STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245319	A. Building B. Wing	04/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LA Crescent Health Services	101 South Hill Street LA Crescent, MN 55947

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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 0684 Level of Harm - Immediate jeopardy to resident health or safety 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 prevent complications of enteral feeding and failed to provide appropriate treatment and services for 1 of 1 resident (R5) reviewed who required tube feedings and medication administration through a gastrostomy tube (g-tube). This failure created the likelihood of serious harm for R5, including worsening symptoms of nausea and vomiting, and additional hospital visits. The immediate jeopardy (IJ) began on 4/8/26 when the facility failed to follow professional standards of medication administration through a g-tube, pharmacy directions for medication administration, identify the symptoms and side effects of incorrectly using the g-tube. Subsequently, R5 experienced nausea and vomiting and was sent to the hospital with a diagnosis of pneumonia. The administrator and director of nursing (DON) were notified of the IJ on 4/9/26 at 6:17 p.m. The IJ was removed on 4/13/26 at 4:07 p.m., however, noncompliance remained at a lower scope and severity of D, indicating no actual harm with potential for more than minimal harm that was not widespread.Findings include: R5's quarterly Minimum Data set (MDS) dated [DATE], indicated R5 had moderate cognitive impairment with no rejection of care. R5 required hydration and nutrition via a feeding tube (g-tube). R5 was admitted to the facility on [DATE] with an admission diagnosis of moderate protein-calorie malnutrition, dysphagia (difficulty swallowing), muscle weakness, type 2 diabetes, hypothyroidism (thyroid gland does not produce enough thyroid hormone, symptoms include fatigue, weight gain, cold intolerance, and depression), hyperparathyroidism (parathyroid gland produces too much hormone, symptoms include high blood calcium levels, feeling weak, nausea, vomiting, loss of appetite, constipation, and abdominal pain), and hypercalcemia (blood calcium level greater than 10.5 milligram (mg) per deciliter (dl) causing fatigue, nausea, vomiting, constipation, confusion, cognitive changes, and irregular heart rhythms). A review of R5's medical record identified the following hospitalizations/emergency room visits identified on: 1) 2/12/26: R5 was sent to the hospital after a fall with decrease cognition and returned to the facility on 2/22/26; the primary diagnosis was hypercalcemia. R'5 Power of Attorney (POA) was activated during this hospital visit and thereafter due to ongoing intermittent confusion. Record review of R5's progress notes indicated the following concerns prior to being sent to emergency room:2/6/26 at 11:31 p.m.: stated she was sick to her stomach, the record lacked provider notification2/7/26 at 5:13 p.m.: declined oral medication, she did not wish to take them, the record lacked provider notification2/7/26 at 10:54 p.m., stated she was feeling nauseous and just can't take them, referring to her medications, which she refused. The record lacked provider notification2/9/26 at 3:30 p.m.: R5 took her medications through her g-tube but vomited shortly after administration, record lacked provider notification2/11/26 at 2:07 p.m.: R5 refused all medications stating, her stomach can't handle it.2/12/26 at 10:13 a.m., sent to emergency room 2) 3/6/26: R5 was sent to the hospital as a result of increased nausea and vomiting and returned to the facility on 3/10/26; the primary diagnosis was hypercalcemia. Record review of R5's progress notes indicated the following concerns prior to being sent to emergency room:3/1/26 at 12:33 p.m.: R5's g-tube was flushed and R5 reported feeling nauseous after flush3/2/26 at 10:46 a.m.: R5's g-tube was flushed and R5 reported feeling nauseous after flush3/3/26 at 2:28 p.m., in-person visit with physician assistant (PA)-A, (continued on next page)

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

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	discussed R5's ongoing nausea, no new orders written3/4/26 at 5:28 p.m., notified by hospital team the calcium level is high from recent blood draw, increase cinacalcet to 90 mg, stop vitamin D, push fluids, and repeat calcium level on 3/6/263/6/26 at 12:56 p.m.: R5 vomiting again, instruction to send to emergency room3/10/26 at 4:55 p.m.: POA remains activated 3) 4/6/26: R5 was sent to the emergency room as a result of increased abdominal pain and returned to the facility on 4/6/26; the primary diagnosis was pleural effusion (collection of fluid around your lungs.) Record review of R5's progress notes indicated the following concerns prior to being sent to emergency room:3/17/26 6:06 p.m.: R5 experienced nausea and vomiting, no record of provider or POA notification3/29/26 at 12:07 p.m.: R5 experienced nausea and vomiting after morning medications, no record of provider or POA notification3/30/26 at 12:13 p.m.: R5 experienced nausea and vomiting after morning medications, no record of provider or POA notification3/31/26 at 3:40 p.m.: R5 experienced nausea and vomiting after medications, no record of provider or POA notification4/5/26 at 12:00 p.m.: R5 experienced right-sided abdominal pain that continues until 4/6/26 at 12:00 p.m., ongoing nausea, vomiting, pain; resident sent to emergency room 4) 4/8/26: R5 was sent to the hospital and returned to the facility on 4/9/26; the primary diagnosis was right-sided pneumonia (acute inflammation of the lung caused by an infection, commonly caused by aspiration.). Record review of R5's progress notes indicated the following concerns prior to being sent to emergency room:4/6/26 at 6:00 p.m.: returned from emergency room, R5 was noted to have a heavy stool burden, R5 refused laxatives, no record of provider or POA notification4/7/26 at 5:16 a.m.: R5 refused laxatives, no record of provider or POA notification4/7/26 at 12:22 p.m.: R5 refused laxatives, no record of provider or POA notification4/7/26 at 8:58 p.m.: R5 stated her upper right quadrant pain is worse, no record of provider or POA notification4/8/26 at 12:15 p.m.: R5 received daily medications and 150 ml water flush while positioned less than 30 degrees4/8/26 at 12:42 p.m.: R5 experienced nausea and increased right upper quadrant pain4/8/26 at 2:38 p.m.: R5 experienced nausea and vomiting after receiving 60 ml of the 150 ml water flush, did not proceed with entire amount due to vomiting, R5's care plan indicated the following:-administer tube feeding formula, hydration, and flushes per order-elevate HOB 30-45 degrees (did not provide direction for when and how long to elevate HOB) R5's care plan lacked resident-specific interventions to monitor or prevent recurrence of nausea, vomiting, and abdominal pain; to include the signs and symptoms of hypercalcemia; which include mental status changes, muscle spasms, abdominal pain, and constipation. Additionally, the care plan lacked assessment and interventions for the risk of fluid volume deficits. R5's provider order, dated 1/26/26, included tube feedings (Vital Advanced Formula at 100 milliliter (ml)/hour (hr) for 13 hours) via g-tube. R5 received 150 ml water flush in g-tube every 4 hours, including during tube feeding. R5 received 150 ml of water flush in g-tube after medication administration for the AM medication pass. R5's physician orders included:-levothyroxine (thyroid medication) 88 micrograms (mcg) via g-tube daily (instruction to give on an empty stomach and not with 4 hours of iron supplements or antacids)-prednisone (steroid) 4 milligrams (mg) via g-tube daily (instruction to take with food)-iron-vitamins oral liquid 15 ml via g-tube daily (instruction to take on an empty stomach or with food if it upsets stomach.-folic acid (vitamin) 1 mg via g-tube daily-apixaban (blood thinner) 2.5 mg via g-tube twice daily-metoprolol tartate (blood pressure) 12.5 mg via g-tube twice daily-senna (laxative) 8.6 mg via g-tube twice daily-cinacalcet (overactive parathyroid) 30 mg via g-tube twice daily-omeprazole-syrspend (antacid) SF Akla oral suspension 10 ml daily-ascorbic acid (vitamin C) 500 mg via g-tube daily During an interview on 4/7/26 at 11:47 a.m., physician assistant (PA)-A stated R5 has a complicated gastrointestinal (GI) tract. R5 has hyperparathyroidism and this is the source of her hypercalcemia. R5 is no longer a surgical candidate to have her parathyroid removed, symptom management has been the primary direction of care. PA-A stated electrolyte imbalances will be an ongoing concern for R5. PA-A stated she is unsure how often the nutrition team is working with R5 or how involved they are with her care. According to the American Society for Parenteral and Enteral Nutrition article, Medication via Enteral Feeding Tubes: A Clinician's Guide, located at (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	https://nutritioncare.org/wp-content/uploads/2026/04/Medications-Via-EN-Tubes.pdf, identified prior to administering medications through a g-tube, medications should be verified for right client, right medication, right dose, right time, right route, and right documentation. When administering medication through a g-tube, medications should be crushed and diluted with 15-20 milliliters (ml) of purified water separately. Additionally, the head of the bed (HOB) should be elevated at least 30-45 degrees during medication administration and for at least 30-60 minutes after medication administration to prevent aspiration and support safe, effective delivery of medication. Further, proper positioning supports breathing, reduces pressure on the abdomen, and improves resident comfort. Lastly, complications from g-tube misuse can lead to nausea, vomiting, abdominal pain, tube clogging, aspiration, and toxicities. During an observation on 4/8/26 at 9:39 a.m., registered nurse (RN)-A prepared R5's morning medication administration. RN-A removed and prepped the above-named medications and put each medication in a medication cup. RN-A did not know when the most recent tube feeds had completed. RN-A failed to identify the medication levothyroxine had a pharmacy warning to give on an empty stomach and not within 4 hours of iron supplements (prepped iron-multivitamin suspension) or antacids (prepped omeprazole suspension), which she was preparing to administer at the same time. RN-A failed to identify prednisone should be given with food (tube feeding ended at 5:42 AM.) RN-A failed to identify iron-multivitamin suspension should be given on an empty stomach. Additionally, RN-A prepped the iron-multivitamin suspension with 20ml instead of the ordered 15ml. Prior to medication administration, R5 required enhanced barrier precaution (EBP) due to an indwelling medical device (g-tube). RN-A failed to apply the appropriate personal protective equipment (PPE) prior to providing care. At time of administration, RN-A failed to ensure the head of the bed was 30-45 degrees, with the bed remaining at approximately 10 degrees and R5 slouched down in the bed. RN-A stated R5 received a 30ml water flush before medication administration, 30ml water flush in between each medication, and a 150ml water flush at the end of the medication administration. During medication administration, RN-A diluted each medication with approximately 2ml of water, which failed to dilute the medication enough to allow it to pass through the g-tube. When RN-A put the medication into the barrel of syringe attached to the g-tube, the medication was not diluted enough to flow, RN-A then begun adding additional unmeasured amounts of water and continued to add until the medication would flow; 2 medications required pressure from the syringe plunger to flow through the g-tube. During medication administration process, R5 stated she was having increased nausea and abdominal pain. RN-A failed to recognize R5 was still not at the correct position. During administration RN-A failed to flush the g-tube between medications levothyroxine and metoprolol. RN-A was unsure what effect this could have on R5. After administration was completed, RN-A failed to set the head of the bed up to 30-45 degrees; bed remained at approximately 10 degrees with R5 slouched down in bed. During an interview on 4/8/26 at 10:36 a.m., RN-A stated she was unsure how much additional water she had added to dilute medication enough to flow through R5's g-tube; she guessed it was approximately 5ml. RN-A stated with the complete medication administration and water flushes; R5 had received approximately 450 ml of liquid. RN-A stated she had not had g-tube education for some time. RN-A stated the facility had not had a resident that required tube feedings or had a g-tube for about a year or year and a half. RN-A stated she had been taking care of R5 since her admission in January. During an interview on 4/8/26 at 2:39 p.m., physician assistant (PA)-A stated the resident had been experiencing ongoing nausea and vomiting with intermittent abdominal pain since returning from the hospital on 3/10/26. When R5 returned to the facility on 3/10/26 her calcium level was 9.5. PA-A stated she expected facility staff to know the basic signs and symptoms of hypercalcemia, including mental status changes, nausea, vomiting, and constipation. PA-A stated she expected the nursing team to follow the standard of practice when administering medication via g-tube, including sitting the head of bed at 30-45 degrees during and after tube feeding and medication administration. Additionally, she was unsure of the amount of water needed to dilute the medication; however, she would anticipate this to be approximately 5-10 ml of (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	water, and the nurse should be keeping track of this to adjust the water flushes during administration. PA-A stated she relies on the pharmacist to know what medication can be given at what times in relation to the tube feeding and on the pharmacy team to tell her if there are any specific medication interactions. During observation on 04/08/2026 at 3:09 PM, emergency services arrived at the facility to take R5 to the emergency room; RN-A stated R5 had been experiencing worsening nausea and vomiting and abdominal pain. During an interview on 4/9/26 at 8:53 a.m., PA-B stated she was the hospitalist who cared for R5 during her 3/6/26 to 3/10/26 hospital admission. PA-B stated she had included a statement in her discharge summary that stated, We have asked the staff at your skilled nursing facility (SNF) receive additional education on management of your feeding tube. PA-B stated she included this statement because R5 had told her she felt the staff at the facility did not know how to use her g-tube. PA-B stated she would expect the facility providers to manage the calcium levels after discharge. PA-B expected the head of the bed to be elevated to 30-45 degrees during and after tube feedings and medication administration. PA-B stated medication interactions should be managed by the facility provider and pharmacist. PA-B stated medication administration times should be assessed by the facility provider and pharmacist. PA-B stated medications given with other medications or around tube feedings can have side effects for R5 that include nausea, vomiting, abdominal pain, increased absorption, or decreased absorption. PA-B stated mismanagement of the g-tube with both tube feedings and medication administration could result in complications for R5. These complications could include harm, injury, and in worst case, death. During interview on 4/9/26 at 9:59 a.m., pharmacist (PH)-A stated the hours and times of administration are determined by the facility provider, pharmacist, and manufacturer guidelines. PH-A stated R5 should be in an upright position during tube feedings and medication administration and up to an hour afterwards. Medication interactions should be managed by the facility provider and pharmacist. If medication interactions aren't completed, R5 could experience ineffective medications, medication side effects, and symptom side effects. PH-A stated medications such as prednisone should be taken with food to prevent nausea and vomiting. Medications such as levothyroxine, in this situation, should have been given before the tube feedings were started or several hours after tube feedings have stopped. Additionally, levothyroxine should be spaced at least 4 hours from the iron vitamin solution and the omeprazole solution. PH-A stated the medication errors should have been identified by the facility provider and pharmacist upon medication review at time of admission. During an interview on 4/9/26 at 11:22 a.m., licensed practical nurse (LPN)-B stated R5 had frequent nausea and vomiting. LPN-B stated they only track R5's bowel movements for output. LPN-B stated R5's emesis are not documented in R5's medical record. LPN-B described the process of administering medications via g-tube which did not include elevating head of bed during or after administration of medications or enteral feedings. During an interview on 4/9/26 at 11:42 a.m., registered nurse (RN)-B stated R5 was admitted to her unit at the hospital yesterday evening. Upon arrival at the hospital unit, R5 was nauseous and vomiting. R5 was given medication to resolve these symptoms. RN-B stated she had given R5 her normal medications this morning. RN-B stated the resident has not experienced nausea or vomiting since yesterday. RN-B stated R5 was able to take sips of water or clear liquids without experiencing nausea or vomiting. RN-B stated the resident must be sitting at least 30-45-degree angle during tube feeding and medication administration. RN-B stated if R5 receives tube feeding when not at the correct angle, she is at risk for nausea, vomiting, and abdominal pain. Additionally, she would be at a high risk for aspiration or aspiration pneumonia. During an interview on 04/09/2026 at 11:54 AM, PA-C stated frequently monitoring of calcium should be complete weekly until R5's calcium levels are stable, then monthly, then every six months. R5 has been on cinacalcet to manage her high calcium levels; she is on a consistent dose, but ongoing monitoring should still be weekly to bi-weekly. PA-C stated the most common symptoms of hypercalcemia included altered mental status, muscle cramps, and constipation. Nausea and vomiting aren't necessarily a symptom of hypercalcemia; but they are symptoms of the cinacalcet. PA-C stated if R5 was having nausea and vomiting, there is probably (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	another cause for her symptoms. PA-C stated she would expect the facility staff to know the signs and symptoms of hypercalcemia, medication side effects, and how to properly manage the g-tube during tube feedings and medication administration. PA-C stated if R5's g-tube was mismanaged, R5 could be at risk for harm, increasing symptoms of nausea and vomiting and abdominal pain. Additionally, improper positioning during tube feeding and medication administration could result in serious risk for aspiration or other complications. During an interview on 4/15/26 at 11: 46 a.m., pharmacist (PH)-B stated when a resident has been admitted to the facility, she reviews the discharge summary to verify medications and compare them to the facility medication administration record (MAR). If she notices any discrepancies, she will write a recommendation for the provider to review and determine appropriateness of medication; she would expect response from the provider in one week. PH-B stated she does not evaluate each medication for interactions; the pharmacy providing the medication will go through the interaction checker; the interaction warnings then get placed on the medication and the medication is delivered to the facility. PH-B stated she doesn't check when medications are administered in relation to the tube feedings; she would expect nursing to follow the administration directions from the pharmacy. PH-B stated it is important to follow the administration directions from pharmacy; but could not speak to the importance of accurate medication administration timing. During an interview on 4/7/26 at 3:15 p.m., vice president of success (VPS)-A stated nurses were educated about g-tubes annually and for regular competencies. VPS-A stated nurses can receive g-tube education sporadically; they didn't believe nursing staff were educated about the needs of R5 prior to her arrival. During an interview on 4/7/26 at 3:25 p.m., director of nursing (DON) stated she believed the facility provided education to staff about g-tubes but couldn't find the specific education. DON stated she would expect education to be given for g-tubes, tube feeding administration, medication administration, g-tube complications, and g-tube side effects or symptoms. DON stated the facility had not cared for a resident with a g-tube in about a year. DON stated, generally g-tube education is annually, she did not provide g-tube education to staff about this R5 and her specific needs. DON stated it would have been beneficial to have educated staff specifically about R5 so staff could be prepared for any complications. On 4/14/26 at 10:22 a.m., a call was placed to the facility Medical Director; no return call received. A facility g-tube education titled Enteral Nutrition and Drug Administration dated as provided on 12/22/25, this education failed to identify practice standards for medication administration and tube feeding administration. A facility policy titled Enhanced Barrier Precautions (EBP) dated 8/8/25, high-contact resident care activities include device care or use: feeding tubes. EBP should be followed when performing high-contact resident care activities. A facility policy titled Medication Administration dated January 2026, medications are administered in accordance with written orders of the prescriber. Timing of medication administration must align with manufacturer specifications. A facility policy titled Medical Director Responsibilities dated 4/22/25, the medical director's responsibilities include implementation of resident care policies, such as ensuring physicians and other practitioners adhere to facility policies on diagnosing and prescribing medications and intervening with a health care practitioner regarding medical care that is inconsistent with current professional standards of care. A Facility assessment dated [DATE], training and skills unique to resident population: our nurses are trained in enteral feedings; our facility not only conducts a skill assessment during floor orientation of nurses and nursing assistants but also conducts monthly competencies of various skills to ensure that annual training occurs to keep skills honed. The IJ that began on 4/9/26 was removed on 4/10/26 when it was verified the facility implemented the following:-The facility immediately addressed R5's medical needs (nausea, vomiting, medications, and g-tube management)-The facility developed strategies to prevent g-tube complications during and after tube feedings and medication administration (staff education, g-tube education, and medication administration via g-tubes)-The facility reviewed and updated if needed g-tube policies including medication administration through a g-tube, condition monitoring, and fluid management-R5's medications were reviewed by a pharmacist (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	and medication director to ensure appropriate timing is optimal to prevent nausea and vomiting-The facility developed processes to evaluate and monitor the side effects and effectiveness of medications-The facility educated staff on the policy and procedures to ensure consistency in the care of residents with g-tubes-The facility educated staff on the potential medication side effects and monitoring as well as the disease process for hypothyroidism, hyperparathyroidism (hypercalcemia). -The facility educated staff about tube feedings and the procedures and standards of practice of medication administration via a g-tube-Audit will be conducted by the DON or designee starting 4/10/26 on tube feeding administration, medication administration via g-tubes and positioning of residents with enteral nutrition or medications. Audits will be completed daily on varying shifts x7 days. Audits will continue no less than 3 times per week for 4 weeks or until substantial compliance is maintained. DON or designee will review facility charting daily to identify resident change in condition, to ensure proper documentation of assessments/evaluation and timely provider notification. These audits will be completed daily x7 days then with morning clinical 5 days per week for 8 more weeks or until substantial compliance is maintained. -Results of audits will be brought to Quality Assurance and Performance Improvement (QAPI) for review and recommendation-QAPI meeting on 4/10/26 to discuss with interdisciplinary team (IDT) and medical director to review findings and ongoing plan

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F 0841 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many Note: The nursing home is disputing this citation.	Designate a physician to serve as medical director responsible for implementation of resident care policies and coordination of medical care in the facility. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to ensure 1 of 1 medical director had appropriate oversight of policies and procedures and ensured appropriate medical care was being provided for 1 of 1 (R5) resident who experienced complications from tube feedings and medication administration through a gastrostomy tube (g-tube).Refer to 684 Findings include: R5's quarterly Minimum Data set (MDS) dated [DATE], indicated R5 had clear speech, no hearing disabilities, and used corrective lenses. R5 had moderate cognitive impairment with no rejection of care. R5 had no impairments of her upper extremities and used a walker. R5 was independent with eating, required set up/clean up assistance with oral hygiene, and required partial to moderate assistance with toileting, showering/bathing, dressing, and personal hygiene. R5 had occasional urinary incontinence but was always continent of bowel. R5 required hydration and nutrition via a feeding tube (g-tube). R5's current, undated care plan indicated the following:-urinary incontinence: report changes in skin integrity found during daily care-potential for pressure ulcer development:administer treatments as ordered, and monitor effectivenessfollow facility policies/protocols for the prevention/treatment of skin breakdownmonitor nutritional statusmonitor/document/report any changes in skin status: appearance, color, wound healing, signs and symptoms of infection, wound size (length x width x depth)-The need for a feeding tube/potential complications from that tube. R5 was to have no complications from the feeding tube. Staff were to administer formula and hydration and flushes per order. R5's care plan lacked identification of skin breakdown on R5's coccyx; further lacking goals and interventions for monitoring, treating, and documenting R5's actual skin breakdown. Additionally, R5's care plan lacked identification of R5's refusal of cares and treatments; further lacking goals and interventions to apply when R5 refused cares and treatments. R5's care plan lacked identification of R5's risk for fluid-volume imbalances; further lacking goals and interventions for monitoring, treating and documentation. R5's care plan lacked specific time requirements to elevate the head of the bed (HOB) to 30-45 degrees during and after tube feeding. Lastly, R5's care plan lacked specific symptoms, side effects, and monitoring of hypercalcemia, hypothyroidism, and hyperparathyroidism. R5's provider order, dated 1/26/26, included tube feedings (Vital Advanced Formula at 100 milliliter (ml)/hour (hr) for 13 hours) via g-tube. R5 received 150ml water flush in g-tube every 4 hours, including during tube feeding. R5 received 150ml of water flush in g-tube after medication administration for the AM medication pass. R5's physician's orders included:-levothyroxine (thyroid medication) 88 micrograms (mcg) via g-tube daily (instruction to give on an empty stomach and not with 4 hours of iron supplements or antacids)-prednisone (steroid) 4 milligrams (mg) via g-tube daily (instruction to take with food)-iron-vitamins oral liquid 15 ml via g-tube daily (instruction to take on an empty stomach or with food if it upsets stomach.-folic acid (vitamin) 1 mg via g-tube daily-apixaban (blood thinner) 2.5 mg via g-tube twice daily-metoprolol tartate (blood pressure) 12.5 mg via g-tube twice daily-senna (laxative) 8.6 mg via g-tube twice daily-cinacalcet (overactive parathyroid) 30 mg via g-tube twice daily-omeprazole-syrspend (antacid) SF Akla oral suspension 10 ml daily-ascorbic acid (vitamin C) 500 mg via g-tube daily R5's physician's orders lacked monitoring of electrolytes, monitoring accurate intake and output, managing fluid balance in relation to tube feedings and free water, medication interaction and interventions to prevent adverse effects, a process to monitor ongoing symptoms of nausea, vomiting, abdominal pain, and when staff should alert the provider when R5 refuses medications or treatments. During an interview on 4/7/26 at 11:47 a.m., physician assistant (PA)-A stated R5 has a complicated gastrointestinal (GI) tract. R5 has hyperparathyroidism and this is the source of her hypercalcemia. R5 is no longer a surgical candidate to have her parathyroid removed, symptom management has been the primary direction of care. PA-A stated electrolyte imbalances will be an ongoing concern for R5. PA-A stated she didn't have plans to order (continued on next page)

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LA Crescent Health Services	101 South Hill Street LA Crescent, MN 55947

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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 0841 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many Note: The nursing home is disputing this citation.	follow up bloodwork to monitor electrolytes because she thought the consulting services (Nephrology, Endocrinology) would be monitoring them. PA-A stated she was not sure what the electrolyte monitoring schedule would be. PA-A stated she is unsure how often the nutrition team is working with R5 or how involved they are with her care. She is unsure if the nutrition team was monitoring specifically intake and output. During an interview on 4/7/26 at 12:02 p.m., director of nursing (DON) stated the medical director could be available during survey; he was seeing patients at his outpatient clinic. Further, he had been the medical director at the facility for a short time and this position at the facility was new to him; his first medical director position in long-term care. During a follow up interview on 4/8/26 at 2:39 p.m., PA-A stated she relied on the pharmacist to know what medication can be given at what times in relation to the tube feeding and on the pharmacy team to tell her if there are any specific medication interactions. PA-A had not directly communicated to the facility consultant pharmacist about R5's medication needs in relation to her tube feedings. During an interview on 4/9/26 at 8:53 a.m., PA-B stated she was the hospitalist who cared for R5 during her 3/6/26 to 3/10/26 hospital admission. PA-B stated she expected the facility providers to manage the calcium levels after discharge as she was a member of the hospital consulting service and infrequently sees R5. PA-B stated medication interactions should be managed by the facility provider and pharmacist; additionally, medication administration times should be assessed by the facility provider and pharmacist. During an interview on 04/09/2026 at 11:54 AM, PA-C stated frequently monitoring of calcium should be complete weekly until R5's calcium levels are stable, then monthly, then every six months. R5 has been on cinacalcet to manage her high calcium levels; she is on a consistent dose, but ongoing monitoring should still be weekly to bi-weekly. PA-C stated the facility providers are responsible for monitoring electrolytes, she would not be requesting electrolyte levels unless she saw R5 again as outpatient or in the hospital. During an observation on 4/10/26 at 3:18 p.m., the DON and vice president of success (VPS)-A stated they were waiting for the medical director to sign off on the immediate jeopardy (IJ) plan of correction; stating, having a difficult time reaching him, he is seeing outpatients. The VPS stated she wasn't sure if he understood what an IJ was and the importance of lifting the IJ. On 4/14/26 at 10:22 a.m., a call was placed to the facility Medical Director; no return call received. A facility policy titled Medical Director Responsibilities dated 4/22/25, the medical director responsibilities included addressing issues related to coordination of medical care and implementation of resident care policies, ensuring the appropriateness and quality of medical care and medically related care, discussing and intervening (as appropriate) with a health care practitioner regarding medical care that is inconsistent with current standards of care.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review, the facility failed to ensure food was served in a timely manner to preserve desired temperatures of food for 4 of 4 residents (R1, R10, R15, R30) reviewed who expressed concerns for food temperatures and palatability. This had the potential to affect all residents who consumed food from the facility kitchen. Findings include: On 4/8/26 at 1:34 p.m., an informal resident council meeting was held with R10, R15 and R30. The residents were asked, as part of the meeting, about bedtime snacks which prompted a conversation regarding food. R30 stated that she eats in the dining room for her meals and her food was frequently served cold. R30 stated this had been an issue for a long time and had talked to staff about this. R10 stated today my food was ice cold even with the cover on it. R10 stated the facility started putting covers on the food and it isn't helpful. R10 stated he eats his meals in the dining room, and his meals are almost always cold when they should be hot. R10 stated he had talked to staff about this. R15 stated she eats in the dining room, and it had been an ongoing issue with getting served cold food when it should be hot. R1's quarterly Minimum Data Set (MDS) dated [DATE], identified R1 had no cognitive impairment, demonstrated no hallucinations or delusional thinking during the review period, and was independent with eating. During an interview on 4/6/26 at 2:56 p.m., R1 stated the food is cold and he must send it back a lot, it doesn't matter if he eats in the dining hall or his room; the food is always cold. The facility had the hardest time keeping eggs, mashed potatoes, and beans warm. He stated he has told them so many times and, no one ever does anything about it. During an observation on 4/7/26 at 8:13 a.m., R1 was observed in the dining hall tasting his food (French toast), he motioned for dietary staff to come to his table. R1 asked them to heat up his food. R10's comprehensive Minimum Data Set (MDS) dated [DATE], identified R10 had no cognitive impairment, demonstrated no hallucinations or delusional thinking during the review period, and was independent with eating. During an observation on 4/7/26 at 8:18 a.m., R10 was observed in the dining hall tasting his food (French toast, eggs), he motioned for dietary staff to come to his table. R1 asked them to heat up his food. R15's quarterly Minimum Data Set (MDS) dated [DATE], identified R15 had no cognitive impairment, demonstrated no hallucinations or delusional thinking during the review period, and was required setup/clean up assistance with eating. During an interview on 4/7/26 at 8:40 a.m., R15 stated the food is cold sometimes, and doesn't know why they have such a hard time keeping the food warm, especially when residents are in the dining hall. She has stopped telling staff about the cold food, they don't do anything to change how they keep things hot. R30's quarterly Minimum Data Set (MDS) dated [DATE], identified R30 had no cognitive impairment, demonstrated no hallucinations or delusional thinking during the review period, and was required (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	setup/clean up assistance with eating. During an interview and tray tasting on 4/7/26 at 12:37 p.m., dietary manager (DM)-A stated the plate covers in the dining hall, seen this morning, were just started today as a response to complaints of cold food. DM manager tasted food and noted the temperature of the food seemed appropriate to her. She does not attend resident council; she might at some point but right now she hasn't gone to any of the meetings. It is important to know how residents feel about the food so she can adjust based on their concerns. During an interview on 4/7/26 at 1:15 p.m., ombudsman (OM)-A stated residents at the facility started reaching out to her in October 2025 about the ongoing concerns with food temperatures and food being served cold. She also informed management about food menu options as well. During an interview on 4/13/26 at 10:04 a.m., DM-A stated residents frequently ask for foods to be reheated during meal services. Again, stated the lids on meal plates were started as a response to complaints about food temperatures; was unsure if they are helping with temperature or not. During an interview on 4/14/26 at 9:27 a.m., administrator stated she would expect residents to tell any facility staff about cold food. She stated she had not heard any concerns about cold food recently. Additionally, the plate lids weren't necessarily new, they just resumed the practice as an infection prevention method. Due to recent dietary staff changes and recommendations from the regional dietary staff, they had ceased this practice; but now had opted to bring it back. It is important to keep foods warm, so residents enjoy their food. A facility policy titled Food Temperatures dated 8/16/22, food must be cooked to appropriate temperatures, held appropriate temperatures.

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review, the facility failed to comprehensively assess and care plan to ensure competency and safety with self-administration of medication for 1 of 1 resident (R20) observed to be self-administering medication in their room.Findings include: R20's quarterly Minimum Data Set (MDS) assessment, dated 3/12/26, identified R20 had intact cognition. On 4/8/26 at approximately 7:20 a.m., R20 was observed sitting in her Broda chair (a type of positioning chair) in her room. R20 was administered her morning oral medications by registered nurse (RN)-A along with an inhaler after performing a respiratory assessment. RN-A prepared R20's nebulizer and placed the mask on R20's face. RN-A placed R20's call light pad on her lap and instructed her to turn her call light on when the treatment was completed. R20 stated she always puts the light on when she was finished with the treatment. On 4/8/26 at 7:52 a.m., assistant director of nursing (ADON) told RN-A that she had removed R20 nebulizer mask and performed the post - respiratory assessment. R20's April medication/treatment administration report (MAR), printed 4/14/26, included the following order:-Ipratropium-Albuterol Inhalation Solution 0.5-2.5 (3) milligram(mg)/3millilter(ml) (a combination of two medications in one solution used to help open airways and prevent worsening of airflow obstruction) - 1 dose inhale orally two times a day related to chronic respiratory failure with hypoxia with a start date of 3/12/26. The record indicated the medication was administered twice a day as ordered as of print date of MAR.The MAR lacked evidence that R20 was able to administer the medication independently after staff set up. R20's order summary report, dated 4/14/26, included the following order:-Ipratropium-Albuterol Inhalation Solution 0.5-2.5(3) mg/3ml - 1 dose inhale orally two times a day related to chronic respiratory failure with hypoxia with a start date of 3/12/26.The order summary report lacked an order or evidence that R20 was able to administer the medication independently after staff set up. R20's care plan, with an initiation date of 4/8/26 (after survey entrance) for self-administration of medications/treatments indicated nurse to set up Neb and place mask on resident for resident to complete without supervision. Nurse to return to take mask off and complete [NAME] respiratory assessment when treatment is complete. The care plan lacked evidence of identification of R20 being assessed and able to self-administer nebulizer prior to 4/8/26. R20's entire medical record was reviewed and lacked any assessment, physician order, or care planning which demonstrated R20 had been evaluated for their ability to self-administer medication. During an interview on 4/8/26 at 11:50 a.m., RN-A stated if a resident was cognitively aware, then the resident could be left alone with a nebulizer after set up. RN-A stated we know our residents and who can be left alone with nebulizer treatments. RN-A verified that R20 was left alone in her room with her nebulizer treatment this morning and this was the facility practice. RN-A stated R20 was able to push her call light when the treatment was completed to have the mask removed. RN-A stated a self-administration assessment should be completed for residents who self-administer medications. RN-A verified an assessment had not been completed for R20. During an interview on 4/8/26 at 11:56 a.m., ADON verified she had turned off R20's nebulizer treatment earlier today and removed her nebulizer mask. ADON verified R20 had been in her room alone. ADON stated if a resident was left in their room while completing a nebulizer treatment, it would be expected a self-administration of medication assessment would be completed as this would be self-administration of medication. ADON verified this had not been completed for R20. ADON stated she was going to complete an assessment. During an interview on 4/14/26 at 9:58 a.m., director of nursing (DON) stated the expectation would be if a resident was left with a nebulizer, a self-administration of medication assessment would be completed as it's important because the residents have to have the knowledge and understanding of what the medications is used for and why. DON stated they must be properly assessed. A facility policy titled Medication Administration Self-Administration by resident, reviewed 1/26, identified residents who desire to self-administer medications are permitted to do so with a prescriber's order (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and if the nursing care center's interdisciplinary team has determined that the practice would be safe and the medications are appropriate and safe for self-administration. Facilities must adhere to state specific laws and regulations. Furthermore, the document identified an assessment will be conducted to assess the resident's cognitive, physical and visual ability to carry out the responsibility.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to notify the resident representative/Power of Attorney (POA) about refusal of care and/or treatment for 1 of 1 resident (R5) reviewed for notification of changes.Findings include: R5's quarterly Minimum Data set (MDS) dated [DATE], indicated R5 had clear speech, no hearing disabilities, and used corrective lenses. R5 had moderate cognitive impairment with no rejection of care. R5 had no impairments of her upper extremities and used a walker. R5 was independent with eating, required set up/clean up assistance with oral hygiene, and required partial to moderate assistance with toileting, showering/bathing, dressing, and personal hygiene. R5 had occasional urinary incontinence but was always continent of bowel. R5 required hydration and nutrition via a feeding tube (g-tube). During a record review, R5's dismissal summary from the 2/12/26 hospitalization; the hospital physician stated, R5 is unable to receive and evaluate information effectively and communicate decisions necessary to manager her health. I recommend that the provisions contained in her Power of Attorney for Health Care be activated. During a record review, R5's POA was activated at the facility upon return from the 2/12/26 hospitalization. R5's care plan failed to address R5's refusals of care; additionally, the care plan failed to provide direction, so staff know when to notify provider and POA about refusals of care and medications. R5's orders failed to address R5's refusals of care; additionally, the orders lacked direction, so staff knew when to notify the medical providers and POA about refusals of care and medications. During record review, R5 refused medications or treatment on the following dates after the POA was activated:-3/6/26: refusal to have blood drawn, no POA notification-4/6/26: refused weight measurements, no POA notification-4/7/26 at 5:16 a.m.: refused constipation medication, no POA notification-4/7/26 at 12:22 p.m.: refused constipation medication, no POA notification-4/7/26 at 8:58 p.m.: R5 stated her pain was worse, no POA notification-4/8/26 at 4:58 a.m.: R5 stated her pain had gotten worse, refused all bowel medications, no POA notifications During record review, there was no documentation R5's POA had been notified prior to leaving the facility to go to the emergency room (ER) on 2/12/26 after suffering a fall at the facility. During an interview on 4/7/26 at 3:25 p.m., director of nursing (DON) stated R5's POA was activated when she returned from the hospital on 2/22/26. DON stated the POA was activated when R5 was in the hospital because R5 had increasing periods of confusion and lack of understanding about her medical status. DON confirmed R5 has been intermittently refusing cares or treatments since the beginning of February. DON stated the facility doesn't notify the POA of refusals, probably should if the resident doesn't understand her condition or how the meds work. DON stated it is important to notify the POA about refusal of cares and treatments, so the POA knows the treatments R5 is or isn't receiving. Attempted phone call to speak with R5 POA made on 4/7/26 at 10:45 a.m. During an interview on 4/8/26 at 2:39 p.m., physician assistant (PA)-A stated she was aware R5 had intermittently been refusing medications. PA-A stated she would expect to be notified of ongoing refusals. PA-A stated R5 did not have an order to notify facility providers or POA of refusals of cares or treatments. PA-A stated notification to the POA is important, so the POA understands what treatments R5 isn't getting and why. Additionally, the POA may have some influence with R5 and encourage R5 to accept the cares and treatments. A facility policy titled Change in Condition of the Resident dated 9/20/2022, the facility should immediately inform the resident representative when there is a need to alter treatment or a need to discontinue an existing treatment due to adverse consequences, or to commence a new form of treatment.

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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 interview and document review, the facility failed to ensure appropriate side effect monitoring for potential orthostatic hypotension (sudden drop in blood pressure what occurs when a person stands up after sitting or lying down) was completed for 1 of 1 resident (R15) reviewed for unnecessary medication use and who consumed antipsychotic medication.Findings include: Review of the 7/24/24, Olanzapine guidelines, located at: https://www.drugs.com/olanzapine.html#side-effects, identified olanzapine may cause serious side effects such as low blood pressure. Common side effects of olanzapine that affect 5% or more people who take it include postural hypotension (a drop in blood pressure when going from a lying or sitting position to standing). R15's quarterly Minimum Data Set (MDS), dated [DATE], identified R15 had no cognitive impairment and demonstrated no hallucinations or delusional thinking during the review period. Further, the MDS recorded R15 consumed antipsychotic, antidepressant, and antianxiety medications. During a record review, R15's orders reflected showed R15 received olanzapine 10 milligrams (mg) every evening before bedtime. Additionally, orthostatic BP laying, sitting, and standing; documented in the electronic medical record on the 9th of every month. During a record review, R15's orders reflected orthostatic BP laying, sitting, and standing; documented in the electronic medical record on the 9th of every month. During a record review of R15's orthostatic blood pressures from October 2025 through April 2026 identified there were no orthostatic blood pressures completed in October, January, March, or April During a record review of R15's pharmacy review and recommendations indicated the following. In:-4/7/26: did not address orthostatic blood pressures not done in March 2026 or April 2026-2/5/26: did not address orthostatic blood pressure not done in January 2026-11/4/26: did not address orthostatic blood pressure not done in October 2026 During an interview on 4/7/25 at 3:25 p.m., director of nursing (DON) stated R15 is currently taking an antipsychotic medication and should have her orthostatic blood pressure completed monthly. Additionally, if orthostatic blood pressures are ordered, it is her expectation they get completed monthly. When the consultant pharmacist performs the monthly review of medications, she would identify when orthostatic blood pressures aren't being completed and would put the reminder to complete them in her monthly recommendations. Lastly, orthostatic blood pressure measurements are important so that staff can identify adverse medication effects as soon as possible. During an interview on 04/15/2026 at 11:46 a.m., pharmacist (PH)-B stated when she completes the medication monthly review, she would review the orders to make sure there was an order to complete orthostatic blood pressures, not necessarily whether they were completed. She would expect nursing to complete the orders as written and document why they weren't done. Since it isn't routine for her to check the actual completion of orthostatic blood pressures, she would not put in the monthly medication review to remind staff to complete them. PH-B stated orthostatic blood pressure monitoring can be important because you can identify medication issues if a resident has positive orthostatic blood pressures. A policy titled Use of Psychotropic Medications, dated 4/27/25 showed the effects of the psychotropic medications on a resident's physical, mental, and psychosocial well-being will be evaluated on an ongoing basis, such as: upon physician evaluation, during the pharmacist's monthly medication review, during the MDS review, and in accordance with nurse assessments and medication monitoring parameter consistent with clinical standards of practice, manufacturer's specifications, and the resident's comprehensive care plan. The resident's response to the medications, including progress towards goals and presence/absence of adverse consequences, shall be documented in the resident's medical record.

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. Based on interview and document review, the facility to implement policies and procedures to ensure the State agency (SA) was notified in a timely manner for allegations of abuse for 1 of 1 residents (R32) whose allegations were reviewed.Findings include: R32's significant change in status Minimum Data Set (MDS) assessment, dated 1/24/26, identified R32 had moderately impaired cognition, required maximum staff assistance with dressing, moderate assistance with transfers and displayed no hallucinations, delusions, or rejection of care behaviors. R32's care plan, initiated on 6/20/23, identified R32 as a vulnerable adult at risk for potential abuse due to Alzheimer's disease and identified facility staff are education on reporting abuse and facility staff will follow facility policy and procedures. During an observation on 4/6/26 at 2:08 p.m., R32 was observed playing Bingo in the dining room with other residents and staff. At 3:36 p.m., R32 was observed sitting in her wheelchair in her room. R32 stated she couldn't remember how long she had been at the facility and directed the surveyor to ask her kids. R32 stated staff are nice and if she had any issues with staff, she would know what to do (as she raised her fist). During an interview on 4/7/26 at 12:32 p.m., complainant (C)-A stated they had witnessed nurse aide (NA)-G telling R32 to shut the [expletive] up and you need to stop acting like that. C-A stated she stopped the administrator the day it happened as the administrator was walking passed and she spoke to her. C-A doesn't recall exactly when this happened. C-A reported it to the State Agency as she didn't think anything at the facility was being done. A message was left for R32's power of attorney (POA)-A requesting a call back. A second message requesting a call back was left on 4/7/26 at 1:48 p.m. for R32's POA-A. A return call was not received. Grievances for the past 6 months for the facility were reviewed. No grievances were provided indicating any abuse being investigated for R32. Allegations of abuse reported in the past 6 months requested. No allegations were provided involving R32. R32's progress notes from 2/1/26 to 4/6/26 were reviewed. Progress notes lacked identification of abuse or abuse being investigated. During an interview on 4/7/26 at 4:51 p.m., the administrator stated the expectation was if any staff expected abuse, it would be reported to the administrator or the director of nursing immediately for further investigation. All staff are trained on abuse and the expectations of reporting abuse. If a staff member was talking to a resident, as stated above, that would be considered verbal abuse and would need immediate intervention which included reporting to the State Agency and a full investigation was to occur. She was not aware of this incident until today after surveyor interviewed C-A. She had not recalled if C-A stopped her in the hallway to talk to her or if C-A had told the administrator about any abuse concerns with R32. The administrator stated she had already begun a full investigation and filed a facility reported incident with the State Agency as it was a reportable incident as it would be considered an allegation of verbal abuse. During a follow up interview on 4/8/26 at 1:14 p.m., administrator shared the investigation that had been completed so far which included staff interviews, and review of R32's care plan, progress notes, trauma assessment, and skin checks, along with staff education, all notifications completed, and other resident interviews that had been provided at this time. During a follow up interview on 4/10/26 at 11:29 a.m., C-A stated they had gotten training on reporting abuse prior to initially reporting abuse. C-A stated since 4/7/26, they have gotten additional training on what to say when reporting abuse. C-A stated when they had stopped administrator in the hallway to report concerns of abuse, they didn't tell administrator they had actual concerns about alleged abuse. C-A stated she told the administrator they wanted to talk about R32 and NA-G but didn't tell the administrator what the concerns were. C-A stated she didn't follow back up with the administrator to explain she had concerns about alleged abuse. During an interview on 4/13/26 at 11:38 a.m., NA-G stated they had received education on abuse which included definitions and examples of abuse. The facility had called her in the last couple of days to talk about the incident with R32. During an interview on 4/14/26 at 9:57 a.m., director of nursing (DON) stated the expectation was if abuse was suspected, staff would intervene and communicate to management, (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and it would be reported immediately. During an interview on 4/14/26 at 11:27 a.m., administrator stated they developed a new procedure following the above noted abuse allegation, as it was determined staff needed additional education on how to report abuse, specifically need to make sure they are saying what they are trying to say. The administrator stated they are also implementing another step that will involve staff writing a statement to ensure nothing gets lost or was missed as it was with this incident. The facility Abuse, Neglect, and Exploitation policy, reviewed 7/15/22, indicated a statement of the facility was to provide protection for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property. The policy defined abuse as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. Furthermore, Verbal Abuse means the use of oral, written or gestured communication or sounds that willfully included disparaging and derogatory terms to residents or their families, or within their hearing distance regardless of their age, ability to comprehend, or disability. New employees were to be educated on abuse, neglect, exploitation and misappropriation of resident property during initial orientation and existing staff were to receive annual education through planned in-services and as needed, which included the reporting process for abuse. The facility was to report all alleged violations to the administrator, State Agency, Adult Protective Serves and to all other required agencies within the specified timeframe.

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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 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 notify the Office of the State Long-Term Cate (LTC) Ombudsman for 2 of 2 residents (R5 and R39) reviewed for hospitalizations and discharges. Findings include: R5's quarterly Minimum Data set (MDS) dated [DATE], indicated R5 had clear speech, no hearing disabilities, and used corrective lenses. R5 had moderate cognitive impairment with no rejection of care. R5 had no impairments of her upper extremities and used a walker. R5 was independent with eating, required set up/clean up assistance with oral hygiene, and required partial to moderate assistance with toileting, showering/bathing, dressing, and personal hygiene. R5 had occasional urinary incontinence but was always continent of bowel. R5's face sheet indicated R5 was originally admitted to the facility on [DATE]. R5 was hospitalized on [DATE] and 3/6/26. R5's Progress notes lacked any communication with the ombudsman after each hospitalization. Review of the notices to the Ombudsman, provided by the facility, identified the notice sent on 3/8/26 did not include R5's hospitalizations. During an interview on 4/7/26 at 12:52 p.m., ombudsman (OM)-A stated she had received a notification from the facility on 3/8/26; this notification contained information about hospitalizations, transfers, and discharges from November and December. OM-A stated she has not received any other notifications for the months of January, February, and March. During an interview on 4/10/26 at 10:22 a.m., social services (SS)-A stated he is responsible for sending notification to the ombudsman about hospitalizations, transfers, and discharges; these notifications are supposed to be sent monthly. SS-A confirmed he is behind a little with submitting the notifications to the ombudsman. SS-A stated ombudsman notification are important, so residents have advocate if they feel they have been wrongly hospitalized , transferred, or discharged . R39's admission Minimum Data Set (MDS) assessment, dated 2/17/26, identified R39 had moderately impaired cognition and required moderate to maximum staff assistance with activities of daily living (ADLs). R39's diagnoses included: displaced fracture of the base of the left femur, hip fracture, coronary artery disease (heart disease), heart failure (heart not functioning properly), hypertension (high blood pressure), and diabetes mellitus (condition where the body's ability to manage glucose is impaired). R39's progress dated 2/11/26 to 3/6/26 identified a progress note dated 2/11/26 at 10:53 a.m., indicated R39 was admitted to the facility. Another progress noted dated 3/6/26 at 5:43 p.m., indicated R39 discharged home to a new apartment from the facility. The progress notes lacked any communication with ombudsman during planning process of R39's discharge. Review of the notices to the Ombudsman, provided by the facility, identified a notice sent on 3/8/26 did not include R39. (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/13/26 at 9:56 a.m., social services (SS)-A stated that he had worked with R39 for her planned discharge. SS-A stated R39 had a case manager who also assisted with the discharge. SS-A stated he had not coordinated with the ombudsman or updated the ombudsman that R39 was planning to discharge prior to discharge. SS-A was unsure if he updated the ombudsman after R39 discharged . If R39 was not on the list provided to surveyors that was sent to the ombudsman's office the beginning of March, then the ombudsman had not been notified. A facility policy titled Transfer and Discharge (including AMA), reviewed 7/15/22, identified for non-emergency transfer or discharges which were initiated by the facility and return not anticipated, a copy of notice shall be provided to a representative of the Office of the State Long-Term Care Ombudsman. Furthermore, instances of emergency transfers/discharges, the social services director or designee, shall provide notice of transfer to a representative of the State Long-term Care Ombudsman via monthly list.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to develop and implement a person-centered care plan for 1 of 1 resident (R5) reviewed for comprehensive care plans.Findings include: R5's quarterly Minimum Data set (MDS) dated [DATE], indicated R5 had clear speech, no hearing disabilities, and used corrective lenses. R5 had moderate cognitive impairment with no rejection of care. R5 had no impairments of her upper extremities and used a walker. R5 was independent with eating, required set up/clean up assistance with oral hygiene, and required partial to moderate assistance with toileting, showering/bathing, dressing, and personal hygiene. R5 had occasional urinary incontinence but was always continent of bowel. R5 required hydration and nutrition via a feeding tube (g-tube). R5's hospital Discharge summary dated [DATE] noted the following:-Pressure injury to coccyx: red, blanchable: treatment offloading, barrier cream (Zinc, Petroleum) and open to air-Skin problem to left heel: clean, dry, intact: treatment offloading and open to air-Skin problem to right heel: clean, dry, intact: treatment open to air R5's current, undated care plan indicated the following:-urinary incontinence: report changes in skin integrity found during daily care-potential for pressure ulcer development:administer treatments as ordered, and monitor effectivenessfollow facility policies/protocols for the prevention/treatment of skin breakdownmonitor nutritional statusmonitor/document/report any changes in skin status: appearance, color, wound healing, signs and symptoms of infection, wound size (length x width x depth)-The need for a feeding tube/potential complications from that tube. R5 was to have no complications from the feeding tube. Staff were to administer formula and hydration and flushes per order. R5's care plan lacked identification of skin breakdown on R5's coccyx; further lacking goals and interventions for monitoring, treating, and documenting R5's actual skin breakdown. Additionally, R5's care plan lacked identification of R5's refusal of cares and treatments; further lacking goals and interventions to apply when R5 refused cares and treatments. R5's care plan lacked identification of R5's risk for fluid-volume imbalances; further lacking goals and interventions for monitoring, treating and documentation. R5's care plan lacked specific time requirements to elevate the head of the bed (HOB) to 30-45 degrees during and after tube feeding. Lastly, R5's care plan lacked specific symptoms and side effects of hypercalcemia, hypothyroidism, and hyperparathyroidism. R5's February, March, and April 2026 treatment administration record (TAR) noted to Monitor Mepilex dressing to buttock daily and change every 3 days and as needed when soiled beginning on 2/25/26. February, March, and April TAR lacked additional interventions to prevent or mitigate the worsening of skin issues such as position change schedule, heel protectors, barrier creams, toileting program, and pressure offloading interventions. During an interview on 4/7/26 at 11:47 a.m., physician assistant (PA)-A stated R5 is a complicated resident due to her multiple medical problems including hypercalcemia, hypothyroidism, hyperparathyroidism, nausea, vomiting, and gastrectomy tube (g-tube) a device surgically inserted through the belly directly into the stomach to deliver nutrition, fluids, and medications). PA-A stated she would expect to see a care plan for each of these areas. During an interview on 4/7/26 at 3:25 p.m., director of nursing (DON) stated R5 had a Stage I pressure ulcer; her care plan did not reflect any goals or interventions to care for and prevent worsening of the pressure ulcer. DON confirmed R5's care plan only indicated a risk for pressure ulcers; should have identified the actual Stage I pressure ulcer and contain interventions such as encouraging position changes, how often to monitor the coccyx, and treatment directions. The DON stated R5's care plan did not include information about her refusal of cares and treatments. The DON stated this care plan would identify the interventions that could have worked to encourage R5 to follow care and treatment orders. The DON stated R5 did not have a fluid-volume care plan. This care plan would be beneficial so staff could monitor and document fluids; this would be important for the resident since she had a G-tube. The DON stated this (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident is complicated, R5's care plan should probably have more detail about her medical conditions so staff could be aware of the symptoms or side effects. The DON stated a complete and comprehensive care plan is important so facility staff could identify, monitor, and treat R5's medical issues. During an interview on 4/8/26 at 2:39 p.m., PA-A stated she would expect a complete and comprehensive care plan; a comprehensive care plan allows the facility to adjust cares and interventions based on R5's needs and desire for treatment. PA-A stated she would specifically expect to see a care plan for skin breakdown, fluid intake-output, refusals of care, and tube feeding care. PA-A stated care plans are important because they can be tied into the treatment and medication tasks the facility staff perform; without a specific care plan, staff might not know how to provide specific types of care. A facility policy titled Comprehensive Care Plan dated 9/23/2022, the facility will develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that include measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment. These objectives will be used to monitor the residents' progress. Alternative interventions will be documented, as needed.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure professional standards of practice were followed during medication administration for 1 of 1 resident (R5) reviewed for gastrostomy tube (g-tube) medication administration.Findings include:According to the American Society for Parenteral and Enteral Nutrition article, Medication via Enteral Feeding Tubes: A Clinician's Guide, located at https://nutritioncare.org/wp-content/uploads/2026/04/Medications-Via-EN-Tubes.pdf, identified prior to administering medications through a g-tube, medications should be verified for right client, right medication, right dose, right time, right route, and right documentation. When administering medication through a g-tube, medications should be crushed and diluted with 15-20 milliliters (ml) of purified water (sterile or distilled) separately. Additionally, the head of the bed (HOB) should be elevated at least 30-45 degrees during medication administration and for at least 30-60 minutes after medication administration to prevent aspiration and support safe, effective delivery of medication. Lastly, proper positioning supports breathing, reduces pressure on the abdomen, and improves resident comfort. R5's quarterly Minimum Data set (MDS) dated [DATE], indicated R5 had clear speech, no hearing disabilities, and used corrective lenses. R5 had moderate cognitive impairment with no rejection of care. R5 had no impairments of her upper extremities and used a walker. R5 was independent with eating, required set up/clean up assistance with oral hygiene, and required partial to moderate assistance with toileting, showering/bathing, dressing, and personal hygiene. R5 had occasional urinary incontinence but was always continent of bowel. R5 required hydration and nutrition via a feeding tube (g-tube). R5's care plan indicated the following:-administer tube feeding formula, hydration, and flushes per order-elevate HOB 30-45 degrees (did not provide direction for when and how long to elevate HOB) R5's provider orders included tube feedings (Vital Advanced Formula at 100ml/hr for 13 hours) via g-tube. R5 was to receive 150ml free-water flush in g-tube every 4 hours, including during tube feeding. R5 was to receive 150ml of water flush in her g-tube after medication administration for the AM medication pass. R5's medication orders included:-levothyroxine (thyroid medication) 88 micrograms (mcg) via g-tube daily (instruction to give on an empty stomach and not with 4 hours of iron supplements or antacids) -prednisone (steroid) 4 milligrams (mg) via g-tube daily (instruction to take with food) -iron-vitamins oral liquid 15ml via g-tube daily (instruction to take on an empty stomach or with food if it upsets stomach. -folic acid (vitamin) 1mg via g-tube daily -apixaban (blood thinner) 2.5mg via g-tube twice daily -metoprolol tartate (blood pressure) 12.5mg via g-tube twice daily -senna (laxative) 8.6mg via g-tube twice daily -cinacalcet (overactive parathyroid) 30mg via g-tube twice daily -omeprazole-syrspend (antacid) SF Akla oral suspension 10ml daily -ascorbic acid (vitamin C) 500mg via g-tube daily Review of the April 2026, Medication administration Record (MAR) identified R5's last tube feeding ended at 5:42 AM. During observation and interview on 4/8/26 at 09:39 a.m., registered nurse (RN)-A prepped R5's morning medication administration. RN-A removed and prepped the above-named medications and put each medication in a medication cup. RN-A did not know when R5 had their last tube feeding completed. Prior to medication administration, R5 required enhanced barrier precaution (EBP) due to an indwelling medical device (g-tube). RN-A failed to apply the appropriate personal protective equipment (PPE) prior to providing care. RN-A failed to ensure the head of the bed was at 30-45 degrees, with the bed remaining at approximately 10 degrees while R5 was observed to be slouched down in the bed. RN-A stated R5 received a 30 ml water flush before medication administration, 30 ml water flush in between each medication, and a 150 ml water flush at the end of the medication administration. During medication administration, RN-A diluted each medication with approximately 2 ml of tap water, which failed to dilute the medication enough to allow it to pass through the g-tube. When RN-A put the medication into the barrel of syringe attached to the g-tube, the medication was (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	not diluted enough to flow. RN-A then began adding additional unmeasured amounts of tap water into the g-tube and continued to add water until the medication would flow; 2 medications she added additional tap water had to use the syringe plunger to apply pressure to advance the medication. During medication administration process, R5 stated she was having increased nausea and abdominal pain. RN-A failed to recognize R5 was still not at the correct positioning and was now experiencing side effects of incorrect positioning. During administration RN-A failed to flush the g-tube between medications levothyroxine and metoprolol. RN-A was unsure what effect this could have on R5. After administration was completed, RN-A failed to once again, to ensure R5's HOB was set to 30-45 degrees. During the above observation, it was identified RN-A failed to:Identify the medication, levothyroxine, had a pharmacy warning to give on an empty stomach and not within 4 hours of iron supplements (prepped iron-multivitamin suspension) or antacids (prepped omeprazole suspension). Identify prednisone should be given with food or that R5's iron-multivitamin suspension should be given on an empty stomach. prep the iron-multivitamin suspension with 15 ml and instead prepped with 20 ml of water. Prior to medication administration, R5 required enhanced barrier precaution (EBP) due to an indwelling medical device (g-tube). RN-A failed to apply the appropriate personal protective equipment (PPE) (gloves and gown?) prior to providing care. During an interview on 4/8/26 at 10:36 a.m., RN-A stated she was unsure how much additional water she had added to dilute medication enough to flow through tube; she guessed it was approximately 5 ml. RN-A stated with the complete medication administration and water flushes; R5 had received approximately 450 ml of liquid. RN-A stated she had not had g-tube education for some time. RN-A stated she should probably have sat R5 upright in bed, but she looked ok, so she administered the medication. RN-A stated the facility had not had a resident that required tube feedings or had a g-tube for about a year or year and a half. RN-A stated she thought it was fine to have used tap water for the medication dilution and water flushes and could not state what other types of water could be used for medication administration using a g-tube. RN-A stated she had been taking care of R5 since her admission in January. During an interview on 4/8/26 at 2:39 p.m., physician assistant (PA)-A stated the resident had been experiencing ongoing nausea and vomiting with intermittent abdominal pain since returning from the hospital on 3/10/26. PA-A stated she expected the nursing team to follow the standard of practice when administering medication via g-tube, including elevating the HOB at 30-45 degrees during and after tube feeding and medication administration and using sterile water to dilute medications and water flushes. Additionally, she was unsure of the amount of water needed to dilute the medication; however, she would anticipate this to be approximately 5-10ml of water and the nurse should be keeping track of this to adjust the water flushes during administration. PA-A stated abdominal pain and increased nausea, and vomiting could be side effects of having the HOB less than 30 degrees. During an observation on 4/8/26 at 3:09 p.m., R5 was seen being taken via ambulance to the local emergency room; RN-A stated R5 was sent to the emergency room due to vomiting since receiving medications this morning. During an interview on 4/9/26 at 8:53 a.m., physician assistant (PA)-B stated R5 should be seated at a 30-45-degree angle, at minimum, for tube feeding and medication administration and remain upright for 30-60 minutes after completion. PA-B stated medications should be given as ordered, especially right dose. PA-B stated after crushing medications, nurses should follow national standards for administering medication, to include medication dilution and free water flushes. During an interview on 4/14/26 at 10:29 a.m., director of nursing (DON) stated she expected R5 to have received the correct ordered dose of medication. The correct medication dilution should have been with 15 ml of sterile water, not tap water; to ensure the medication didn't get clogged in the tube. The HOB should be elevated to about 30-45-degrees for tube feedings and medication administration; to prevent aspiration, pain, and discomfort during feedings or medication administration. The DON stated she expected nurses to know what side effects R5 had related to receiving medications via g-tube, abdominal discomfort, nausea, vomiting, and constipation. Facility g-tube education titled Enteral Nutrition and Drug Administration dated as provided on (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	12/22/25, failed to identify practice standards for medication administration and tube feeding administration. A facility policy titled Medication Administration dated 1/26, medication dose should be verified three times before administration; when pulling medication, when dose is prepared, and before dose is administered. If a resident is tube-fed, staff were to ensure medications were crushed finely to prevent clogging. Medications were to be administered in accordance with written orders. Timing must align with manufacturer's specifications. Review of the 8/10/22, Verifying Placement of Tube Feeding policy identified before beginning a feeding, flushing the tube, or administering a medication via a feeding tube, proper placement and functioning of the tube was to be verified. A resident's HOB was to be kept elevated, at a minimum, of 30 degrees at all times to prevent aspiration and pneumonia. To verify tube placement, staff were to check that the enteral retention device was properly attached to the abdominal wall by gently tugging on the tube and noting the marking on the tube. Staff were to notify the supervisor and/or physician of abnormal findings. Next, they were to measure the length of the tube from insertion site to the tip and record the length prior to feedings etc per facility policy. If staff were unable to confirm placement, they were to notify the supervisor and/or physician. Staff were to also measure the pH (acidity) of gastric secretions by drawing back on the syringe slowly to obtain 5-10 ml of stomach aspirate, place into a cup, and dip a pH strip into the aspirate. Gastric fluid should usually have a pH of 5 or less. Staff were to then flush the tube with 30 ml of water or per physician's order. Staff were to monitor residents for complications such as respiratory distress which may indicate aspiration or tube dislodgement. A facility job description titled Registered Nurse dated 2/14/2018, the registered nurse (RN) adheres to the standards of care for the area, manages environment to maintain resident safety, and supervises the resident care activity. RNs prepares and administers medications and performs treatments as ordered by the physician.

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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 monitor and implement individualized interventions to prevent/mitigate the risk of pressure ulcers and/or deterioration for 1 of 1 resident (R5) reviewed for pressure ulcers.Findings Include: R5's quarterly Minimum Data set (MDS) dated [DATE], indicated R5 had clear speech, no hearing disabilities, and used corrective lenses. R5 had moderate cognitive impairment with no rejection of care. R5 had no impairments of her upper extremities and used a walker. R5 was independent with eating, required set up/clean up assistance with oral hygiene, and required partial to moderate assistance with toileting, showering/bathing, dressing, and personal hygiene. R5 had occasional urinary incontinence but was always continent of bowel. R5's current face sheet identified diagnoses of moderate protein-calorie malnutrition, dysphagia (difficulty swallowing), muscle weakness, type 2 diabetes, hypothyroidism (thyroid gland does not produce enough thyroid hormone, symptoms include fatigue, weight gain, cold intolerance, and depression), hyperparathyroidism (parathyroid gland produces too much hormone, symptoms include high blood calcium levels, feeling weak, nausea, vomiting, loss of appetite, constipation, and abdominal pain), and hypercalcemia (blood calcium level greater than 10.5 milligram (mg) per deciliter (dl) causing fatigue, nausea, vomiting, constipation, confusion, cognitive changes, and irregular heart rhythms). R5's hospital Discharge summary dated [DATE] noted the following:-Pressure injury to coccyx: red, blanchable: treatment offloading, barrier cream (Zinc, Petroleum) and open to air-Skin problem to left heel: clean, dry, intact: treatment offloading and open to air-Skin problem to right heel: clean, dry, intact: treatment open to air R5's care plan indicated the following:-urinary incontinence: report changes in skin integrity found during daily care-potential for pressure ulcer development: -administer treatments as ordered, and monitor effectiveness-follow facility policies/protocols for the prevention/treatment of skin breakdown-monitor nutritional status-monitor/document/report any changes in skin status: appearance, color, woundhealing, signs and symptoms of infection, wound size (length x width x depth) R5's care plan lacked resident-specific interventions to prevent or mitigate pressure ulcers that included reposition changes, specialty pressure redistribution boots for heels, toileting program to prevent wet skin, specialty padding for chairs, and barrier protection creams. R5's February, March, and April 2026 treatment administration record (TAR) noted to Monitor Mepilex dressing to buttock daily and change every 3 days and as needed when soiled beginning on 2/25/26. February, March, and April TAR lacked additional interventions to prevent or mitigate the worsening of skin issues such as position change schedule, heel protectors, barrier creams, toileting program, and pressure offloading interventions. R5's weekly skin assessments were completed 1/23/26, 1/30/26, 2/7/26, 3/3/26, 3/27/26, and 4/3/26, stating no skin issues. The weekly skin assessments failed to identify R5's coccyx stage I pressure injury, ongoing monitoring, and ongoing assessments. During an interview on 4/7/26 at 11:31 a.m., R5 stated she does have breakdown on her buttocks. R5 stated the staff at the facility put a covering over it every few days; sometimes it gets wet when she is incontinent, so they must replace it then too. R5 is unsure if the skin breakdown is better or worse because she can't see it. Sometimes her buttocks and her heels get sore; but she doesn't get up much so that won't change much. R5 doesn't remember if facility staff have asked her to reposition herself or offered to assist her to reposition. R5 prefers to sit up because she gets nauseous a lot. During an observation and interview on 4/7/26 at 11:47 a.m., physician assistant (PA)-A stated she was not aware R5 had any skin breakdown on her coccyx and awas unaware of fragile skin on her heels. PA-A and the director of nursing (DON) evaluated R5's coccyx, PA-A stated this was a stage I pressure ulcer. Additionally, the mepilex dressing on the coccyx was not placed correctly to prevent further skin breakdown. PA-A stated she would expect to see a pressure ulcer care plan with interventions to prevent further breakdown. During an interview on 4/7/26 at 12:02 p.m., DON stated R5 came back from the hospital (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	in February with a stage I pressure ulcer. DON stated the facility ordered the mepilex for her coccyx, but she acknowledged the facility did not update the care plan or TAR to include interventions to prevent or mitigate skin breakdown. DON was unaware about the fragile skin on her heels; acknowledged R5 should have had interventions in place to prevent pressure injuries of her heels. During a follow up interview on 4/7/26 at 3:25 p.m., DON stated R5's care plan was appropriate when she first arrived in January; but should have been updated upon her return in February to include interventions to prevent or mitigate skin breakdown. DON confirmed R5 had a current stage I pressure ulcer. Additionally, the DON confirmed the facility had not been assessing the coccyx weekly since 3/4/26. The DON stated it is important to implement a complete resident-specific care plan to prevent additional skin breakdown and alterations. A facility policy titled Pressure Injuries and Non-Pressure Injuries dated 7/20/22, the facility will complete a comprehensive assessment to identify risk factors for the development of pressure injuries and put in place measures intended to achieve the goal of prevention of pressure injuries in our residents. For those residents admitted with, or who subsequently developed a pressure injury or impaired skin integrity, they will receive care, treatment, and services that seek to promote healing, prevent infection, and prevent further development of pressure injuries/impaired skin integrity.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to monitor daily oral intake and daily output; additionally, the facility failed to develop a system to monitor and assess daily intake and output for 1 of 1 resident (R5) reviewed who required nutritional and hydration support via a gastrostomy tube (g-tube).Findings Include: R5's quarterly Minimum Data set (MDS) dated [DATE], indicated R5 had clear speech, no hearing disabilities, and used corrective lenses. R5 required hydration and nutrition via a feeding tube (g-tube). R5's current face sheet identified diagnoses of moderate protein-calorie malnutrition, dysphagia (difficulty swallowing) requiring the placement of a gastrostomy tube (g-tube) for nutrition and medication administration. R5's care plan dated 1/26/26 indicated R5 required tube feeding, hydration, and flushes per order, check tube placement prior to meds and feedings, elevating head of bed 30-45 degrees, care of tube per orders, and report signs of aspiration or intolerance of feeding. R5's care plan lacked identification for a risk in decreased hydration, lacked the specific signs and symptoms of aspiration, lacked resident-specific interventions to mitigate complications when using the g-tube, and lacked guidance and collaboration for monitoring fluid balance and imbalance. R5's current physician orders included tube feedings (Vital Advanced Formula at 100 milliliters (ml)/hour (hr) for 13 hours) via g-tube. R5 received 150 ml water flush in g-tube every 4 hours, including during tube feeding. R5 received 150ml of water flush in g-tube after medication administration for the AM medication pass. R5's orders lacked a clear monitoring system for intake and output including urine output, emesis amounts, amount of bowel movement, and amount of oral intake. R5's nutrition assessments dated 1/22/26, 3/2/26, and 3/16/26: section 30 failed to accurately identify how much oral intake the resident received (to adjust free water amounts), section 36 failed to identify gastrointestinal (GI) concerns such as nausea and vomiting, and section 44 failed to identify the amount of emesis the resident experienced (to know when to adjust free water amounts). R5's electronic medical record lacked collaboration, assessments, and outcome about who would be overseeing and managing daily intake and output in relation to the amount of tube feeding and free water flushes R5 should have received to maintain adequate fluid and nutrition. Additionally, the medical record and testing lacked collaboration and follow up to monitor and assess previously known electrolyte imbalances (high calcium, low potassium, high sodium) with a previously low Albumin level of 3.0 (could indicate malnutrition) on 1/6/26. During an interview on 4/7/26 at 11:31 a.m., R5 stated they give her a lot of water during the day and then in the evening they start her tube feedings; she thinks it is just too much liquid for [her] to handle, and she gets nauseous and vomits at times. R5 stated she wasn't sure who kept track of all that liquid going in, but she felt like it was too much. During observation and interview on 4/7/26 at 11:47 p.m., physician assistant (PA)-A had entered R5's room to evaluate her pressure ulcer; upon entering, the resident was vomiting and handed the emesis bag to the nurse. The emesis bag contained approximately 300ml of vomit; a later record review noted this amount was not documented in a treatment administration record (TAR) nor a progress note. Additionally, the TAR and task list did not contain an option to document any output. PA-A stated R5's GI tract was complicated due to her hyperparathyroidism resulting in high calcium levels; symptom management is the primary treatment option as R5 is no longer a surgical candidate. She was not aware how often nutrition is involved with her care. She was not actively monitoring daily intake and output. She stated she also did not have any laboratory orders for blood draws to assess electrolyte imbalances; the teams in the hospital might be managing that. During an interview on 4/7/26 at 3:25 p.m., director of nursing (DON) stated R5's tube feeding care plan should have been more resident-specific to include aspects of care such as head-of-bed elevation, medication administration, g-tube complications, and symptoms and side effects. The DON acknowledged they should have been monitoring R5's intake and output more (continued on next page)

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	245319	A. Building B. Wing	04/14/2026

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	closely, especially the emesis amounts. Fluid balance is important for R5 since she is receiving tube feedings and free water flushes. Staff needed to make sure her hydration and nutrition are adequate. A facility g-tube education titled Enteral Nutrition and Drug Administration dated as provided on 12/22/25, this education failed to identify practice standards for medication administration and tube feeding administration.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on observation, interview, and document review, the facility failed to ensure oxygen tubing was changed according to standards of care to prevent respiratory infections for 1 of 1 residents (R16) who required oxygen for chronic respiratory failure with hypoxia (a condition where the lungs are unable to adequately oxygenate the blood).Findings include: R16's quarterly Minimum Data Set (MDS) assessment, dated 2/11/26, identified R15 had intact cognition with no hallucinations, delusions, or rejection of care with admission date of 11/21/25. R16's admission record indicated on 2/18/26, R16's primary diagnosis was end stage renal disease with secondary diagnoses of chronic respiratory failure with hypoxia, biventricular heart failure (heart not working correctly), dependency on supplemental oxygen, unspecified right bundle-branch block (condition where electrical conduction in the heart is impaired), thoracis aortic ectasia (dilation or bulging in aorta in the chest), and atrial fibrillation (heart not beating correctly). Additional secondary diagnosis, dated 1/21/25, included: pulmonary hypertension (high blood pressure in the arteries of the lungs that strains the heart), and pleural effusion (buildup of excess fluid between the layers of the pleura surrounding the lungs). During an interview on 4/6/26 at 4:08 p.m., R16 was observed to be sitting in his wheelchair receiving oxygen via nasal canula from an oxygen concentrator at 2 liters(l)/minute. R16's oxygen tubing did not have a date or label on it. R16 was observed to have a portable oxygen tank on the back of his wheelchair with the oxygen tubing with nasal cannula attached wrapped around it with no date on it. R16 was not sure when the oxygen tubing had been changed. R16's care plan, printed 4/7/26, identified R16 was at risk for respiratory impairment related to chronic respiratory failure with hypoxia with an intervention to administer oxygen per MD orders. The care plan lacked any indication on how often the oxygen tubing should be changed or who would be responsible for changing the oxygen tubing. R16's Order Summary Report, dated 4/6/26, included the following orders:- 2L continuous oxygen via nasal cannula. Concentrator and cylinders with contents and regulators with a start date of 2/18/26. The Order Summary Report lacked evidence of an order to change oxygen tubing. R16's medication and treatment administration record (MAR/TAR) for 4/1/26 to 4/14/26 included the following orders:-change oxygen tubing and humidifier bottles weekly. Date tubing in the afternoon every Thursday with a start date of 4/16/26.- Change oxygen tubing and humidifier bottles weekly. Date tubing as needed for visibly soiled or known contamination with a start date of 4/9/26. This order had a start date after survey entrance.-Oxygen at 2L/minute via nasal cannula every shift with a start date of 4/9/26 R16's Medication Administration Record and Treatment Administration Record (MAR/TAR) for March 2026 was reviewed and lacked any order for oxygen use or changing of oxygen tubing or oxygen supplies. R16's task log was reviewed and did not include any change of oxygen tubing. R16's progress notes from 3/1/26 through 4/7/26, made no mention of any oxygen tubing having been changed by staff. Observation and interview ON 4/7/26 at 8:29 a.m., of R16 identified he was observed sitting in his room in his wheelchair and reported he just got done eating. R16's oxygen tubing from the oxygen tank on the back of the chair was observed to be partially on the floor with no date on it. R16's oxygen tubing from the concentrator, which R16 was observed wearing, did not have a date on it. R16 stated the facility will change the tubing when it doesn't fit but couldn't explain what that meant or when the last time the tubing was changed. At 12:17 p.m., R16 was observed in the dining room for lunch. R16 was observed to have oxygen on via nasal cannula from his portable tank located on the back of his wheelchair. The oxygen tubing remained undated or labeled. On 4/8/26 at 9:55 a.m., R16 was observed to be leaving the facility. R16 was observed to have nasal cannula on and receiving oxygen from portable oxygen tank located on the back of his wheelchair. The oxygen tubing remained undated or labeled. On 4/9/26 at 2:53 p.m., R16 was observed propelling self in wheelchair in his room. R16 was observed receiving oxygen via nasal cannula from the portable tank located on the back of his wheelchair. The oxygen tubing, including the nasal cannula, from the oxygen concentrator was noted to be laying in a box on the floor. Neither oxygen tubing was dated or (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	labeled. R16 stated he was unsure when the oxygen tubing was last changed. During an interview on 4/9/26 at 2:54 p.m., NA-C stated they are familiar with R16. Staff put oxygen on and off residents including R16. NA-C stated nursing assistants do not change oxygen tubing. NA-C observed R16's oxygen tubing and verified the set of oxygen tubing (from the oxygen tank or oxygen concentrator) was dated or labeled. NA-C stated they are unsure when it was last changed as it was not dated. During an interview on 4/10/26 at 12:54 p.m., nursing assistant (NA)-A stated they do not change the oxygen tubing for residents. Staff only turn the oxygen on and off and do not adjust any settings. NA-A thought it was the nurse's responsibility to change the tubing as nurse aides have never changed oxygen tubing. During an interview on 4/10/26 at 1:03 p.m., registered nurse (RN)-A stated oxygen tubing and supplies should be changed weekly to prevent infections and the nurses are responsible for this. During an interview and document review on 4/10/26 at 1:04 p.m., RN-C stated oxygen tubing should be changed weekly, and nurses were responsible for ensuring that was completed. RN-C stated there would be an order to change the oxygen tubing. RN-C stated it was expected to date and label the oxygen tubing also. RN-C reviewed R16's medical record and verified the order to change R16's oxygen tubing was entered on 4/9/16 (after survey entrance) and there was no previous order. RN-C stated it was important to change oxygen tubing to prevent infection and prevent build up in the nasal cannula. During an interview on 4/10/26 at 3:21 p.m., the assistant director of nursing (ADON) stated the expectation was oxygen tubing was changed weekly for infection control purposes as not changing it can contribute to respiratory illnesses. The expectation would be for tubing and all supplies to be dated and labeled. The ADON verified there were no additional nursing or physician's orders prior to 4/9/26, to change R16's oxygen tubing or humidifier bottles and there should have been. On 4/14/26 at 9:53 a.m., the director of nursing (DON) stated the expectation would be oxygen tubing would be changed weekly and as needed to help decrease risk of infection as not changing it can put a resident more at risk for infection. This was to be documented on the MAR/TAR. Review of the current, undated Northwest Respiratory Services instruction sheet for oxygen use the facility used for direction for staff, identified staff were to change tubing every month and the nasal cannula every week.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. Based on interview and document review, the facility failed to implement or maintain an appropriate communication and collaboration system with an outside dialysis clinic to promote continuity of care and reduce the risk of complication (i.e., missed orders, insufficient preparation for treatment), ensure contact information for dialysis clinic was on the care plan and ensure orders were accurate for monitoring dialysis site for 1 of 1 residents (R16) reviewed for dialysis care and services. Findings include: R16's quarterly Minimum Data Set (MDS) assessment, dated 2/11/26, identified R16 had intact cognition with no hallucinations, delusions, or rejection of care. R16 required maximum amount of assistance or was dependent on staff for all Activities of Daily Living (ADLs) except showering (which R16 refused) and oral hygiene/eating which required staff set up. In addition, the MDS outline R16 received hemodialysis while a resident at the facility. R16's admission record indicated on 2/18/26, R16's primary diagnosis was end-stage renal disease. A secondary diagnosis, dated 11/21/25, included dependence on renal dialysis. During an interview on 4/6/26 at 4:08 p.m., R16 stated he goes to dialysis three days a week and had been on dialysis for about 8 months. R16 stated his dialysis access site was located on his right upper chest (a central venous catheter (CVC)) and showed the surveyor. R16's dialysis access site was covered with a bandage. R16's care plan, printed 4/7/26, indicated R16 had chronic kidney disease: end stage renal disease and dependence on renal dialysis with the following interventions:Check access site for lack of thrill/bruit, evidence of infection, swelling. or excessive bleeding per facility guidelines. Report abnormalities to MD.Confer with MD (physician) and/or dialysis treatment center regarding changes in medication.Coordinate dialysis care with dialysis treatment center.Dialysis 3 times/week at [general clinic name] M/W/F. Sack Lunch to be sent with.Diet per MD orders. Initiated on 12/3/25Fluid restriction per MD orders.Monitor vital signs as ordered.No blood pressure, IVS, or lab draws from right arm.Obtain labs as ordered and notify MD of results.R16's care plan lacked contact information for dialysis clinic including the phone number and address, the type of dialysis access site R16 had, appropriate monitoring for the type of dialysis access site, and evidence or direction on how or how often the facility would coordinate or collaborate with the offsite dialysis clinic. R16's Order Summary Report, dated 4/7/26, included the following orders:Dialysis - nurse must complete a post-dialysis UDA (assessment) in the afternoon every Monday, Wednesday, Friday with a start date of 11/24/25.Dialysis - nurse must complete a pre-dialysis UDA, print and send with resident to dialysis in the morning every Monday, Wednesday and Friday with a start date of 11/24/25.Do not obtain blood pressure or blood draws on the dialysis access site - right arm with a start date of 11/21/25.Enhanced barrier precautions related to dialysis every shift with a start date of 11/21/25.Fistula/AV Graft Site: Location right IJ (internal jugular vein) - Monitor site for presence of thrill, bruit, and signs and symptoms (s/s)x of infection. Notify MD for any abnormal findings. every shift with a start date of 11/24/25. Although this was initiated as an order, there was no indication R16 actually had a fistula or graft and no evidence the facility had clarified this order for accuracy.Hemo Dialysis (right tunneled catheter) (CVC) three times a week on Monday/Wednesday/Friday for dialysis at 11:00 a.m. with a return pick up time of 3:00 p.m. with a start date of 11/24/25.If the dialysis site is oozing, apply moderate pressure until bleeding subsides. (Do not use pressure dressings or bandages that will restrict blood flow. If bleeding continues, resident to be evaluated by physician for further intervention and dialysis center to be notified.) every shift as needed with a start date of 11/21/25. R16's Medication Administration Record and Treatment Administration Record (MAR/TAR) for March and April 2026 identified:Dialysis - nurse must complete post-dialysis UDA (assessment) in the afternoon every Monday, Wednesday, Friday with a start date of 11/24/25. All of which were documented as completed except 3/20/26 which was blank.Dialysis - nurse must complete pre-dialysis UDA, print and send with resident to dialysis in the morning every Monday, Wednesday and Friday with a start date of 11/24/25. All of which were documented as (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	completed.Hemo Dialysis (right tunneled catheter) three times a week on Monday/Wednesday/Friday for dialysis at 11:00 a.m. with a return pick up time of 3:00 p.m. with a start date of 11/24/25. All of which were documented as completed.Remove dressing to fistula/graft site 4-6 hours post dialysis. Dialysis over at approximately 2-230pm most days, dressing should get removed at approximately 6/630-8pm in the evenings on M/W/F with a start date of 11/24/25 and end date of 4/6/26. Documentation indicated this was completed all days except 4/6/26. Although this was initiated on the TAR, there was no indication R16 actually had a fistula or graft and no evidence the facility had clarified this order for accuracy. The CVC site was not mentioned that staff should be only inspecting the dressing for signs or increased bleeding or infection surrounding the site with specific instructions to call the dialysis center (ESRD) if the dressing needed to be changed or removed, as it would be done weekly in the ESRD setting.If dialysis site is oozing, apply moderate pressure until bleeding subsides. (Do not use pressure dressings or bandages that will restrict blood flow. If bleeding continues, resident to be evaluated by physician for further intervention and dialysis center to be notified.) every shift as needed with a start date of 11/21/25.Fistula/AV Graft Site: Location right IJ - Monitor site for presence of thrill, bruit, and s/sx of infection. Notify MD for any abnormal findings every shift with a start date of 11/21/25 and end date of 4/10/26. Documentation indicated this was completed every day except for the following:3/8/26 night shift: coded with a 9 (9 indicated per chart codes other/see progress note).3/9/26 night shift: coded with a 93/27/26 evening shift: coded with a 93/27/26 night shift: coded with a 93/28/26 day and evening shifts: coded with 2 (2 indicated per chart codes as refused) and night shift was blank.3/29/26 day and evening shifts coded with 2.3/30/26 night shift coded with a 2.3/31/26 day shift: coded with a 2. R16's Post Dialysis Assessments reviewed from 3/1/26 to 4/6/26 and identified the following relevant information. On:4/6/26: dialysis paperwork received (answered yes), weight was dated 3/25/26 at 3:27 p.m., and other vitals dated 4/6/26 at 7:17 a.m. No other pertinent information documented.4/3/26: dialysis paperwork received, weight was dated 3/25/26 at 3:27 p.m. Thrill palpated, and bruit auscultated - both indicated yes. Pertinent information section - notified dialysis regarding sevelamer (medication used to control phosphorus levels for people on dialysis) and side effect.4/1/26: dialysis paperwork received, weight was dated 3/25/26 at 3:27 p.m. No other pertinent information documented.3/30/26: dialysis paperwork received, weight was dated 3/25/26 at 3:27 p.m. Thrill palpated, and bruit auscultated - both indicated no. No other pertinent information documented.3/27/26: dialysis paperwork received, weight was dated 3/25/26 at 3:27 p.m. Temperature from 3/27/26 at 9:28 a.m., and respirations from 3/27/26 at 9:28 a.m. Thrill palpated, and bruit auscultated - both indicated yes. Other pertinent information documented as none.3/25/26: dialysis paperwork received. Temperature from 3/27/26 at 9:09 a.m., and respirations from 3/27/26 9:10 a.m. No other pertinent information documented.3/23/26: dialysis paperwork received. Thrill palpated, and bruit auscultated - both indicated yes. No other pertinent information documented.3/20/26: dialysis paperwork received. All vital signs including weight were dated 3/18/26. Thrill palpated, and bruit auscultated - both indicated yes. No other pertinent information documented.3/18/26: dialysis paperwork received. Thrill palpated, and bruit auscultated - both indicated yes. No other pertinent information documented.3/16/26: dialysis paperwork received. Weight was dated 3/14/26 at 2:09 p.m. Thrill palpated, and bruit auscultated - both indicated no. No other pertinent information documented.3/13/26: dialysis paperwork received. Thrill palpated, and bruit auscultated - both indicated yes. Other pertinent information documented as none.3/11/26: dialysis paperwork received. Weight dated 3/10/26 at 10:07 a.m. and all other vital dated 3/11/26 at 10:13 a.m. Thrill palpated, and bruit auscultated - both indicated yes with radio button answer. No other pertinent information documented.3/9/26: dialysis paperwork received. Weight dated 3/3/26 at 5:56 p.m. and all other vitals dated 3/8/26 at 1:43 p.m. Thrill palpated, and bruit auscultated - both indicated yes with radio button answer. Other pertinent information documented as none.3/6/26: dialysis paperwork received. Weight dated 3/3/26 at 5:56 p.m. and all other vitals dated 3/8/26 at 1:43 p.m. Thrill palpated, and bruit auscultated - both (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	indicated no with radio button answer. The document was signed on 3/8/26.3/5/26: dialysis paperwork received. Weight dated 3/3/26 at 5:56 p.m. and all other vital signs dated 3/4/36 at 4:55 p.m. Thrill palpated, and bruit auscultated - both indicated yes with radio button answer. No other pertinent information documented.3/4/26: dialysis paperwork received. Weight dated 3/3/26 at 5:56 p.m. Thrill palpated, and bruit auscultated - both indicated yes with radio button answer. No other pertinent information documented.3/2/26: dialysis paperwork received. Weight dated 2/26/26 at 12:44 p.m. Thrill palpated, and bruit auscultated - both indicated yes with radio button answer. No other pertinent information documented.There was no evidence to support documentation had been received from the dialysis facility, nor was there evidence R16 had a fistula or graft, either old and non-functioning or new and developing where a bruit and thrill would need to be checked. R16's progress notes, dated 3/1/26 to 4/6/26, were reviewed and identified staff were documenting some vitals and/or were using old data, however, the notes lacked the necessary observations of the current dialysis CVC for most notes. It was unknown if staff were referring to the CVC site as noted below: 3/2/26 at 6:05 p.m., R16 had dialysis treatment. No new orders received. Bruit auscultated. Thrill was palpated. No bleeding noted at access site.3/4/26 at 4:55 p.m. Bruit auscultated. Thrill was palpated. No bleeding noted at access site.3/4/26 at 3:27 p.m.: R16 had dialysis treatment. No new orders received. Vital Signs: -W [weight] 197.0 lbs on 3/3/26. His blood pressure (BP) was 98/58 millimeters of mercury (mm/hg) on 3/4/26. R16's temperature (T) was 98.4 degrees Fahrenheit (F), pulse (P) 58 (beats per minute (BPM)) and his respirations (RR) were 16 (breaths per minute (bpm)).3/5/26 at 1:32 p.m.: R16 had dialysis treatment. No new orders received. W 197.0 lbs on 3/3/26. His BP was 98/58 mm/hg and on 3/4/26 staff documented his previous T of 98.4 degrees F, P of 58 bpm and RR was16 bpm. Bruit auscultated. Thrill was palpated. No bleeding noted at access site. No new vitals had been obtained.3/6/26 at 5:30 p.m.: R16 had dialysis treatment. No new orders received. Bruit not auscultated. Thrill was not palpated. No bleeding noted at access site.3/9/26 at 5:53 p.m.: R16 had dialysis treatment. No new orders received. Bruit auscultated. Thrill was palpated. No bleeding noted at access site.3/11/26 at 6:32 p.m.: R16 had dialysis treatment. No new orders received. Vital Signs: W 205.8 lbs. on 3/10/26. His BP 107/57, T 97.9 degrees F, P 61 bpm, and RR was 16 bpm, were all used from vitals acquired earlier that day. Bruit auscultated. Thrill was palpated. No bleeding noted at access site.3/13/26 at 5:58 p.m.: R16 had dialysis treatment. No new orders received. Bruit auscultated. Thrill was palpated. No bleeding noted at access site.3/16/26 at 5:27 p.m.: R16 had dialysis treatment. No new orders received. Vital Signs: -W 205.6 lbs was obtained on 3/14/26. His BP 88/68 mm/hg, T was 98.2 F, P was 80 bpm, and RR was 16 and noted as taken on 3/16/26 at 9:42 a.m. Bruit not auscultated. Thrill was not palpated. No bleeding noted at access site.3/18/26 at 5:52 p.m.: R16 had dialysis treatment. No new orders received. Vital Signs: -W 207.7 lbs on 3/18/26 at 4:10 p.m. on Wheelchair scale; BP 84/49 on 3/18/26 at 6:09 p.m. Sitting l/arm; T 98.8 on 3/18/26 at 6:09 p.m.: P 71 on 3/18/26 at 6:09 p.m. and R -16 on 3/18/26 at 6:09 a.m. Bruit auscultated. Thrill was palpated. No bleeding noted at access site.3/20/26 at 9:03 a.m.: R16 had dialysis treatment. No new orders received. Vital Signs staff documented were noted to be from 3/18/26, 2 days previously and not upon return from dialysis. Staff continued to document Bruit auscultated. Thrill was palpated. No bleeding noted at access site.3/21/26 at 1:19 p.m., staff mentioned an order note: resident has a tunneled chest catheter and are unable to assess bruit/thrill with catheter. Only if resident had fistula/graft. There was no indication or mention staff had contacted the physician to discontinue the order to check for bruit and thrill on a non-existent fistula or graft.3/22/26 at 6:36 a.m.: order note: resident has a tunneled chest catheter. Unable to assess bruit/thrill as not a fistula or graft. Again, there was no indication or mention staff had contacted the physician to discontinue the order to check for bruit and thrill on a non-existent fistula or graft.3/23/26 at 4:06 p.m.: R16 had dialysis treatment. No new orders received. Vital Signs had been appropriately taken. However, staff still documented Bruit auscultated. Thrill palpated. No bleeding noted at access site.3/25/26 at 3:36 p.m.: R16 had dialysis treatment. No new orders received. Vital (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Signs had been appropriately taken. This time, staff documented No bleeding noted at access site., however, it was unclear if staff had identified this was the CVC or a non-existent fistula or graft.3/27/26 at 5:58 p.m.: R16 had dialysis treatment. No new orders received. Vital Signs: -W 212.9 lbs on 3/25/26 at 3:37 p.m. on Wheelchair scale; BP 98/67 on 3/27/26 at 5:59 p.m. Sitting l/arm; T 98.2 on 3/27/26 at 9:28 a.m.: P 65 on 3/27/26 at 6:00 p.m. and R -17 on 3/27/26 at 9:28 a.m. Bruit auscultated. Thrill was palpated. No bleeding noted at access site. 3/30/26 through 4/6/26, staff continued to document old vital sign data that had been taken sometimes from almost a week prior and were either documenting Bruit not auscultated. Thrill was not palpated. No bleeding noted at access site. or No bleeding noted at access site.R16's medical record (paper chart and electronic medical record) was reviewed and lacked any summary report after dialysis to include vital signs, weights (pre-dialysis and post-dialysis), medications administered at dialysis, orders, or any overall concerns with R16 during dialysis. Furthermore, R16's medical record lacked facility communication with dialysis center related to medication refusals in a timely manner, changes or declines in condition unrelated to dialysis. During an interview and document review on 4/10/26 at 1:04 p.m., registered nurse (RN)-C stated when a resident goes to dialysis, a pre and post assessment was to be completed. RN-C stated they are familiar with R16. The pre-assessment should be sent with the resident along with the order summary. If R16 doesn't come back with paperwork such as vitals signs, medications administered, a run report, they don't' do anything. She doesn't call the facility herself to follow up as she figured if they [dialysis] didn't send any paperwork then there weren't any concerns. RN-C assesses the site upon return for signs of infection. RN-C stated R16 had a right IJ (internal jugular) catheter for his dialysis catheter which would not have a thrill or bruit, so she doesn't check for a thrill or bruit. RN-C verified the MAR/TAR indicated to check for thrill and bruit and shouldn't. During an interview on 4/10/26 at 1:04 p.m., RN-A stated a pre and post assessment was completed on R16 on dialysis days. RN-A stated if she ever called dialysis, it would be documented in a progress note. RN-A checks R16's catheter site for any signs of infection. RN-A stated she doesn't check for thrill or bruit as R16's dialysis site wouldn't have one due to the type of site. Staff often don't get anything back from dialysis. RN-A stated they send a notebook with R16 that dialysis can write in if needed. RN-A unsure if this was documented in the resident's medical record. During an interview and document review on 4/10/26 at 3:23 p.m., assistant director of nursing (ADON) identified the facility has a legal pad of note paper that was sent back and forth for communication between the facility and dialysis center. The ADON was unsure if any of this was documented in R16's medical record. The dialysis center does not send any paperwork to the facility such as report runs which would include medications, weights before and after treatment, vital signs, etc. The ADON verified the contact information for the dialysis center was not on the care plan. During a follow up interview on 4/13/26 at 10:19 a.m., the ADON verified the contact number for dialysis was not listed on the care plan or on the banner in R16's medical record. She had now asked that any information in the notebook be entered into the medical record. ADON verified this would not necessarily include medical information obtained during dialysis. During an interview on 4/13/26 at 11:06 a.m., the dialysis registered nurse (RN)-D stated they are the dialysis care facility R16 received his treatment at. The facility sends paperwork and notebook with R16 about 50% of the time. The facility had never requested any documentation from the dialysis center, therefore, they have never sent any to the facility. The dialysis center was not updated on medication changes from the facility. If R16 stated his medications were changed, the dialysis center has the capability to access what medications have been filled at pharmacies. RN-D verified they do not send the facility any weights, medications administered during dialysis, pressures on treatments, vitals, etc. During an interview on 4/14/26 at 9:50 a.m., director of nursing (DON) stated the expectation was the facility was communicating effectively with dialysis and receiving information needed to care for the residents. The DON verified the facility was not receiving information needed from the dialysis center such as vitals, weights, medications received, etc. and verified the facility had not been requesting this information. The DON (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	also verified the contact information was not listed on R16's care plan nor on the banner of the electronic medical record and should be. A facility policy titled Hemodialysis, reviewed 9/10/23, identified the facility will ensure that the place of care for dialysis include the dialysis facility name and phone number. Furthermore, the facility was to coordinate and collaborate with the dialysis facility to ensure:a. The residents' needs related to dialysis treatments are met;b. The provision of the dialysis treatments and care of the resident meets current standards of practice for the safe administration of the dialysis treatments.c. Documentation requirements are met to ensure that treatments are provided as ordered by the nephrologist, attending practitioner and dialysis team; andd. There was to be ongoing communication and collaboration for the development and implementation of the dialysis care plan by nursing home and dialysis staff.

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F 0710 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Obtain a doctor's order to admit a resident and ensure the resident is under a doctor's care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to ensure 1 of 1 primary care physician assistant (PA-A) had appropriately managed the care for 1 of 1 resident (R5) who experienced complications from tube feedings and medication administration through a gastrostomy tube (g-tube). Refer to F684Findings include: R5's quarterly Minimum Data set (MDS) dated [DATE], indicated R5 had clear speech, no hearing disabilities, and used corrective lenses. R5 had moderate cognitive impairment with no rejection of care. R5 had no impairments of her upper extremities and used a walker. R5 was independent with eating, required set up/clean up assistance with oral hygiene, and required partial to moderate assistance with toileting, showering/bathing, dressing, and personal hygiene. R5 had occasional urinary incontinence but was always continent of bowel. R5 required hydration and nutrition via a feeding tube (g-tube). R5's current, undated care plan indicated the following:-urinary incontinence: report changes in skin integrity found during daily care-potential for pressure ulcer development:administer treatments as ordered, and monitor effectivenessfollow facility policies/protocols for the prevention/treatment of skin breakdownmonitor nutritional statusmonitor/document/report any changes in skin status: appearance, color, wound healing, signs and symptoms of infection, wound size (length x width x depth)The need for a feeding tube/potential complications from that tube. R5 was to have no complications from the feeding tube. Staff were to administer formula and hydration and flushes per order.R5's care plan lacked identification of skin breakdown on R5's coccyx; further lacking goals and interventions for monitoring, treating, and documenting R5's actual skin breakdown. Additionally, R5's care plan lacked identification of R5's refusal of cares and treatments; further lacking goals and interventions to apply when R5 refused cares and treatments. R5's care plan lacked identification of R5's risk for fluid-volume imbalances; further lacking goals and interventions for monitoring, treating and documentation. R5's care plan lacked specific time requirements to elevate the head of the bed (HOB) to 30-45 degrees during and after tube feeding. Lastly, R5's care plan lacked specific symptoms, side effects, and monitoring of hypercalcemia, hypothyroidism, and hyperparathyroidism. R5's provider order, dated 1/26/26, included tube feedings (Vital Advanced Formula at 100 milliliter (ml)/hour (hr) for 13 hours) via g-tube. R5 received 150 milliliters (ml) water flush in g-tube every 4 hours, including during tube feeding. R5 received 150 ml of water flush in g-tube after medication administration for the AM medication pass. R5's physician's orders, dated 1/26/26, included:-levothyroxine 88 micrograms (mcg) via g-tube daily (instruction to give on an empty stomach and not with 4 hours of iron supplements or antacids)-prednisone 4 mg via g-tube daily (instruction to take with food) -iron-vitamins oral liquid 15 ml via g-tube daily (instruction to take on an empty stomach or with food if it upsets stomach.) -folic acid 1 milligrams (mg) via g-tube daily -apixaban 2.5 mg via g-tube twice daily -metoprolol tartrate 12.5 mg via g-tube twice daily -senna 8.6 mg via g-tube twice daily -cinacalcet 30 mg via g-tube twice daily -omeprazole- oral suspension 10ml daily -ascorbic acid 500 mg via g-tube daily R5's physician's orders lacked monitoring of electrolytes, monitoring accurate intake and output, managing fluid balance in relation to tube feedings and free water, medication interaction and interventions to prevent adverse effects, a process to monitor ongoing symptoms of nausea, vomiting, abdominal pain, and when staff should alert the provider when R5 refuses medications or treatments. During an interview on 4/7/26 at 11:47 a.m., physician assistant (PA)-A stated R5 has a complicated gastrointestinal (GI) tract. R5 has hyperparathyroidism and this is the source of her hypercalcemia. R5 is no longer a surgical candidate to have her parathyroid removed, symptom management has been the primary direction of care. PA-A stated electrolyte imbalances will be an ongoing concern for R5. PA-A stated she didn't have plans to order follow up bloodwork to monitor electrolytes because she thought the consulting services (Nephrology, Endocrinology) would be monitoring them. PA-A stated she was not sure what the electrolyte monitoring schedule would be. (continued on next page)

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F 0710 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PA-A stated she is unsure how often the nutrition team is working with R5 or how involved they are with her care. She is unsure if the nutrition team was monitoring specifically intake and output. During a follow up interview on 4/8/26 at 2:39 p.m., PA-A stated she relied on the pharmacist to know what medication can be given at what times in relation to the tube feeding and on the pharmacy team to tell her if there are any specific medication interactions. PA-A had not directly communicated to the facility consultant pharmacist about R5's medication needs in relation to her tube feedings. During an interview on 4/9/26 at 8:53 a.m., PA-B stated she was the hospitalist who cared for R5 during her 3/6/26 to 3/10/26 hospital admission. PA-B stated she expected the facility providers to manage the calcium levels after discharge as she was a member of the hospital consulting service and infrequently sees R5. PA-B stated medication interactions should be managed by the facility provider and pharmacist; additionally, medication administration times should be assessed by the facility provider and pharmacist. During an interview on 04/09/2026 at 11:54 AM, PA-C stated frequently monitoring of calcium should be complete weekly until R5's calcium levels are stable, then monthly, then every six months. R5 has been on cinacalcet to manage her high calcium levels; she is on a consistent dose, but ongoing monitoring should still be weekly to bi-weekly. PA-C stated the facility providers are responsible for monitoring electrolytes, she would not be requesting electrolyte levels unless she saw R5 again as outpatient or in the hospital. On 4/14/26 at 10:22 a.m., a call was placed to the facility Medical Director; no return call received. A facility policy titled Medical Director Responsibilities dated 4/22/25, the medical director responsibilities included addressing issues related to coordination of medical care an implementation of resident care policies, ensuring the appropriateness and quality of medical care and medically related care, discussing and intervening (as appropriate) with a health care practitioner regarding medical care that is inconsistent with current standards of care.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to identify irregularities in monthly drug regimen monitoring review for 1 of 5 residents (R15) reviewed for unnecessary medications who received antipsychotic medications. Additionally, the facility failed to identify potential medication side effects for 1 of 1 resident (R5) reviewed for medication administration.Findings include: R15's quarterly Minimum Data Set (MDS), dated [DATE], identified R15 had no cognitive impairment and demonstrated no hallucinations or delusional thinking during the review period. Further, the MDS recorded R15 consumed antipsychotic, antidepressant, and antianxiety medications. Review of the 7/24/24, Olanzapine guidelines, located at: https://www.drugs.com/olanzapine.html#side-effects, identified olanzapine may cause serious side effects such as low blood pressure. Common side effects of olanzapine that affect 5% or more people who take it include postural hypotension (a drop in blood pressure when going from a lying or sitting position to standing) During a record review, R15's orders reflected showed R15 received olanzapine 10 milligrams (mg) every evening before bedtime. Additionally, orthostatic BP laying, sitting, and standing; documented in the electronic medical record on the 9th of every month. During a record review of R15's orthostatic blood pressures from October 2025 through April 2026 identified there were no orthostatic blood pressures completed in October, January, March, or April. During a record review of R15's pharmacy review and recommendations, the pharmacist failed to address the lack of blood pressure monitoring being completed by staff in the course of their monthly reviews on 11/4/25, 2/5/26, and 4/7/26 for the above-mentioned months. During an interview on 4/7/25 at 3:25 p.m., director of nursing (DON) stated R15 is currently taking an antipsychotic medication and should have her orthostatic blood pressure completed monthly. Additionally, if orthostatic blood pressures were ordered, it was her expectation they should get completed monthly. When the consultant pharmacist performed the monthly review of medications, they were to identify when orthostatic blood pressures weren't being completed and should put the reminder to complete them in her monthly recommendations. Lastly, orthostatic blood pressure measurements are important so that staff can identify adverse medication effects as soon as possible. During an interview on 04/15/2026 at 11:46 a.m., pharmacist (PH)-B stated when she completes the medication monthly review, she would review the orders to make sure there was an order to complete orthostatic blood pressures, not necessarily whether they were completed. Additionally, she would expect nursing to complete the orders as written and document why they weren't done. Lastly, since it isn't routine for her to check the actual completion of orthostatic blood pressures, she would not put in the monthly medication review to remind staff to complete them. PH-B stated orthostatic blood pressure monitoring can be important because you can identify medication issues if a resident has positive orthostatic blood pressures. R5According to the American Society for Parenteral and Enteral Nutrition article, Medication via Enteral Feeding Tubes: A Clinician's Guide, located at https://nutritioncare.org/wp-content/uploads/2026/04/Medications-Via-EN-Tubes.pdf, identified prior to administering medications through a g-tube, medications should be verified for right client, right medication, right dose, right time, right route, and right documentation. When administering medication through a g-tube, medications should be crushed and diluted with 15-20 milliliters (ml) of purified water separately. Additionally, the head of the bed (HOB) should be elevated at least 30-45 degrees during medication administration and for at least 30-60 minutes after medication administration to prevent aspiration and support safe, effective delivery of medication. Further, proper positioning supports breathing, reduces pressure on the abdomen, and improves resident comfort. Lastly, complications from g-tube misuse can lead to nausea, vomiting, abdominal pain, tube clogging, aspiration, and toxicities. R5's quarterly Minimum Data set (MDS) dated [DATE], indicated R5 had (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	moderate cognitive impairment with no rejection of care. R5 required hydration and nutrition via a feeding tube (g-tube). R5's care plan indicated the following:-administer tube feeding formula, hydration, and flushes per order-elevate HOB 30-45 degrees (did not provide direction for when and how long to elevate HOB) R5's care plan lacked resident-specific interventions to monitor or prevent recurrence of nausea, vomiting, and abdominal pain; to include the signs and symptoms of hypercalcemia; which include mental status changes, muscle spasms, abdominal pain, and constipation. R5's phyician's order, dated 1/26/26, included tube feedings (Vital Advanced Formula at 100 milliliter (ml)/hour (hr) for 13 hours) via g-tube. R5 received 150 ml water flush in g-tube every 4 hours, including during tube feeding. R5 received 150 ml of water flush in g-tube after medication administration for the AM medication pass. R5's physician's orders included:-levothyroxine (thyroid medication) 88 micrograms (mcg) via g-tube daily (instruction to give on an empty stomach and not with 4 hours of iron supplements or antacids) -prednisone (steroid) 4 milligrams (mg) via g-tube daily (instruction to take with food) -iron-vitamins oral liquid 15 ml via g-tube daily (instruction to take on an empty stomach or with food if it upsets stomach. -folic acid (vitamin) 1 mg via g-tube daily -apixaban (blood thinner) 2.5 mg via g-tube twice daily -metoprolol tartate (blood pressure) 12.5 mg via g-tube twice daily -senna (laxative) 8.6 mg via g-tube twice daily -cinacalcet (overactive parathyroid) 30 mg via g-tube twice daily -omeprazole-syrspend (antacid) SF Akla oral suspension 10 ml daily -ascorbic acid (vitamin C) 500 mg via g-tube daily During an interview on 4/8/26 at 2:39 p.m., physician assistant (PA)-A stated the resident had been experiencing ongoing nausea and vomiting with intermittent abdominal pain since returning from the hospital on 3/10/26. Additionally, she relies on the consultant pharmacist to know what medication can be given at what times in relation to the tube feeding and on the pharmacy team to tell her if there are any specific medication interactions. During an interview on 4/9/26 at 8:53 a.m., PA-B stated she was the hospitalist who cared for R5 during her 3/6/26 to 3/10/26 hospital admission. Additionally, medication interactions should be managed by the facility provider and pharmacist. Further, medication administration times should be assessed by the facility provider and pharmacist. Medications given with other medications or around tube feedings can have side effects for R5 that include nausea, vomiting, abdominal pain, increased absorption, or decreased absorption. During interview on 4/9/26 at 9:59 a.m., pharmacist (PH)-A stated the hours and times of administration are determined by the facility provider, pharmacist, and manufacturer guidelines. Medication interactions should be managed by the facility provider and pharmacist. If medication interactions aren't completed, R5 could experience ineffective medications, medication side effects, and symptom side effects. PH-A stated medications such as prednisone should be taken with food to prevent nausea and vomiting. Medications such as levothyroxine, in this situation, should have been given before the tube feedings were started or several hours after tube feedings have stopped. Levothyroxine should be spaced at least 4 hours from the iron vitamin solution and the omeprazole solution. The medication errors should have been identified by the facility provider and pharmacist upon medication review at time of admission. During an interview on 4/15/26 at 11: 46 a.m., pharmacist (PH)-B stated when a resident has been admitted to the facility, she reviews the discharge summary to verify medications and compare them to the facility medication administration record (MAR). If she notices any discrepancies, she will write a recommendation for the provider to review and determine appropriateness of medication; she would expect response from the provider in one week. PH-B stated she does not evaluate each medication for interactions. PH-B stated she doesn't check when medications are administered in relation to the tube feedings; she would expect nursing to follow the administration directions from the pharmacy. PH-B stated it is important to follow the administration directions from pharmacy; but could not speak to the importance of accurate medication administration timing. A policy titled Use of Psychotropic Medications, dated 4/27/25 showed the effects of the psychotropic medications on a resident's physical, mental, and psychosocial well-being will be evaluated on an ongoing basis, such as: upon physician evaluation, during the pharmacist's monthly medication review, during the MDS review, and (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	in accordance with nurse assessments and medication monitoring parameter consistent with clinical standards of practice, manufacturer's specifications, and the resident's comprehensive care plan. The resident's response to the medications, including progress towards goals and presence/absence of adverse consequences, shall be documented in the resident's medical record. A facility policy titled Medication Administration dated January 2026, medications are administered in accordance with written orders of the prescriber. Timing of medication administration must align with manufacturer specifications.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to ensure a medication administration error rate of less than 5 percent (%) resulting in an 8.57 % medication error rate, identified during 3 of 25 medication administration observations. Findings include: R5's quarterly Minimum Data set (MDS) dated [DATE], indicated R5 had moderate cognitive impairment with no rejection of care. R5 required hydration and nutrition via a feeding tube (g-tube). R5's physician's orders included:-levothyroxine (thyroid medication) 88 micrograms (mcg) via g-tube daily (instruction to give on an empty stomach and not with 4 hours of iron supplements or antacids) -prednisone (steroid) 4 milligrams (mg) via g-tube daily (instruction to take with food) -iron-vitamins oral liquid 15 ml via g-tube daily (instruction to take on an empty stomach or with food if it upsets stomach. -folic acid (vitamin) 1 mg via g-tube daily -apixaban (blood thinner) 2.5 mg via g-tube twice daily -metoprolol tartate (blood pressure) 12.5 mg via g-tube twice daily -senna (laxative) 8.6 mg via g-tube twice daily -cinacalcet (overactive parathyroid) 30 mg via g-tube twice daily -omeprazole-syrspend (antacid) SF Akla oral suspension 10 ml daily (prepped 15ml) -ascorbic acid (vitamin C) 500 mg via g-tube daily During an observation on 4/8/26 at 9:39 a.m., registered nurse (RN)-A prepared R5's morning medication administration. RN-A removed and prepped the above-named medications and put each medication in a medication cup. RN-A did not know when the most recent tube feeds had completed. RN-A failed to identify the medication levothyroxine had a pharmacy warning to give on an empty stomach and not within 4 hours of iron supplements (prepped iron-multivitamin suspension) or antacids (prepped omeprazole suspension), which she was preparing to administer at the same time. RN-A failed to identify prednisone should be given with food (tube feeding ended at 5:42 AM.) RN-A failed to identify iron-multivitamin suspension should be given on an empty stomach. Additionally, RN-A prepped the iron-multivitamin suspension with 15 ml instead of the ordered 10 ml. During an interview on 4/8/26 at 10:36 a.m., RN-A stated she had not had g-tube education for some time. RN-A stated the facility had not had a resident that required tube feedings with medication administration or had a g-tube for about a year or year and a half. RN-A stated she had been taking care of R5 since her admission in January. RN-A stated she should have read the pharmacy alerts on the medications. She acknowledged she should have verified the liquid dose a 2nd time to make sure she had the right amount of the liquid. During an interview on 4/9/26 at 11:22 a.m., assistant director of nursing (ADON) stated the process to administer medication includes verifying the right resident, right dose, right route, right drug, and right time. She stated if the individual medications have a pharmacy alert such as take with food, don't give with certain medications; it is an expectation you follow those drug administration guidelines. She stated if you don't follow those recommendations, medications could be less effective, more effective, cause side effects, or not be effective at all. During an interview on 4/15/26 at 11: 46 a.m., pharmacist (PH)-B stated she doesn't check when medications are administered in relation to the tube feedings; she would expect nursing to follow the administration directions from the pharmacy. PH-B stated it is important to follow the administration directions from pharmacy; but could not speak to the importance of accurate medication administration timing. During an interview on 4/14/26 at 9:35 a.m., the administrator stated the medication regulation is facilities should have less than a 5% error rate. The facility's medication error rate of 8.57% is above the acceptable regulation standard. Staff should be confirming the five medication rights (right resident, right dose, right route, right drug, and right time) and it is an expectation staff should follow the pharmacy directions on each medication package. If staff can't follow the direction of medication from pharmacy, they are expected to reach out to pharmacy or the resident's provider to get order administration clarification. She stated the importance of performing medication administration accurately is to maintain patient safety. A facility policy titled Medication Administration dated January 2026, medications are administered in accordance with written orders of the prescriber. Timing of medication administration must align with manufacturer specifications.

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations (including nights and weekends) and emergencies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to implement their facility assessment to identify 1 of 1 resident (R5) who required specialty care and services and the facility failed to train and perform skill competencies as outlined in the facility assessment.Refer to F684 Findings include: R5's quarterly Minimum Data set (MDS) dated [DATE], indicated R5 had moderate cognitive impairment with no rejection of care. R5 required hydration and nutrition via a feeding tube (g-tube). R5 was admitted to the facility on [DATE] with an admission diagnosis of moderate protein-calorie malnutrition, dysphagia (difficulty swallowing), muscle weakness, type 2 diabetes, hypothyroidism (thyroid gland does not produce enough thyroid hormone, symptoms include fatigue, weight gain, cold intolerance, and depression), hyperparathyroidism (parathyroid gland produces too much hormone, symptoms include high blood calcium levels, feeling weak, nausea, vomiting, loss of appetite, constipation, and abdominal pain), and hypercalcemia (blood calcium level greater than 10.5 milligram (mg) per deciliter (dl) causing fatigue, nausea, vomiting, constipation, confusion, cognitive changes, and irregular heart rhythms). A review of R5's medical record identified the following hospitalizations/emergency room visits identified on:2/12/26: R5 was sent to the hospital after a fall with decrease cognition and returned to the facility on 2/22/26; the primary diagnosis was hypercalcemia. R'5 Power of Attorney (POA) was activated during this hospital visit and thereafter due to ongoing intermittent confusion.3/6/26: R5 was sent to the hospital as a result of increased nausea and vomiting and returned to the facility on 3/10/26; the primary diagnosis was hypercalcemia. 4/6/26: R5 was sent to the emergency room as a result of increased abdominal pain and returned to the facility on 4/6/26; the primary diagnosis was pleural effusion (collection of fluid around your lungs.) 4/8/26: R5 was sent to the hospital and returned to the facility on 4/9/26; the primary diagnosis was right-sided pneumonia (acute inflammation of the lung caused by an infection, commonly caused by aspiration.). R5's care plan indicated the following:-administer tube feeding formula, hydration, and flushes per order-elevate HOB 30-45 degrees (did not provide direction for when and how long to elevate HOB) R5's care plan lacked resident-specific interventions to monitor or prevent recurrence of nausea, vomiting, and abdominal pain; to include the signs and symptoms of hypercalcemia; which include mental status changes, muscle spasms, abdominal pain, and constipation. Additionally, the care plan lacked assessment and interventions for the risk of fluid volume deficits. R5's provider order, dated 1/26/26, included tube feedings (Vital Advanced Formula at 100 milliliter (ml)/hour (hr) for 13 hours) via g-tube. R5 received 150 ml water flush in g-tube every 4 hours, including during tube feeding. R5 received 150 ml of water flush in g-tube after medication administration for the AM medication pass. R5's physician orders included:-levothyroxine (thyroid medication) 88 micrograms (mcg) via g-tube daily (instruction to give on an empty stomach and not with 4 hours of iron supplements or antacids) -prednisone (steroid) 4 milligrams (mg) via g-tube daily (instruction to take with food) -iron-vitamins oral liquid 15 ml via g-tube daily (instruction to take on an empty stomach or with food if it upsets stomach. -folic acid (vitamin) 1 mg via g-tube daily -apixaban (blood thinner) 2.5 mg via g-tube twice daily -metoprolol tartate (blood pressure) 12.5 mg via g-tube twice daily -senna (laxative) 8.6 mg via g-tube twice daily -cinacalcet (overactive parathyroid) 30 mg via g-tube twice daily -omeprazole-syrspend (antacid) SF Akla oral suspension 10 ml daily -ascorbic acid (vitamin C) 500 mg via g-tube daily According to the American Society for Parenteral and Enteral Nutrition article, Medication via Enteral Feeding Tubes: A Clinician's Guide, located at https://nutritioncare.org/wp-content/uploads/2026/04/Medications-Via-EN-Tubes.pdf, identified prior to administering medications through a g-tube, medications should be verified for right client, right medication, right dose, right time, right route, and right documentation. When (continued on next page)

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	administering medication through a g-tube, medications should be crushed and diluted with 15-20 milliliters (ml) of purified water separately. Additionally, the head of the bed (HOB) should be elevated at least 30-45 degrees during medication administration and for at least 30-60 minutes after medication administration to prevent aspiration and support safe, effective delivery of medication. Further, proper positioning supports breathing, reduces pressure on the abdomen, and improves resident comfort. Lastly, complications from g-tube misuse can lead to nausea, vomiting, abdominal pain, tube clogging, aspiration, and toxicities. During an observation on 4/8/26 at 9:39 a.m., registered nurse (RN)-A prepared R5's morning medication administration. RN-A removed and prepped the above-named medications and put each medication in a medication cup. RN-A did not know when the most recent tube feeds had completed. RN-A failed to identify the medication levothyroxine had a pharmacy warning to give on an empty stomach and not within 4 hours of iron supplements (prepped iron-multivitamin suspension) or antacids (prepped omeprazole suspension), which she was preparing to administer at the same time. RN-A failed to identify prednisone should be given with food (tube feeding ended at 5:42 AM.) RN-A failed to identify iron-multivitamin suspension should be given on an empty stomach. Additionally, RN-A prepped the iron-multivitamin suspension with 20ml instead of the ordered 15ml. Prior to medication administration, R5 required enhanced barrier precaution (EBP) due to an indwelling medical device (g-tube). RN-A failed to apply the appropriate personal protective equipment (PPE) prior to providing care. At time of administration, RN-A failed to ensure the head of the bed was 30-45 degrees, with the bed remaining at approximately 10 degrees and R5 slouched down in the bed. RN-A stated R5 received a 30ml water flush before medication administration, 30ml water flush in between each medication, and a 150ml water flush at the end of the medication administration. During medication administration, RN-A diluted each medication with approximately 2ml of water, which failed to dilute the medication enough to allow it to pass through the g-tube. When RN-A put the medication into the barrel of syringe attached to the g-tube, the medication was not diluted enough to flow, RN-A then begun adding additional unmeasured amounts of water and continued to add until the medication would flow; 2 medications required pressure from the syringe plunger to flow through the g-tube. During medication administration process, R5 stated she was having increased nausea and abdominal pain. RN-A failed to recognize R5 was still not at the correct position. During administration RN-A failed to flush the g-tube between medications levothyroxine and metoprolol. RN-A was unsure what effect this could have on R5. After administration was completed, RN-A failed to set the head of the bed up to 30-45 degrees; bed remained at approximately 10 degrees with R5 slouched down in bed. During an interview on 4/8/26 at 10:36 a.m., RN-A stated she had not had g-tube education for some time. RN-A stated the facility had not had a resident that required tube feedings or had a g-tube for about a year or year and a half. RN-A stated she had been taking care of R5 since her admission in January. During an interview on 4/9/26 at 11:22 a.m., licensed practical nurse (LPN)-B stated R5 had frequent nausea and vomiting. LPN-B stated they only track R5's bowel movements for output. LPN-B stated R5's emesis are not documented in R5's medical record. LPN-B described the process of administering medications via g-tube which did not include elevating head of bed during or after administration of medications or enteral feedings. During an interview on 4/7/26 at 3:15 p.m., vice president of success (VPS)-A stated nurses wereeducated about g-tubes annually and for regular competencies. VPS-A stated nurses can receive g-tube education sporadically; they didn't believe nursing staff were educated about the needs of R5 prior to her arrival. During an interview on 4/7/26 at 3:25 p.m., director of nursing (DON) stated she believed the facility provided education to staff about g-tubes but couldn't find the specific education. DON stated she would expect education to be given for g-tubes, tube feeding administration, medication administration, g-tube complications, and g-tube side effects or symptoms. DON stated the facility had not cared for a resident with a g-tube in about a year. DON stated, generally g-tube education is annually, she did not provide g-tube education to staff about this R5 and her specific needs. DON stated it would have been beneficial to have educated staff specifically about R5 so staff could be prepared for any complications. A Facility (continued on next page)

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	assessment dated [DATE], the facility leadership uses the facility assessment for decision-making purposes including when to consider specific staffing needs for each resident unit in the facility and adjust as necessary based on changes to its resident population. Further, training and skills unique to resident population: our nurses are trained in enteral feedings; our facility not only conducts a skill assessment during floor orientation of nurses and nursing assistants but also conducts monthly competencies of various skills to ensure that annual training occurs to keep skills honed. Relias training and skill competencies are scheduled monthly. Facility staff are specifically trained with skills unique to resident population, such as tube feedings.

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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 2 of 2 residents (R5, R20) reviewed for transmission-based precautions.Findings include: R20's quarterly Minimum Data Set (MDS) assessment, dated 3/12/26, identified R20 had intact cognition with no hallucination, delusions or other behavioral symptoms noted and was dependent on staff for activities of daily living (ADLs) except eating which R20 required maximal staff assistance. The MDS indicated R20 had an indwelling catheter. During an observation on 4/8/26 at approximately 7:20 a.m., RN-A was observed to enter R20's room and performed hand hygiene prior to entering room with hand sanitizer. A plastic bin was observed outside the doorway and inside the bin were personal protective gowns and gloves. Hand sanitizer was available from a dispenser on the wall. On the door, was a single page sign hung indicating Enhanced Barrier Precautions. Signage was orange in color, CDC (Center for Disease Control and Prevention) emblem on the bottom right corner, two stop signs on the upper right and upper left corners of the page and indicated: Everyone must: Clean their hands, including before entering and when leaving the room, and Providers and Staff must also: 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, Device care or use: central line, urinary catheter, feeding tube, tracheostomy. Wounds Care: any skin opening requiring a dressing. R20 was observed sitting in her Broda chair (a type of positioning chair) in her room. R20 was administered her morning oral medications by registered nurse (RN)-A. RN-A performed a respiratory assessment on R20 which included a pulse oximeter reading, and breath sounds. RN-A held R20's inhaler while she did the treatment, then had R20 rinse her mouth and spit in a cup that RN-A was holding. RN-A prepared R20's nebulizer and placed the mask on R20's face. RN-A placed R20's call light pad on her lap and instructed her to turn her call light on when the treatment was completed. RN-A exited R20's room and used hand sanitizer. R20's April medication/treatment administration report (MAR), printed 4/14/26, included the following order: -Ipratropium-Albuterol Inhalation Solution 0.5-2.5 (3) milligram(mg)/3millilter(ml) (a combination of two medications in one solution used to help open airways and prevent worsening of airflow obstruction) - 1 dose inhale orally two times a day related to chronic respiratory failure with hypoxia with a start date of 3/12/26. The record indicated the medication was administered twice a day as ordered as of print date of MAR. -Respiratory assessment prior to nebulizer treatment. Document Respirations, Pulse, O2 Sat, and lung sounds prior to nebulizer treatment two times a day. The record indicated the assessment was completed twice a day as ordered as of the print time of the MAR along with lung sounds being documented with code. -Respiratory assessment after nebulizer treatment. Document Respirations, Pulse, O2 Sat, and lung sounds prior to nebulizer treatment two times a day. The record indicated the assessment was completed twice a day as ordered as of the print time of the MAR along with lung sounds being (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	documented with code. -Change foley catheter monthly and as needed using a 18Fr silicone indwelling catheter 10cc balloon. One time a day once a month on 18 day of the month and as needed using a 18Fr silicone indwelling catheter 10cc balloon with a start date of 3/18/26. -Irrigate foley catheter daily and as needed with 122 cc. can use tap water or sterile water per facility preference one time a day for catheter care with a start date of 2/20/26. -Catheter care every morning and at bedtime for urinary retention with a start date of 1/20/26. R20's order summary report, dated 4/14/26, included the following order: -Ipratropium-Albuterol Inhalation Solution 0.5-2.5(3) mg/3ml - 1 dose inhale orally two times a day related to chronic respiratory failure with hypoxia with a start date of 3/12/26. -Catheter Care every morning and at bedtime for urinary retention starting 1/20/26. -Change foley catheter monthly and as needed using a 18Fr silicone indwelling catheter 10cc balloon. One time a day once a month on 18 day of the month and as needed using a 18Fr silicone indwelling catheter 10cc balloon with a start date of 3/18/26. -Irrigate foley catheter daily and as needed with 122 cc. can use tap water or sterile water per facility preference one time a day for catheter care with a start date of 2/20/26. R20's care plan, initiated on 1/20/26, indicated R20 had indwelling urinary catheter. Interventions were all updated on 3/8/26 and included: administer medications per MD order; catheter care; catheter collection bag place din dignity bag holder on b ed/wheelchair; change urinary collection bag as needed; maintain drainage bag below bladder level; report any changes in amount and color, or odor of urine; report to MD signs of UTI (urinary tract infection) such as blood, cloudy urine, fever, increased restlessness, lethargy, complaints of pain or burning. The care plan lacked identification R20 was on enhanced barrier precautions. During an interview on 4/8/26 at 11:50 a.m., RN-A verified they did administer R20's medications 4/8/26 which included a nebulizer, inhaler, oral medications and performed a respiratory assessment. RN-A stated they did not wear a gown and stated they did not touch R20's catheter which was the reason R20 was on EBP. RN-A stated they should have worn a gown since they did a respiratory assessment with the resident and the EBP sign on the door. R5's quarterly Minimum Data set (MDS) dated [DATE], indicated R5 had clear speech, no hearing disabilities, and used corrective lenses. R5 had moderate cognitive impairment with no rejection of care. R5 required hydration and nutrition via a feeding tube (g-tube). During an observation on 4/8/26 at 9:39 a.m., registered nurse (RN)-A prepared R5's morning medication administration. RN-A removed and prepped the above-named medications and put each medication in a medication cup. Prior to medication administration, R5 required enhanced barrier precaution (EBP) due to an indwelling medical device (g-tube). RN-A failed to apply the appropriate (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	personal protective equipment (PPE) prior to providing care. During an interview on 4/8/26 at 10:36 a.m., RN-A stated she should have been wearing the appropriate personal protective equipment (PPE) when providing care or administering medications to R5. She stated R5 required enhanced barrier precautions (EBP) and additional PPE (gown and gloves) were needed due to her g-tube. She stated the appropriate PPE is important to prevent the spread of infection from residents to residents. During an interview on 4/14/26 at 9:55 a.m., director of nursing (DON) stated the expectation would be that if a resident on enhanced barrier precautions, the proper PPE would be worn as this helps stop the transmission of infections. DON stated she would expect proper PPE to be worn for a resident on EBP while a respiratory assessment is being performed along with a setting up and administering a nebulizer treatment. A facility policy titled Enhanced Barrier Precautions, dated 8/8/24, identified the facility will implement enhanced barrier precautions for the prevention of transmission of multidrug-resistant organisms and an order for enhanced barrier precautions will be initiated for residents with any of the following: Wounds (e.g., chronic wounds such as pressure ulcers, diabetic foot ulcers, unhealed surgical wounds, and chronic venous stasis ulcers) and/or indwelling medical devices (e.g., central lines, peripherally inserted central catheters (PICCs), hemodialysis catheters, urinary catheters, feeding tubes, tracheostomy/ventilator tubes) even if the resident is not known to be infected or colonized with a [NAME]. Ostomies, such as colostomies or ileostomies, are not defined as a wound for Enhanced Barrier Precautions.

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F 0941 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop, implement, and/or maintain an effective training program that includes effective communications for direct care staff members. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to ensure staff completed mandatory communication training for 2 of 10 staff (nursing assistant (NA)-A, licensed practical nurse (LPN)-B) reviewed for training requirements. This had the potential to affect all 34 residents residing in the facility. Findings include: The facility assessment dated [DATE], indicated the facility had developed a training program that included an orientation process and ongoing training for all new and existing staff to ensure the programs meet the regulatory requirements. The assessment indicated all staff were to receive training in communicating effectively. During an interview on 4/13/26 at 10:59 a.m., administrator stated she was responsible for overseeing and ensuring all staff completed the required training. During a follow up interview on 4/14/26 at 11:06 a.m., the administrator was informed the education on effective communication was not found the personal files she had provided for LPN-B and NA-A. Administrator verified the trainings had not been completed at this time for either LPN-B or NA-A. A facility policy regarding required staff training was requested and not received.

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F 0944 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Conduct mandatory training, for all staff, on the facility?s Quality Assurance and Performance Improvement Program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to ensure staff completed mandatory quality assurance and performance improvement training for 6 of 10 staff (registered nurse (RN)-A, licensed practical nurse (LPN)-B, nursing assistant (NA)-A, NA-D, NA-E, and NA-F) reviewed for training requirements. This had the potential to affect all 34 residents residing in the facility. Findings include: The facility assessment dated [DATE], indicated the facility had developed a training program that included an orientation process and ongoing training for all new and existing staff to ensure the programs meet the regulatory requirements. The assessment indicated all staff were to receive training in quality assurance and performance improvement (QAPI). During an interview on 4/13/26 at 10:59 a.m., administrator stated she was responsible for overseeing and ensuring all staff completed the required training. During a follow up interview on 4/14/26 at 11:06 a.m., the administrator was informed the education on QAPI was no found the personal files she had provided for LPN-B and RN-A. Administrator verified the trainings had not been completed at this time for either LPN-B or RN-A. Administrator reviewed trainings upon orientation and verified QAPI trainings are not completed at orientation. Administrator stated they are completed through the online training program at this time. Furthermore, training was not completed at this time for NA-A, NA-D, NA-E or NA-F upon further review. A facility policy regarding required staff training was requested and not received.

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F 0577 Level of Harm - Potential for minimal harm Residents Affected - Many	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. Based on observation, interview and document review, the facility failed to ensure the most recent survey results were posted in a prominent location and readily accessible to person wishing to review such information. This had potential to affect all 34 residents residing in the nursing home or any visitors who wanted to review this information. Findings include: The CMS Provider History Report, dated 4/3/26, identified the completed recertification for the previous three years, with the most recently completed recertification survey having exited on 2/6/25. On 4/8/26 at 1:34 p.m., an informal resident council meeting was held with R10, R15 and R30. The residents were asked, as part of the meeting, if the most recent survey results were readily posted within the facility for them to review at leisure. However, none of the residents voiced they knew the location or these results, nor had the results been discussed with them during the resident council meetings. During an interview and tour on 4/10/26 at 8:22 a.m., administrator stated she was responsible for the survey results binder. The survey binder was located near the main entrance at waist level and was labeled State Survey Results. Administrator reviewed the binder and verified the most recent survey exited on 2/6/25 did not include the plan of correction nor the life safety code component. The binder did not contain any of the life safety code surveys for the past 3 years. The survey results binder did not include any signage that additional survey results were available upon request. The bulletin board above where the survey binder was located did not include any signage of additional survey results available upon request. Administrator stated she didn't realize the life safety code surveys needed to be included or the plan of corrections. Administrator stated she would get this updated. A facility policy titled Availability of Survey Results, reviewed 6/16/22, indicated the facility will maintain reports of any survey, certifications, and complaint investigations made respecting the facility during the 3 preceding years, and any plan of correction in effect with respect to the facility.