7/26/23 and was cognitively intact. The MDS further indicated R25 required substantial to maximum assistance with dressing, bathing and toileting. During an interview on 3/17 and 10:09 a.m., R25's family member (FM)-A stated she had concerns about R25 being left alone in the bathroom due to her having multiple fainting episodes while on the toilet, stating she believes she had an episode most recently on 3/1/26 while on the toilet. FM-A stated they were not sure what was causing the fainting episodes, but the facility was aware she was having them. R25's care plan, lacked any mention of R25's fainting spells to include interventions for her safety or interventions for staff to take during or after a fainting spell. R25's Orders, dated 7/29/25, contained an order for DNR (do not resuscitate), do not transfer to ER (emergency room) for fainting episode less than 15 minutes. Call family immediately. R25's progress note, dated 12/30/25, indicated R25 had a fainting episode while sitting on the toilet and had a drop of blood coming from her mouth from possibly biting her tongue or cheek. R25's progress note, dated 11/12/25, indicated R25 passed out while being transferred from the toilet to her bed via a stand lift. During an interview on 3/18/26 at 9:36 a.m., nursing assistant (NA)-E stated R25 transferred via an easy stand and staff had to pretty much do everything for her. NA-E stated R25 has had three fainting spells in the past year that she was aware of, stating R25 will be on the toilet and just kind of tip over but that she could be left in the bathroom alone and would use the call light when she was done. During an interview on 3/19/26 at approximately 7:30 a.m., registered nurse (RN)-F stated she did not often work with R25 and she was not aware of any fainting spells but that R25 was able to be left alone in the bathroom. During an interview on 3/19/26 at approximately 11:30 a.m., clinical coordinator and registered nurse (RN)-E stated she was aware of R25's fainting spells and the thought was she maybe having vasovagal episode (a common, usually harmless, faint caused by an overactive nervous system, leading to a sudden drop in heart rate and blood pressure which can be caused when straining to defecate) but the family has also brought up concerns of possible seizures. CC-A stated the episodes seemed to mostly happen when she was on the toilet and that she did not feel R25 was safe to be left alone on the toilet. CC-A confirmed these episodes or safety precautions to not leave R25 alone on the toilet were not care planned or ordered and they should have been. During an interview on 3/20/26 at 8:10 a.m., the director of nursing (DON) stated she was aware of R25 having one or two fainting episodes on the toilet but was under the impression most of the episodes happened at night while R25 was in bed. The DON stated there should be something in place to protect R25 during the fainting episodes.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review the facility failed to ensure residents using a continuous positive airway pressure (CPAP) machine had appropriate orders for use to include equipment settings for 1 of 2 residents (R19) reviewed for respiratory care. Findings include:R19's annual Minimum Data Set (MDS) dated [DATE], indicated R19 had intact cognition, no rejection of care behaviors, and was diagnosed with heart failure, kidney failure, and diabetes. The MDS indicated R19 had a functional limitation in range of motion to both upper extremities, needed moderate assistance with toileting hygiene, was dependent for bathing, and needed moderate assistance for bed mobility. R19's care plan dated 12/22/25, indicated that staff were to assist R19 in applying his CPAP machine per MD/NP orders. R19's order summary dated 3/17/26, included multiple orders for weekly and daily cleaning and maintenance of R19's CPAP/BiPAP machine. The order summary included an order dated 6/9/25, to place R19's CPAP or BiPAP on at bedtime, check overnight, remove in the morning, clean the tubing, and fill the chamber with water before use. The order summary did not include equipment settings.R19's medication/treatment administration record dated 3/1/26 to 3/18/26 at 8:00 a.m., indicated R19's CPAP/BiPAP had been applied every night and removed every morning during the period. During an interview and observation on 3/17/26 at 10:52 a.m., R19 was observed in his room in his wheelchair with a ResMed Airsense 10 CPAP machine on his bedside table. R19 stated he wore his CPAP machine at night and had since prior to being admitted to the facility. During an interview and observation on 3/18/26 at 10:58 a.m., registered nurse (RN)-A stated he was unsure what R19's CPAP settings were, as the machines came preset and the nursing staff just started the machine every night for the resident. RN-A stated he was unsure where the settings would be documented but thought they should be found somewhere in R19's medical record.During an interview on 3/19/26 at 11:49 a.m., the nurse manager for the unit, RN-B, stated R19 had entered the facility with the CPAP machine and was unsure if they had any record of the settings, but did not think they did. RN-B stated she would review the medical record and provide the order for the settings if she found it. No order for settings was received. During an interview on 3/20/26 at 7:56 a.m., the director of nursing (DON) stated that usually, residents were admitted from the hospital or the community and already had their CPAP machine with preset settings. The DON stated that she would expect these orders to be to be a part of a resident's medical record. The facility's CPAP and BiPAP Management policy dated 1/2023, indicated that staff should review the care plan and the physician's orders if required, but did not give further instructions as to what these orders should include.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to ensure the consulting pharmacist (CP) identified and acted upon 1 of 5 residents (R5) reviewed who had psychotropic medications without an adequate medical diagnosis for ongoing use. Findings include:R5's quarterly Minimum Data Set (MDS) dated [DATE], indicated R5 had severely impaired cognition and was diagnosed with dementia and depression. The MDS indicated R5 did not have hallucinations, delusions, or rejection of care during the look-back period. R5's Medical Diagnosis summary dated 4/14/25, included a diagnosis of dementia with other behavioral disturbance dated 4/14/25, depression, a cognitive communication deficit, and an additional diagnosis dated 6/25/21 for dementia without behavioral/psychotic/mood disturbance or anxiety. R5's care plan dated 10/31/25, indicated R5 received antipsychotic medication for dementia with behavioral disturbance. The care plan indicated R5's 6.25 mg of Seroquel two times a day had been decreased to once a day at bedtime on 9/19/24. The care plan indicated that the benefits of the medication outweighed the risks of it use. The care plan included target behaviors of crying and talking about needing to get out. The antipsychotic medication use care plan's latest revision was 10/31/25. R5's Provider's Orders form dated 2/12/26, indicated R5 had an order to restart 6.25 milligrams (mg) of Seroquel (an antipsychotic medication) daily at 2 p.m. for a diagnosis of sundowning (a group of symptoms someone with dementia may experience as the sun sets). R5's provider progress note dated 2/12/26 at 12 a.m., indicated R5 had a diagnosis of vascular dementia, had sundowning association, and used Seroquel 6.25 mg every evening. The note indicated that after the provider had previously planned to discontinue the medication, they had talked with nursing staff and learned that the resident's sundowning started at 2 p.m. every day, and the resident became exit-seeking and wanted to call the police. The provider changed the time of the order to 2 p.m.R5's Pharmacy progress note dated 2/26/26 at 12:17 p.m., indicated R5's medication regimen had been reviewed by the pharmacist, and no irregularities had been identified, and no recommendations were being made. R5's Order Summary dated 3/18/26, included an order dated 2/12/26 for 6.25 mg of Seroquel daily at 2 pm for sundowning. During an interview on 3/19/26 at 9:53 a.m., licensed practical nurse (LPN)-A confirmed he was R5's nurse for the day and worked with her frequently. LPN-A stated, when asked what R5's use of Seroquel, that there were times when R5 would get a little agitated, so she received the medication, but was unsure of any further medical diagnosis for the use of Seroquel. During an interview on 3/19/26 at 12:01 p.m., the nurse manager for the unit, registered nurse (RN)-B, stated she had not realized that the Seroquel had been ordered for sundowning and thought it was weird. RN-B stated she would contact the provider and request that the order be changed to include an appropriate diagnosis. During an interview on 3/20/26 at 7:34 a.m., the CP, stated the pharmacist who usually covered this facility was on leave, but he had worked with the facility previously. The CP stated that when he would review a resident's medications and the resident was on an antipsychotic medication, he would ensure the medication had an appropriate diagnosis. The CP stated that if he had noticed that R5 had an order for Seroquel for sundowning, he would have sent a letter to the provider to double-check that the medication had an appropriate diagnosis. During an interview on 3/20/26 at 7:52 a.m., the director of nursing (DON) stated she would expect the pharmacist to review antipsychotic medications during their monthly reviews to ensure they had an appropriate diagnosis.The facility's Psychotropic Medication Use policy dated 11/2024 indicated the consultant pharmacist would review the resident's medical record for any irregularities, and these would be reported to the director of nursing services and the attending physician to be acted upon.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245312	A. Building B. Wing	03/20/2026

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure medications were administered at the ordered time resulting in worsened pain for 1 of 1 resident (R25) resulting in a significant medication error. Findings include:R25's quarterly minimum data set (MDS), dated [DATE], indicated R25 was admitted to the care facility on 7/26/23, was cognitively intact, and required substantial to maximum assistance with dressing, bathing and toileting. The MDS further indicated R25 received scheduled and as needed pain medication with a pain rating of 7/10 in the past five days. The national library of medicine reports that withdrawal symptoms from baclofen can start within hours of a missed dose to include rebound muscle spasticity and painful spasms. R25' s orders, printed 3/20/26, indicated R25 was receiving the following medications:Baclofen (muscle relaxant used to treat spasticity, specifically spasms, cramping, and tightness) 7.5 milligrams (mg) three times a day at 7:30 a.m., 1:00 p.m., and 6:00 p.m., for muscle spasms and 2.5 mg two times a day as needed for muscle spasms.Give AM meds around 7:30 a.m.R25's medication administration record (MAR), dated 3/1/26 - 3/19/26, indicated R25 rated her pain as 5/10 or higher on 30 shifts (recorded three times a day) and received as needed oxycodone for 9/10 pain on two occasions. R25's care plan, dated 8/14/23, indicated R25 was at risk for pain related to osteoarthritis, neuralgia and neuritis, and lumbar radiculopathy. During interview and observation on 3/17/26 at 10:00 a.m., R25 and family member (FM)-A were sitting in R25's room. FM-A stated R25 had frequent back pain and received Tylenol and baclofen three times a day for pain. FM-A voiced concerns about morning medications repeatedly being administered to R25 late, passed 11 a.m., and stated R25 was scheduled to receive her medications at 7:30 a.m. FM-A stated when medication administration was late, it caused R25 pain. R25 confirmed, stating she was in pain currently. R25 was also displaying visible signs of pain to include restlessness and facial grimacing. By 10:55 a.m., R25 had still not received her morning medications despite them being ordered for 7:30 a.m., administration. During interview on 3/17/26 at 10:58 a.m., trained medication assistant (TMA)-A stated she had not yet administered R25's 7:30 a.m., medications because she was waiting on the nurse to get R25's AREDS 2 (a vitamin for eye health). During an interview on 3/19/26 at 8:10 a.m., TMA-B stated when a specific time is identified for medication administration for a resident, it is expected the medication be given within one hour before and one hour after the specified time. TMA-A confirmed R25's morning medications were ordered to be given at 7:30 a.m. During an interview on 3/19/26 at approximately 11:30 a.m., registered nurse and clinical coordinator (RN)-E stated it would be expected that R25's medications be administered at 7:30 a.m., stating it was concerning that R25's morning medication were being administered past 11:00 a.m. RN-E stated they were aware of the TMA who struggled to administer R25's medication timely. During an interview on 3/20/26 at 8:10 a.m., the director of nursing (DON) stated R25 receiving her morning medication at 11:00 a.m. was an issue and it was expected that medication be administered timely, stating if an exact time for medication was ordered (i.e. 7:30 a.m.) it was expected to be followed. The DON stated R25 was expected to receive her 7:30 a.m. medications at that ordered time to help keep her comfortable. A facility policy, titled Medication Administration Policy, dated 5/2021, indicated the 8 rights of drug administration will be followed when administering all medication, including right time.

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F 0880 Level of Harm - Minimal harm or potential for actual harm 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 enhanced barrier precautions (EBP) were followed for 3 of 6 residents (R26, R51, R4) and failed to perform hand hygiene to reduce the risk of the spread of infection to others for 1 of 6 residents (R51) reviewed for infection control practices.Findings include: R26 R26's annual Minimum Data Set (MDS) dated [DATE] identified R26 had intact cognition and was dependent on staff for all personal cares including transfers. R26's diagnoses include obstructive uropathy (blockage preventing normal urine flow) and used an indwelling catheter (tube from bladder to a bag outside the body to drain urine). R26's physician orders (PO) dated 1/6/2026 stated Enhanced Barrier Precautions due to catheter. Wear gloves and a gown for the following High-Contact Resident Care Activities. Dressing Bathing/Showering Transferring Changing Linens Providing Hygiene Changing briefs or assisting with toileting. R26's care plan dated 4/12/24 included, I require enhanced barrier precautions due to an indwelling medical device. During observation on 3/16/26 at 7:32 p.m., R26's door to the hallway had an Enhanced Barrier Precautions sign attached and a personal protective equipment (PPE) cart was outside the room. During observation and interview on 3/17/26 at 7:47 a.m., nursing assistant (NA)-A combed R26's hair, repositioned her in her wheelchair, and then picked up R26's large urine drainage bag and attached it to the underside of her wheelchair. During this time NA-A did not wear a PPE gown. NA-A stated R26 was on EBP due to her coccyx wound and not the presence of a Foley catheter bag. NA-A stated she wore a PPE gown and surgical mask only when performing any type of perineal (genital area) care. During observation and interview on 3/18/26 at 11:03 a.m., NA-D entered R26's room with portable blood pressure monitor and thermometer unit and obtained blood pressure and temperature of R26 and then exited room after removing gloves and sanitizing unit. NA-D verified he did not wear a PPE gown or mask. NA-D stated, we only wear a gown when we change [R26] because of her wounds on her back and catheter. R51 R51's annual MDS dated [DATE] identified intact cognition and dependence on staff for all hygiene and personal cares. R51 had diagnoses of multiple sclerosis, neurogenic bladder and quadriplegia (paralysis of both arms and legs), and used an indwelling catheter (suprapubic catheter). R51's physician orders (PO) dated 1/6/2026 stated Enhanced Barrier Precautions due to catheter. Wear gloves and a gown for the following High-Contact Resident Care Activities. Dressing Bathing/Showering Transferring Changing Linens Providing Hygiene Changing briefs or assisting with toileting. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R51's care plan dated 4/12/24 state, I require enhanced barrier precautions due to an indwelling medical device. During continuous observation and interview on 3/17/26 from 10:51 a.m. to 11:40 a.m., NA-A and NA-B entered R51's room to transfer R51 from bed to wheelchair using a Hoyer lift (medical device that transfers a person from bed to chair and back again). Both were wearing gloves, PPE gown, and mask. NA-A and NA-B turned R51 from his back to his right-side laying hands on him. NA-B applied ointment to R51's buttock and then both NA-A and NA-B turned R51 back onto his back. NA-B then trimmed an abdominal pad to place around the stoma (opening in the abdomen where the urine drains into a bag). NA-B did not perform hand hygiene or change gloves during this process. NA-A applied an alcohol wipe to exit port of the catheter prior to emptying the urine into a graduated cylinder. NA-A emptied urine into the container and then applied a second alcohol wipe to the exit port. During this time, NA-A did not change her gloves or perform hand hygiene. Both aides assisted R51 to wheelchair using a sling and then adjusted his posture, clothes, and catheter bag once he was in the wheelchair. Upon exiting the room NA-B stated expectation to change gloves, every time I go from one body part to another. NA-B stated she could not recall if she changed her gloves from R51's buttock ointment application to the suprapubic catheter site. NA-A also stated they did not recall changing gloves or performing hand hygiene before emptying R51's catheter. During observation on 3/18/26 at 11:26 a.m., an unidentified staff member went into R51's room to answer a call light. R51 stated he wanted a drink of water. The unidentified staff member did not sanitize or wash hands upon entering R51's room. The unidentified staff member provided water and left the room after sanitizing hands. R51 stated there were times when staff failed to wear a PPE gown when emptying his catheter. During interview with director of nursing (DON) on 3/18/26 at 12:52 p.m., DON stated expectation, of all staff to wash or sanitize their hands prior to entering [any] resident room and on exit. DON stated, EBP is a weakness for us, and stated any time a staff member touched a resident who was in EBP they should be wearing a PPE gown, mask and gloves. She stated handling a catheter without wearing a PPE gown is not acceptable, and staff needed to know what direct patient contact means. DON also stated any time a staff member adjusted or assisted with moving a resident in their wheelchair they should be wearing a PPE gown, gloves and mask. In addition, staff must change gloves when providing cares from one area of the body to another. R4 R4's annual Minimum Data Set (MDS) dated [DATE], indicated R4 had an indwelling urinary catheter and was diagnosed with hypertension and diabetes. R4's Order Summary dated 3/19/26, indicated R4 utilized an indwelling urinary catheter, and catheter care was to be completed every shift. The order summary indicated R4 was on enhanced barrier precautions due to a catheter, so staff were to utilize gloves and gowns during high-contact resident care activities, including dressing, transferring, changing linens, providing hygiene, etc. During an interview and observation on 3/19/26 at 8:14 a.m., licensed practical nurse (LPN)-A was observed completing hand hygiene, applying gloves, and entering R4's room. LPN-A was not observed to put on a gown. A sign indicating R4 was on enhanced barrier precautions was observed on her door, and R4 was observed lying in bed. LPN-A approached R4, asked for her name and date of birth , then used a lancet to draw blood from one of R4's fingers. LPN-A then used a glucometer to take R4's (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	blood sugar reading. LPN-A then uncovered R4's stomach, leaning over her bed with his legs leaning against her covers. LPN-A then administered insulin (an injection used to lower blood sugar) into R4's stomach. LPN-A then removed his gloves and completed hand hygiene. R4 asks to be boosted up in bed, so LPN-A (not wearing any gloves or a gown) leaned over R4's bed, legs touching her bed, grabbed a sheet on the bed that was underneath R4, and attempted to boost her up in bed. When asked when a gown and gloves should be worn when a resident was on enhanced barrier precautions, LPN-A stated that it only needed to be worn when changing wounds or working with the catheter. Undated facility policy titled Infection Control Standard Precautions Facility policy titled CC Enhanced Barrier Precautions modified April 2025, identified EBP (targeted gowns and gloves) are used in conjunction with standard precautions and will be implemented during high contact resident care activities which include, When caring for residents with wounds or indwelling medical devices. In addition: 4. When performing high-contact resident care activities staff should: a. Perform hand hygiene b. [NAME] gloves and a gown c. Complete the high-contact activity d. Remove gloves and gown and dispose of in a trash can in the resident's room or if outside of the resident's room (e.g., shower/tub room or therapy gym) in a trash can contained within the area. e. Perform hand hygiene.