STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245345	A. Building B. Wing	12/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Green Prairie Rehabilitation Center	800 Second Avenue Northwest Plainview, MN 55964

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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 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to organize and participate in resident/family groups in the facility. Based on observation, interview, and document review, the facility failed to ensure residents call lights were answered in a timely manner for 2 of 2 residents (R6, R7) reviewed for grievances. Findings include: R7During an interview on 12/1/25 at 1:04 p.m., R7 stated she sometimes waits 45 minutes before staff respond to her call light. R7 reported I'm not supposed to be walking but sometimes I have to otherwise I have accidents. R7 also reported she has to search for staff when her urinary catheter bag is full. R7's comprehensive Minimum Data Set (MDS) assessment, dated 9/4/25 indicated R7 had mild cognitive impairment.R7's grievance form indicated on 10/2/25, the administrator answered R7's call light. R7 reported to the administrator her call light had been on for a long time. The administrator checked the call light response screen which indicated the call light was on for 12 minutes. The administrator asked the social services director to speak to R7. R7 reported to the social services director her call light was on for a long time without anyone answering. The call button was left on for the entirety of the conversation with both the administrator and social services director before being turned off. Resident stated the light had been on a long time (12 minutes before administrator to answer, 26 minutes total before social service director was able to shut it off after conversation). Resident stated they would like staff to acknowledge they are busy and to let resident know they see her call light is on and will be with her in time. Analysis indicated the social service director checked in with R7 on 10/8/25 who reported staff have been answering call light timely and providing times if unable to get to resident right way. R7's call light logs for dates 11/2/25-12/1/25 indicated R7 had 13 call light times ranging 22-61 minutes from 11/3-11/30/25. R6R6's quarterly (MDS) assessment, dated 11/7/25 indicated R6 was cognitively intact. R6's grievance form dated 9/19/25 indicated R6 reported she waited 1 hour on the morning and evening shift on 9/16 before staff answered her call light. Steps taken to investigate concern/grievance indicated the social service director ran call bell report noting 2 times R6 waited 58 minutes for call bell to be answered. Resolution/Prevent Actions/Follow up indicated R6 was informed of call bell times and staff were reminded to answer call lights promptly. The form indicated a date of resolution of 9/18/25. A resolution report dated 9/19/25 indicated no further review was required. R6's grievance form dated 11/4/25 indicated R6 reported she waited 1 hour for staff to answer her call light on 11/2/25. Steps taken to investigate concerns/grievance indicated the social services director ran the call light log for 11/2/25. The call light log indicated R6 waited 110 minutes during the day however the longest call light was 12 minutes on the evening shift. R6 was informed of the information and the social services director shared findings with nursing team. Date of Resolution was 11/3/25. Resolution report dated 11/4/25 indicated staff verbally educated about answering call lights in a timely manner. Analysis section indicated R6 reported she did not have to wait long in the morning and did not know why the call light was on that long. The grievance indicated there was no further review required. R6's call light logs dated 11/2/25-12/1/25 indicated R6 had 13 call light times ranging 21-71 minutes from 11/4-11/28/25.Further review of facility residents call light logs identified the following.R34R34's comprehensive MDS assessment, dated 11/21/25 indicated R34 was cognitively intact.During an interview on 12/1/25 at 2:32 p.m., R34 reported call light wait times at least 30 minutes up to an hour and a half. R34 reported he has had to just let it go because he could not wait any longer. R34's call (continued on next page)

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

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	light logs for 11/2/25-12/1/25 indicated R34 had 17 call light times ranging 22-80 minutes from 11/5-11/29/25.R1R1's comprehensive MDS assessment, dated 10/21/25 indicated R1 was cognitively intact.During an interview on 12/1/25 at 5:58 p.m., R1 reported he can take himself to the bathroom however needs assistance for toileting hygiene. R1 reported he takes his cell phone to the bathroom with him to play a game while waiting for the staff to answer the call light. R1 added, it takes two games of cribbage before staff come in.R1's call light logs for 11/2/25-12/1/25 indicated R1 had 2 call light times from 21-47 minutes on 11/4/25. In addition, Call light logs from 11/2/35-12/1/25 indicated R28, R15, and R25 had a total of 22 call lights ranging from 20-68 minutes from 11/2-11/28/25. During an interview on 12/02/2025 at 1:50 p.m., nursing assistant (NA)-A stated there are call light screens at the end of each hall that scrolls the room numbers with call lights on. NA-A stated bathroom call lights will scroll first followed by room call lights in order they were turned on. The screen at the end of the hall does not indicate how long the call light has been on. NA-A stated there is a computer screen at nurses' station that indicates exactly what time the call lights went on. During an interview on 12/4/25 at 3:38 p.m., with the administrator and director of nursing (DON), the administrator stated the facility social worker is responsible for documenting grievances. The expectation is to follow-up with the resident the day the grievance is filed and forward the grievance to the appropriate department. Each department is expected to respond to the grievance as soon as possible. The resident is informed of a short-term or long-term solution. If the resident is accepting of the solution, the grievance is closed. The administrator stated she expects the social worker to follow up with the resident and if the issue persists, file another grievance. The DON stated she was aware of R6's grievance and was not aware R7 made a similar grievance. The DON stated she expects call lights to be answered within 15 minutes. The call light logs were discussed with the administrator and DON. The administrator stated there are residents who will push multiple call lights repeatedly and the DON stated there are times staff answer the call light timely however forget to shut the call light off. The administrator stated she had not personally reviewed call light logs. The DON stated she was unaware the call light response times were that long. The DON stated staff use the computer at the nurses' station and the screens at the end of the halls to determine which call lights are on. She confirmed the screens at the end of each hall do not indicate how long the call light has been on.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on observation, interview and document review, the facility failed to ensure flooring was fixed and secure for 1 of 1 resident (R6) reviewed for a safe, comfortable and homelike environment. R6's quarterly Minimum Data Set (MDS) assessment, dated 8/28/25 identified R6 had no cognitive impairment.During observation and interview on 12/1/25 at 5:35 p.m., R6 stated she was unhappy with the transition strip between her room floor and her bathroom floor. R6 stated the transition strip was not secured to the floor and she has caught her shoe on it when using the restroom. R6 stated she would have fixed the transition strip if she were at home. R6 stated she told the facility the transition strip was not secured approximately 2 weeks ago. R6 stated facility staff had not followed up with her about when it will be fixed.Record review showed facility staff submitted a maintenance request on 11/25/25 to have the transition strip repaired or secured. The maintenance record also showed the request to fix the transition strip was completed on 12/1/25; however, the transition strip had not been repaired or secured.During interview on 12/4/25 at 2:48 p.m., the administrator stated she was aware R6's transition strip needed to be repaired or secured. The administrator stated a flooring company recently upgraded the facility floors had been contacted about the transition strip needing repaired; this was the reason the maintenance record was changed to completed because the facility had contacted the flooring company. The administrator confirmed R6's transition strip from her room to the bathroom remained unsecured.A facility policy for maintenance requests was requested and not received.

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. Based on interview and record review, the facility failed to ensure a baseline abnormal involuntary movement assessment was performed for 1 of 1 residents (R3) and proper side effect monitoring was in place for 2 of 5 residents (R3 and R31) reviewed for unnecessary medications who receive antipsychotic medications.Findings include: R3's quarterly minimum data set (MDS) assessment, dated 9/25/25 indicated R3 had moderate cognitive impairment with no behaviors. R3 required partial to substantial assistance for personal and toileting hygiene as well as transfers. The MDS indicated R3 had diagnoses that included debility/cardiorespiratory conditions, orthostatic hypotension (a drop in blood pressure with position changes), heart failure, high blood pressure, and diabetes. R3's diagnoses list included: auditory hallucinations, heart failure, repeated falls, orthostatic blood pressure (a drop in blood pressure with position changes), and depression. R3's cognition care plan indicated R3's orientation fluctuates evidenced by continuous requests to call family, confusion about time, and requests for assistance from staff to get to his car. A care plan titled Potential psychotropic drug ADRs [adverse drug reactions] related to daily use of psychotropic medications indicated: administer as ordered, monitor target behaviors as ordered, and monitor for ADR's such as orthostatic blood pressures monthly and TD [tardive dyskinesia-a potential side effect of antipsychotic medication use that causes abnormal involuntary muscle movement] screening or AIMS [Abnormal involuntary movement screening] per protocol. R3's Medication Administration Record (MAR) indicated the following: -9/29/25 Seroquel (an antipsychotic medication used to treat psychiatric symptoms) 12.5 mg at bedtime -10/17/25 Seroquel 12.5 mg at bedtime and 12.5 mg as needed -11/13/25 Seroquel 12.5 mg during the day and 25 mg at bedtime -antipsychotic medication side effect monitoring that included drowsiness, dizziness, and orthostatic blood pressure monitoring. The Treatment Administration Record (TAR) lacked documentation orthostatic blood pressures were attempted. R3's vital signs record lacked orthostatic blood pressures were attempted. R3's progress notes lacked documentation orthostatic blood pressures were attempted or any refusals. R3's medical record lacked a baseline assessment. R31 (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R31's quarterly Minimum Data Set (MDS) assessment, dated 10/24/25 indicated R31 had moderate cognitive impairment with no behaviors. R31 required partial to moderate assistance with personal and toileting hygiene as well as transfers. R31's diagnosis list included: delirium, history of falling, depression, history of bladder and colon cancer. R31's care plan indicated R31 had some intermittent confusion, likes visiting with staff and other residents when he is in a good mood. A care plan titled Potential for psychotropic drugs ADR's (adverse drug reactions) related to daily use of psychotropic medications indicated: administer medication as ordered, report suspected ADR's to provider, monitor monthly orthostatic blood pressure, and complete TD (tardive dyskinesia-a potential side effect of antipsychotic medication use that causes abnormal involuntary muscle movement) screening or AIMS (Abnormal involuntary movement screening) per protocol. R31's Medication Administration Record (MAR) indicated the following: -Give Seroquel (an antipsychotic medication used to treat psychiatric symptoms) 12.5mg one time a day at 4pm. -Give Seroquel 12.5mg one time a day at 8pm. -monitor orthostatic blood pressure monthly while receiving antipsychotic medications, on the 3rd of every month. R31's Treatment Administration Record (TAR) did not include documentation orthostatic blood pressures were attempted. R31's vital signs lacked orthostatic blood pressures results. R31's progress notes lacked documentation orthostatic blood pressures were attempted or any refusals. During an interview on 12/3/25 at 10:00 a.m., registered nurse (RN)-C stated residents receiving antipsychotic medications have behavior monitoring documented on the TAR. If a resident is having odd symptoms, staff would obtain vital signs. RN-C stated orthostatic blood pressure monitoring is documented on the MAR/TAR. During interview on 12/3/25 at 10:41 a.m., the director of nursing (DON) stated when residents are prescribed antipsychotic medications, the facility obtains consent for the medication, and initiates monitoring for target behaviors, side effects, and orthostatic blood pressures. The DON also stated the facility does a baseline AIMs assessment at the start initiating the medication. The DON confirmed R3 and R31 did not have orthostatic blood pressure monitoring in place and confirmed R3's record lacked a baseline assessment. During interview on 12/3/25 at 8:49 a.m. medical doctor (MD)stated orthostatic measurement are built into routine monitoring to be done at least monthly while residents are taking antipsychotic medications. MD expected pharmacy to confirm orthostatic blood pressures were being completed during the monthly pharmacy reviews; to make recommendations to complete if not being done. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Further, MD stated he would expect the nursing staff to complete all three components (laying, sitting, standing) of orthostatic measurements; if one component couldn't be done due to resident medical status, MD would still expect to see the other components. MD would expect to be notified by nursing or pharmacy if orthostatic measurements weren't being done or were abnormal. During interview on 12/4/25 at 11:31 a.m., pharmacist stated pharmacy reviews were conducted monthly per regulation. Pharmacist stated she reviews the side effect monitoring, target behaviors, and vital signs. Pharmacist stated, if a resident had a pre-existing condition of orthostatic blood pressure; she would only check to see if orthostatic measurements were done if the resident had other cardiac symptoms such as dizziness or shortness of breath. Pharmacist stated she verifies the orthostatic measurement is done prior to starting; but does not monitor to make sure monthly orthostatic measurements are being completed. A policy titled Psychotropic Medication Use Policy dated 5/2025, residents being prescribed antipsychotics will have orthostatic blood pressure performed monthly. Further, an AIMS assessment will be completed at baseline prior to initiation of an antipsychotic.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to identify the root causes of falls in order to appropriately implement person centered interventions to help prevent further falls for 1 of 1 resident (R36) reviewed for accidents.Findings include:R36's comprehensive Minimum Data Set (MDS) assessment, dated 10/14/2025, indicated R36 had intact cognition, independent with eating, sit to stand movement, and ambulation with a walker. R36's admission fall assessment dated [DATE] indicated R36 was at risk for falls. R36's fall care area assessment (CAA) dated 10/2/2025, indicated R36 had previously fallen. R36 was at fall risk due to ongoing physical debility secondary to dementia. R36's care plan revised 10/2/25 outlined the following fall prevention interventions: call light pendant on, use call light pendant sign in room, keep room clean and free of clutter, keep call light within reach, monitor and document on safety. The care plan lacked further fall interventions added after 10/2/25 date.R36's incident progress notes identified the following falls:-11/17/25 at 1:53 p.m., due to ambulating in room without walker, tried to sit down in recliner and sat down too soon, sliding down front of recliner, no injuries.-11/26/25 at 6:24 p.m., due to ambulating in room without walker, trying to get something across the room, turned around and lost balance, no injuries.-11/30 at 12:05 p.m., due to ambulating from bed to chair without walker, feet got tangled and fell, nosebleed, left knee pain, bruising above left eye.-11/30 at 4:24 p.m., due to ambulating in room; unclear if R36 had been using walker at time of fall, 4cm abrasion to mid back.R36's record lacked an analysis of the each of the above falls and lacked any new interventions. During observation on 12/2/25 started at:-11:01 a.m.,R36 was sitting at side of bed with socks on (no grippers). Registered nurse (RN)-C and nursing assistant (NA)-A walked by R36's room.-11:03 a.m., R36 stood up. RN-C walked by room again, looking inside room, and continued walking. R36 walked to door and the closed door. NA-D walked by, opened door and saw R36 sitting on roommate's bed and asked R36 if she needed assistance; R36 stated she needed to use restroom. NA-D assisted R36 to the restroom without offering to put shoes on. NA-D left R36 in restroom alone and closed bathroom door then exited room and closed room door. -11:21 a.m., door was opened and observed R36 exited bathroom and did not use the walker. R36 sat down on roommate's bed and put on clean socks (no grippers) and shoes.-11:26 a.m., NA-A entered room and assisted R36 from roommate's bed back to her own chair and placed walker in front of her.During interview on 12/2/25 at 11:35 a.m., NA-A and NA-D stated R36 is a moderate fall risk due to intermittent confusion. NA-A stated R36 had fallen twice in one day because she just forgot how to walk. NA-D stated R36 falls mostly because she doesn't use her walker when ambulating in her room. NA-A and NA-D stated R36 should have gripper socks on or shoes when ambulating. NA-D confirmed she did not put shoes on R36 prior to placing her in the bathroom; NA-D confirmed this was not a safe thing to do for R36. During an interview on 12/2/25 at 11:40 a.m., RN-C stated R36 liked to walk out in the halls a lot and likes to attend the activities. RN-C confirmed R36 is a moderate fall risk due to intermittent confusion and not using her walker. RN-C confirmed R36 had been mildly injured from falling. RN-C stated the resident should have gripper socks and or shoes on. During interview on 12/2/25 at 2:28 p.m., director of nursing (DON), assistant director of nursing (ADON), and administrator confirmed R36 was a moderate fall risk. DON confirmed R36 had fallen four times in a week. ADON confirmed she would expect to see a comprehensive fall care plan to include appropriate footwear, frequent checks, and always keeping her walker close. DON confirmed R36's care plan was not comprehensive and did not include interventions for appropriate footwear and frequent observations. DON confirmed if staff walked by R36's room and saw resident without proper footwear she would expect them to stop and assist R36 with ensuring she had proper footwear on. During interview on 12/3/25 at 8:49 a.m., medical doctor (MD)-A confirmed he was familiar with R36 and her history and risk for falling. MD-A confirmed the interdisciplinary team had (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	discussed R36 and her fall history and possible interventions. MD-A confirmed he would expect a comprehensive person-centered care plan for R36 to include appropriate footwear and frequent observations. A policy titled fall prevention and management dated 11/2025, if falling recurs despite initial interventions, staff will implement additional or different interventions or indicate why the current approach remains relevant.

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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 ensure the pharmacy consultant identified irregularities in monthly drug regimen reviews for 2 of 5 (R3 and R31) residents reviewed for unnecessary medications who received antipsychotic medications. Findings include: R3's quarterly Minimum Data Set (MDS) assessment, dated 9/25/25 indicated R3 had moderate cognitive impairment with no behaviors. R3 required partial to substantial assistance for personal and toileting hygiene as well as transfers. The MDS indicated R3 had diagnoses that included debility/cardiorespiratory conditions, orthostatic hypotension (a drop in blood pressure with position changes), heart failure, high blood pressure, and diabetes. R3's diagnoses list included: auditory hallucinations, heart failure, repeated falls, orthostatic blood pressure, and depression. R3's care plan titled Potential psychotropic drug ADRs [adverse drug reactions] related to daily use of psychotropic medications indicated: administer as ordered, monitor target behaviors as ordered, and monitor for ADR's such as orthostatic blood pressures monthly and TD [tardive dyskinesia-a potential side effect of antipsychotic medication use that causes abnormal involuntary muscle movement] screening or AIMS [Abnormal involuntary movement screening] per protocol. R3's Medication Administration Record (MAR) indicated the following: -9/29/25 quetiapine (a medication used to treat psychiatric symptoms) 12.5 mg at bedtime -10/17/25 quetiapine 12.5 mg at bedtime and 12.5 mg as needed -11/13/25 quetiapine 12.5 mg during the day and 25 mg at bedtime -antipsychotic medication side effect monitoring that included drowsiness, dizziness, and orthostatic blood pressure monitoring. The MAR lacked documentation orthostatic blood pressures were attempted. R3's vital signs lacked orthostatic blood pressures were attempted. R3's progress notes lacked documentation orthostatic blood pressures were attempted or if R3 refused. R3's medical record lacked a baseline assessment. R3's progress notes indicated the consultant pharmacist made recommendations on 10/3/25 and 11/3/25. On 12/1/25 the consultant pharmacist found no irregularities R3's Pharmacist Recommendation to Provider form dated 10/3/25 indicated R3 had an active order (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	for quetiapine 12.5 mg at bedtime. The recommendation lacked mention of initiating orthostatic blood pressure monitoring or obtaining an baseline assessment. R3's Pharmacist Recommendation to Provider form dated 11/3/25 indicated R3 had an active order for quetiapine 25 mg at bedtime and 12.5 mg daily as needed. The recommendation lacked mention of initiating orthostatic blood pressure monitoring or assessment. R31 R31's quarterly Minimum Data Set (MDS) dated [DATE] indicated R31 had moderate cognitive impairment with no behaviors. R31 required partial to moderate assistance with personal and toileting hygiene as well as transfers. R31's diagnosis list included: chronic kidney disease, delirium, history of falling, depression, history of bladder and colon cancer. R31's care plan titled Potential for psychotropic drugs ADR's (adverse drug reactions) related to daily use of psychotropic medications indicated: administer medication as ordered, report suspected ADR's to provider, monitor monthly orthostatic blood pressure, and complete TD (tardive dyskinesia-a potential side effect of antipsychotic medication use that causes abnormal involuntary muscle movement) screening or AIMS (Abnormal involuntary movement screening) per protocol. R31's Medication Administration Record (MAR) indicated the following: -Give Seroquel (an antipsychotic medication used to treat psychiatric symptoms) 12.5mg one time a day at 4pm. -Give Seroquel 12.5mg one time a day at 8pm. -monitor orthostatic blood pressure monthly with receiving antipsychotic medications, on the 3rd of every month. The treatment administration record (TAR) lacked include documentation orthostatic blood pressures were attempted. R31's vital signs record lacked orthostatic blood pressures were attempted. R31's progress notes lacked documentation orthostatic blood pressures were attempted or any refusals. R31's pharmacy reviews dated July 2025 through December 2025 lacked noting the missing orthostatic measurements and did not recommend for them to be completed. During interview on 12/3/25 at 8:49 a.m. medical doctor (MD) stated orthostatic measurement are built into routine monitoring to be done at least monthly while residents are taking antipsychotic medications. MD expected pharmacy to confirm orthostatic blood pressures were being completed during the monthly pharmacy reviews; to make recommendations to complete if not being done. Further, MD stated he would expect the nursing staff to complete all three components (laying, sitting, standing) of orthostatic measurements; if one component couldn't be done due to resident (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	medical status, MD would still expect to see the other components. MD would expect to be notified by nursing or pharmacy if orthostatic measurements weren't being done or were abnormal. During interview on 12/4/25 at 11:31 a.m., pharmacist stated pharmacy reviews were conducted monthly per regulation. Pharmacist stated she reviews the side effect monitoring, target behaviors, and vital signs. Pharmacist stated, if a resident had a pre-existing condition of orthostatic blood pressure; she would only check to see if orthostatic measurements were done if the resident had other cardiac symptoms such as dizziness or shortness of breath. Pharmacist stated she verifies the orthostatic measurement is done prior to starting; but does not monitor to make sure monthly orthostatic measurements are being completed. A policy titled Consultant Pharmacist Reports: Medication Regiment Review dated May 2022 indicated the pharmacist review involves a thorough review of resident's records and involves reporting findings with recommendations for improvement. The pharmacist reviews the medication regimen at least monthly; incorporating federally mandated standards of care.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245345	A. Building B. Wing	12/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Green Prairie Rehabilitation Center	800 Second Avenue Northwest Plainview, MN 55964

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on interview and document review, the facility failed to ensure medical records were complete and accurately documented for 1 of 1 resident (R6) reviewed for resident records.R6's quarterly Minimum Data Set (MDS) assessment, dated 8/28/25 identified R6 had no cognitive impairment. R6's MDS also indicated behavior symptoms (threatening others, screaming at others, or cursing at others) occurred 1 to 3 days.R6's care plan noted alteration in mood and behavior related to major depressive disorder. Further, resident is known to make inappropriate racial jokes or comments. Additionally, R6 appears to be malcontent as evidenced by complaints about wall paint, flooring, food, and staff. R6 will often refuse care from staff, then file a grievance stating staff did not care for her. Last, R6 can communicate her needs and feelings when asked.R6's orders indicated target behaviors should be monitored every shift, documented as the behavior observed, intervention used, and findings entered in the nursing progress notes. Target behaviors are outlined as: (A) isolation, (B) depressive statements, (C) crying, and (D) feelings of helplessness. Non-pharmacological interventions could include: (0) N/A, (1) redirection, (2) ambulation, (3) offer activity, (4) essential oils, (5) repositioning, (6) toileting, (7) provide 1:1, (8) offer food/fluids, (9) offer pain relief. During interview on 12/1/2025 at 5:36 p.m., R6 stated she gets annoyed with staff and other residents. R6 stated she stays in her room almost 95% of the time because she doesn't want to deal with anyone. R6 stated when she has left her room, she will get angry or upset very easily.R6's treatment administration record (TAR) dated on 10/17/25, target behavior monitoring had been document as no behaviors with no interventions for all three shifts. However, a progress note at 9:42 p.m. detailed R6 had been in her room all shift, slept all shift, and did not eat dinner.R6's TAR dated on 11/26/25, R6's target behavior monitoring was documented as no behaviors. However, upon review of R6's progress notes, at 2:05 a.m. R6 had verbal outbursts with staff, using racial slurs and profanities.R6's TAR dated on 11/28/25, R6's target behavior monitoring was documented as no behaviors. However, upon review of the progress notes, R6 had negative behaviors of refusing cares, accusing staff of things they did not do, and entering the hall to yell at staff.During interview on 12/2/25 at 11:35 a.m., nursing assistant (NA)-C and NA-D stated nursing assistants and nurses can document target behaviors. NA-D stated target behaviors are charted in the TAR. NA-C stated the providers look at the target behaviors in the TAR to know if the medications are working or not.During interview on 12/2/25 at 11:40 a.m., registered nurse (RN)-C stated it is an expectation to chart target behaviors in the TAR as you see them. RN-C stated she would update her charting in the TAR to reflect changes in behavior throughout her shift. RN-C stated the importance of accurate charting in the TAR is so that providers know if medications are working or not; inaccurate charting could mean a resident isn't being treated appropriately.During interview on 12/4/2025 at 10:08 a.m., director of nursing (DON) stated her general overview of R6's October and November TAR was resident had not experienced negative target behaviors. The DON confirmed R6 was prone to negative behaviors of verbal outbursts, racial slurs, refusing cares, and refusing to leave her room. The DON confirmed R6 had negative behaviors on 10/17/25, 11/26/25, and 11/28/25; indicating she would expect to see the specific behaviors documented in the TAR. The DON confirmed if staff had documented no behaviors at the beginning of the shift, then the resident had negative behaviors, the DON would expect staff to update the charting to reflect the specific negative target behaviors. The DON stated the importance of charting accurate target behaviors was so facility staff and providers know if behavior medications are effective. Inaccurate documentation could lead to untreated symptoms.During interview on 12/3/25 at 8:49 a.m., medical doctor (MD)-A stated he would expect target behavior monitoring and interventions to be document in the TAR, with a follow up progress note. MD-A stated it is important to know if a resident is experiencing negative behaviors so medications can be adjusted to treat ongoing symptoms. MD-A stated his general overview of R6's October and November TAR was the resident had not experienced negative target behaviors.A policy for medical record documentation was requested and not received.

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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. Based on observation, interview, and record review, the facility failed to ensure proper use of personal protective equipment (PPE) for 1 of 1 resident reviewed for enhanced barrier precautions (EBP)Findings include: R34's significant change Minimum Data Set (MDS) assessment, dated 9/17/25, indicated R34 was cognitively intact with no behaviors. R34 required partial/moderate assist with oral hygiene, showering, personal hygiene, dressing, some position changes, and sitting to standing. R34 required substantial assist with transferring and applying/removing footwear. It also indicated R34 was dependent on staff for toilet hygiene. R34 was continent of bowels and frequently incontinent of urine. The MDS also indicated R34 had open lesions and skin tears. R34's diagnoses list included cellulitis (infection under the skin) of lower limb.R34's care plan included altered nutrition related to wound healing, urinary incontinence, discomfort related to wounds and immobility, and alteration to skin related to wounds.R34's provider orders included: follow EBP while providing wound cares and other high contact care activities, as well as dressing change orders to all open lower leg wounds. During observation and interview on 12/1/25 at 2:38 p.m., a sign posted on outside R34's room indicated enhanced barrier precautions. The sign provided direction for applying and removing PPE as well as indications when PPE would be used. A plastic dresser containing gloves and gowns was located just outside R34's room. During the interview, R34 stated staff did not always wear gowns when providing cares. R34's stated he had a wound to his lower leg he sustained outside the facility as well as several open blisters from the swelling in his legs. The nurses provide dressing changes and his legs are wrapped to control the swelling. R34's lower legs were observed covered with a compression wrap with a portion of a bandage visible. During observation on 12/2/25 at 9:59 a.m., registered nurse (RN)-B sanitized hands, applied gown, and applied gloves prior to entering R34's room. A couple minutes later, nursing assistant (NA)-A entered R34's room, sanitized her hands, and applied gloves however did not apply a gown. R34 was seated on the commode. RN-B stood on the right side of R34 while NA-A stood to the left side of R34. R34 was assisted to a standing position with a gait belt by RN-B and NA-A. RN-B provided toileting cares while NA-A held the gait belt holding R34 steady. When toileting cares were completed, RN-B and NA-A assist R34 to his nearby recliner. Prior to R34 sitting, NA-A and RN-B reached behind R34 to hold his incontinence product in place while R34 sat down. NA-A's clothing made contact with R34. Once R34 was seated, NA-A removed R34's gait belt, removed gloves, performed hand hygiene, and then left the room. RN-B removed all PPE, washed hands, applied new PPE and provided wound cares to R34's lower extremities with no breaks of infection noted. During an interview on 12/2/25 at 1:50 p.m., NA-A stated infection control training is performed via online training as well as reminders from the facility director of nursing. NA-A indicated gowns and gloves are worn for residents on EBP when toileting or doing things with catheters. NA-A stated she would not wear a gown when transferring a resident on EBP. During an interview on 12/2/25 at 2:42 p.m., NA-B stated she worked for a staffing agency. NA-B reported no extra training for transmission-based precautions and would just read the signs on the door. NA-B stated she would apply PPE prior to entering a residents room anytime cares are performed however would not wear PPE just for transfers because there is no risk of spreading anything. During an interview on 12/2/25 at 2:50 p.m., RN-A could not recall any specific transmission-based precaution training, however stated there is a lot of signage. RN-A stated facility will show staff proper PPE application if staff is unfamiliar with the procedure. RN-A stated she would wear gowns for dressing changes but not for transfers unless there is risk of exposing the wound. RN-A then stated staff should wear gowns when transferring residents with indwelling catheters (tubing inserted in urinary bladder). During an interview on 12/3/25 at 10:41 a.m., the director of nursing (DON) stated staff receive online training upon hire and also perform competencies. She expects staff to read the signs posted on the residents' door for direction on applying PPE. If the facility admits a resident with something unusual the facility will do individual training. The DON stated she does audits of breaks in (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	transmission-based precautions if an issue is reported to her. She does not do spot checks for EBP. The DON stated gown, and gloves are warn when staff are spending an extensive amount of time with residents such as performing cares and toileting. She also expects staff to wear gown and gloves when emptying indwelling catheter bags and dressing changes. She does not expect staff to wear gown and gloves when transferring residents. A policy titled Enhanced Barrier Precautions dated 4/1/24 indicated the purpose of EBP is for the prevention of transmission of multidrug-resistant organisms. EBP is defined as the use of gown and gloves for use during high-contact resident care activities for residents .at increased risk for MDRO [multi-drug resistant organism] acquisition (e.g., residents with wounds or indwelling medical devices). Under the heading Explanation and Compliance Guidelines the policy indicated to initiate enhanced barrier precautions for residents who have chronic wounds. The Implementation of Enhanced Barrier Precautions section indicated, in part, the Infection Preventionist will incorporate periodic monitoring and assessment of adherence to determine the need for additional training and education. The policy defined high-contact resident care activities to include: dressing, bathing, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, device care or use, and wound care.