

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245359	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/17/2026
NAME OF PROVIDER OR SUPPLIER Edenbrook Pine Haven		STREET ADDRESS, CITY, STATE, ZIP CODE 210 Northwest 3rd Street Pine Island, MN 55963	
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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. Based on interview and document review, the facility failed to ensure nursing staff were appropriately oriented and trained for safe medication administration. This resulted in widespread medication administration errors affecting 16 of 25 residents (R4, R7, R10, R12, R16, R18, R20, R23, R25, R27, R29, R30, R31, R37, R39, and R46) on 7/15/26. Findings include: (Cross-reference: Refer to F-760 for the specific medical record data and medication error details for residents R4, R7, R10, R12, R16, R18, R20, R23, R25, R27, R29, R30, R31, R37, R39, and R46.) Review of the facility policy Change in Condition, dated 11/13/24, showed requirements to notify the provider and responsible party of any change in resident physical, psychosocial, or mental status. Line item two listed a medication error or adverse reaction as an example requiring notification. Line item three instructed the nurse to complete and document assessment findings, including vital signs and respiratory/cardiac status, and to notify the provider. During an interview on 7/16/26 at 1:39 p.m., the DON stated a night shift nurse first notified them of the widespread medication errors on the morning of 7/16/26. The DON confirmed that RN-A's orientation competency check-lists were completely missing from the facility records. The DON stated the nursing department did not know who authorized RN-A to clear orientation. The DON stated RN-A and LPN-B should have immediately notified nursing leadership and medical providers about the missed critical medications. During an interview on 7/16/26 at 3:13 p.m., Registered Nurse (RN)-A stated they worked the day shift on 7/15/26. It was their first shift independently off orientation. They were assigned to pass medications to 28 residents. RN-A stated they were unfamiliar with which residents received insulin or time-sensitive medications. At 2:30 p.m., RN-A had failed to pass all day medications, complete treatments, or take vital signs. Licensed Practical Nurse (LPN)-B instructed RN-A to stop passing the day medications and document the omissions. RN-A did not notify a medical provider or the Director of Nursing (DON) regarding the missed insulins or medications. RN-A stated orientation did not cover provider notification protocols. During an interview on 7/16/26 at 4:50 p.m., LPN-B stated they worked the afternoon shift on 7/15/26. RN-A reported missing approximately 50 percent of the scheduled day medications. LPN-B instructed RN-A to stop passing the day medications, leave them unadministered, and document the omissions. LPN-B did not contact medical providers or nursing leadership regarding the missed medications. LPN-B did not review the specific omissions for each resident. LPN-B notified a Nurse Practitioner (NP) about only one resident who experienced high blood sugar after a missed medication dose. Multiple residents experienced elevated blood sugars during the evening shift. LPN-B stated that nurses should contact a provider when insulin, diuretics, or blood pressure medications are missed. During a follow-up interview on 7/17/26 at 9:51 a.m., the DON confirmed the facility's orientation program lacked nursing department oversight and structured competency evaluations. During an interview on 7/17/26 at 10:42 a.m., the administrator confirmed RN-A's (continued on next page)		

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	personnel file contained no nurse-specific orientation or competency tracking documentation. During an interview on 7/17/26 at 11:21 a.m., the Nurse Practitioner (NP) stated the facility did not provide notification of the multiple missed medications and treatments until 7/17/26. The NP stated they had not yet reviewed the specific written notifications in their inbox. The NP stated missed treatments and medications create a potential for resident decline. The NP stated errors involving anticoagulants, antipsychotics, Parkinson's medications, anti-seizure medications, antibiotics, and insulin require timely intervention to prevent decline. The NP stated they require immediate notification for significant medication errors. The NP stated that for a missed insulin dose, nursing staff must assess the resident, check the blood glucose level, and call the provider for orders. The facility policy Medication Error and Drug Interactions dated 8/15/22, directed residents were to be free of significant medication errors. All medication errors were to be reported promptly to the director of nursing, the attending physician, the responsible party, and documented according to established procedures. Significant medication error was defined as one which causes the resident discomfort or jeopardizes resident health or safety. A detailed account of the error should be recorded in the medical record, and a medication risk management report should be completed by the nurse for later review by quality.		

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Administer the facility in a manner that enables it to use its resources effectively and efficiently. Based on interview and record review, the facility administration team failed to provide oversight and implementation of a competency-based nursing orientation program. This administrative failure resulted in a new graduate nurse working independently without verified competencies, leading to a widespread medication error incident involving high-risk medications. This deficient practice had the potential to impact all residents residing at the facility. Findings include: The administrator job description dated 10/25, section Administrator Human Resources Management Responsibilities, identified the administrator was responsible for the elimination and control of safety and health hazards by regularly reviewing work practices and providing employees with training and instructions. The Director of Nursing (DON) job description dated 10/25, indicated the DON was responsible for staff development, effective departmental orientation, and ensuring staff are adequately oriented and trained to perform duties. During an interview on 7/16/26 at 2:00 p.m., the DON confirmed Registered Nurse (RN)-A was a newly hired nurse just off orientation who was involved in a widespread medication error incident on 7/15/26. The DON stated RN-A was not properly evaluated for clinical competency before being placed on the schedule. The DON stated they did not know who determined RN-A was ready to work independently. The DON confirmed that human resources (HR) and the scheduler coordinated nurse orientation, and completed competency checklists went to HR rather than the nursing department. During an interview on 7/16/26 at 3:13 p.m., RN-A stated the day shift on 7/15/26 was their first shift off orientation and their first time passing medications to the 28 residents in the front section. RN-A stated that while insulin management was covered, other high-risk medications, provider notification protocols, and post-fall evaluation protocols were completely omitted. RN-A stated the facility originally promised eight days of orientation, but HR reduced the training period to three days upon arrival. RN-A stated they did not know who their current supervisor was, never had anyone from nursing discuss their schedule, and still possessed their own physical orientation check-off sheets because they did not know where to turn them in. The scheduler was the only individual who communicated with RN-A regarding their placement on the floor schedule. During a follow-up interview on 7/17/26 at 9:51 a.m., the DON confirmed the facility's current nurse orientation program completely excluded oversight from the nursing department. The DON stated the nursing department made no decisions regarding when an orientee was ready to work independently, and a previous proposal to have the DON review orientees for clinical competency was never implemented by administration. During an interview on 7/17/26 at 10:42 a.m., the administrator confirmed they reviewed the personnel files for Licensed Practical Nurse (LPN)-A, LPN-C, LPN-D, and RN-A, and found that none of the files contained any nurse-specific orientation or competency tracking documentation. The administrator confirmed the facility lacked an operational process for checking nurse competency before scheduling independent floor shifts, and instead left it up to individual nurse orientees to self-determine if they felt ready. The administrator confirmed that floor nurses signed off on checklists, but those forms were turned into HR rather than nursing leadership. The facility policy Administering Medications, dated 1/22/24, line item three, indicated the DON was responsible for the supervision and direction of all personnel with medication administration duties and functions.		

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F 0940 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Develop, implement, and/or maintain an effective training program for all new and existing staff members. Based on interview and record review, the facility failed to develop and implement a comprehensive, competency-based nursing orientation program, failed to maintain required competency records in newly hired employee files. This failure resulted in a new graduate nurse working independently without verified competencies, leading to a widespread medication error incident. This deficient practice had the potential to impact all residents who received nursing care at the facility. Findings include: Review of the facility's personnel records for four nurses hired within the last seven months revealed a complete absence of role-specific training documentation: Licensed Practical Nurse (LPN)-A was hired on 6/25/26. The personnel file contained no orientation documents or completed competency evaluations specific to the LPN role. LPN-C was hired on 1/20/26. The personnel file contained no orientation documents or completed competency evaluations specific to the LPN role. LPN-D was hired on 1/20/26. The personnel file contained no orientation documents or completed competency evaluations specific to the LPN role. Registered Nurse (RN)-A was hired on 6/16/26. The personnel file contained no orientation documents or completed competency evaluations specific to the RN role. Review of the facility's Facility Assessment, dated 10/23/25, showed requirements to complete specific nursing staff competencies at the time of hire and annually. These mandatory competencies included lifts, isolation, personal protective equipment donning and doffing, hand hygiene, wound and skin assessment, safe drug administration, medication pass, wound care, blood glucose monitoring, and medication errors. During an interview on 7/16/26 at 11:38 a.m., RN-B stated they were currently in orientation and their fourth and final day of training would conclude the next day. RN-B stated floor nurses signed off on their checklists, but they were unsure if the compressed timeframe provided sufficient training. During an interview on 7/16/26 at 11:42 a.m., LPN-C stated they were precepting RN-B and signing off on the orientation checklists. LPN-C confirmed management recently cut floor orientation from eight days down to three days. LPN-C stated that three days of orientation was insufficient to learn the floor layout and requirements, noting that passing medications to 28 residents on the front unit was excessively difficult for a new nurse. During an interview on 7/16/26 at 2:00 p.m., the Director of Nursing (DON) confirmed RN-A was a newly hired nurse who was placed on the floor independently without proper competency evaluations. The DON confirmed this lack of verified training resulted in a widespread medication error incident on 7/15/26 during RN-A's first solo shift on the 28-resident front medication cart. The DON stated human resources (HR) and the scheduling department coordinated orientation, and completed forms went into an HR mailbox rather than to nursing leadership. The DON stated they did not know who authorized RN-A to clear orientation and start working independently. During an interview on 7/16/26 at 4:50 p.m., LPN-B stated that nurse orientation and facility staffing metrics changed after state oversight left. LPN-B confirmed orientation was cut from eight days to three or four days, which compromised resident safety and increased the risk of missed treatments or medications. During an interview on 7/17/26 at 9:40 a.m., the Staff Scheduler stated they held responsibility for setting up orientation, managing online training modules, and assigning schedules for newly hired RNs, LPNs, and nursing assistants. The Scheduler confirmed floor orientation was reduced from eight days to three days during the previous month. The Scheduler stated they distributed competency bundles to orientees and instructed them to drop the completed sheets directly into the HR mailbox. The Scheduler confirmed the nursing department was completely excluded from this process, no communication regarding competency occurred, and the scheduling (continued on next page)		

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F 0940 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	system lacked a hard stop to verify a nurse's competency before assigning them to independent floor shifts. During a follow-up interview on 7/17/26 at 9:51 a.m., the DON confirmed the current nurse orientation program completely excluded nursing department oversight and had operated that way since November 2025. The DON confirmed that a previous administrative proposal to have the DON review new hires for clinical competency was never implemented. During an interview on 7/17/26 at 10:42 a.m., the administrator confirmed they reviewed the personnel files for LPN-A, LPN-C, LPN-D, and RN-A, and found none contained nurse-specific orientation or competency tracking documentation. The administrator confirmed the facility lacked a valid process to verify nurse competency before scheduling independent floor shifts, instead relying on the new hires to self-determine if they felt ready. The administrator confirmed that while floor preceptors signed off on competency checklists, those forms went to HR instead of nursing leadership for final approval.		

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to organize and participate in resident/family groups in the facility. Based on record review and interview, the facility failed to act upon grievances and recommendations made by the Resident Council regarding delayed call light response times and delayed resident care. This affected 9 of 9 residents who attended the Resident Council meeting. Findings include: R1, R4, R8, R20, R21 R25, R27, R31, and R37 attended a resident council review meeting on 7/15/26 from 10:00 a.m. to 10:40 a.m. During the meeting several residents stated they were concerned because they had not received their morning medications yet and attributed it to the new nurse working the cart. The residents expressed the following concerns r/t to perceived low staffing levels, care delays and long call light wait times. -Each hallway only had one nursing assistant on it to answer call lights and do transfers and cares. -It now took two staff to do device transfers, so they had to wait even longer to get help with getting out of bed or going to the toilet. It took time to find another available NA. -When two NAs were in a room doing a transfer, all the residents on those NA's hallways had to wait for them to finish the transfer before their call light got answered. -Staff answered their light, turned it off, said they would be back and then sometimes they came back, and sometimes they didn't come back at all or they did and said they still couldn't help them yet and would be back later. -Some reported they had urgency with using the toilet so sometimes it was too late by the time a staff was available to help them to the toilet. -One resident reported they had had bowel accidents where they had had to wait two or three hours before staff could get them changed. -Estimated wait times ranged from as little as five minutes and as long as thirty minutes to more than an hour depending on the time of day and shift. -One resident stated they had to wait 40 minutes on the toilet before someone came to help them off. Other residents expressed similar experiences waiting for help off the toilet. -Some staff have said they were short staffed. -Residents stated they did have less staff now then they did before. -It was hard for NAs to answer all the call lights with one NA per hallway. -one had their shower day changed Residents stated they had been bringing these issues up for several months at resident council. All agreed, they felt they had not received a real response from the facility. The administrator talked about meeting staffing numbers, and had talked about doing call light audits, but mostly they had been told they were working on it but none of them knew what that meant. There hadn't been any improvement or any explanation about what was being done. Things have felt worse since they started using two staff for transfers without adding anyone to help. During an interview on 7/15/26 at 11:05 a.m., the administrator stated they had attended four resident council meetings at the facility. Concerns voiced in resident council were recorded and then sent to a department manager to investigate. The administrator confirmed staffing concerns and call light response times had been consistently brought up in the resident council meetings. They had tried to explain the entire hours per patient day to the group several times. They have also told the residents they wished they could add a NA but they had to follow the staffing ratios. The administrator stated if the facility CMI was higher than they could add staff. They were in the process of providing all staff with documentation education to ensure resident levels of care were accurately captured. Residents did complain about call lights taking an hour or more to be answered but usually it turned out residents were not waiting more than a half hour. During an interview on 7/16/26 at 1:03 p.m., the activities director (AD) stated they regularly attended the resident council meetings. Meeting grievances got passed on to the administrator. The two biggest concerns residents continued to express were long call light response times and long waits for care. The recent change to have two staff instead of one with assistive transfer devices has impacted call lights. Residents have not understood the change was made for safety. They have been focused on having extra wait time for two staff to be available to do (continued on next page)		

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	transfers, and how tying up two staff for transfers has created longer wait times for the rest of the residents. The residents have been told call lights can be answered by other staff; it didn't have to be just nursing. All staff have been instructed to answer call lights and get nursing staff if they can't help the residents. There has been some explanation to residents, but so far, they have not felt like they have gotten an adequate response. The AD confirmed call light audits had been brought up in a council meeting, but they were not aware if anything had been done with audit. During an interview on 7/16/26 at 10:48 a.m., the administrator confirmed May 2026, Resident Council Minutes indicated the facility would be conducting call light audits in response to call light concerns. However, this had not been done. They had just learned their call light system did not have the ability to generate wait time reports. The administrator confirmed nobody had conducted manual call light response times audits either and stated they were not sure how it was calculated that residents were not waiting more than thirty minutes for a call light response. In May and June, the big focus for call light response time had been getting staff education on accurate care level capture set-up. Now that this education was in place, they wanted to get call lights on the next quality meeting agenda so they could get a project started. During an interview on 7/16/26 at 1:23 p.m., the director of nursing stated they used to get invited to resident council meetings, but that had not happened in a long time. They had not been notified that there were ongoing call light concerns in resident council. From a nursing perspective, they had not conducted any spot audits of call light response times or completed any other projects related to resident wait times for lights or cares. The DON stated the size and layout of the building in relation to staffing levels made it more challenging to answer call lights and perform cares that required two staff. The DON stated they felt resident acuity should be incorporated into their process for determining staffing levels on the resident units instead primarily calculating numbers based on census. The facility policy Call Light Use and Response dated 7/18/23, indicated the purpose of the policy was to ensure prompt response to residents' call for assistance. The policy instructed lights were to be answered promptly and turned off as soon as staff entered the resident room and attended to the resident's needs. The facility policy Grievances/Concerns dated 10/29/24, identified the facility would make prompt efforts to resolve grievances. The policy identified the process and documentation components for an individual grievance which included resident statement, investigation and findings, facility actions, resolution and prevention, and resident satisfaction level with facility response. The facility policy Resident Council dated 2/2/23, directed when a resident group existed, the facility would listen to the resident views and act upon the concerns and recommendations of residents concerning policies and operation decisions affecting resident care and quality of life in the facility. A staff member would be designated to assist with group meetings and respond to any written requests that resulted from group meetings.		

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 interview and document review, the facility failed to ensure immediate provider notification occurred for 16 out of 25 (R4, R7, R10, R12, R16, R18, R20, R23, R25, R27, R29, R30, R31, R37, R39, and R46) ampled residents who experienced significant medication administration errors, treatment omissions, and missed clinical assessments on 7/15/26. Licensed nursing staff across the day, evening, and night shifts failed to contact the attending providers or conduct required physical assessments. In addition, the facility failed to notify the provider with a weight increase for 1 of 1 resident (R4) reviewed Findings include: Refer to F-Tag 760 for full medical record data on (R4, R7, R10, R12, R16, R18, R20, R23, R25, R27, R29, R30, R31, R37, R39, and R46) detailing specific medication omissions, clinical diagnoses, cognitive status, and specific treatment or assessment failures for the impacted residents. During an interview on 7/16/26 at 1:39 p.m., the DON stated they did not think the day, evening, or night shift nurse had notified a provider regarding residents with missed medications. The DON confirmed that the first notification the medical provider received regarding the massive omissions was when they personally contacted the NP the morning of 7/16/26. The DON stated that the provider should have been notified immediately yesterday regarding missed or late insulin and other missed critical medications. During an interview on 7/16/26 at 3:13 p.m., RN-A confirmed they worked the day shift on 7/15/26. RN-A stated they had not contacted a provider regarding the missed insulin or any of the other late or missed medications. RN-A noted that provider notification for errors had not been covered in their orientation. During an interview on 7/16/26 at 4:50 p.m., LPN-B confirmed they worked the afternoon shift on 7/15/26 and became aware that RN-A had missed approximately half of the day shift medications. LPN-B admitted they did not contact providers regarding the medications that were missed on the day shift. LPN-B only notified the NP about one single resident who had a high blood sugar because the NP happened to be on the floor at the time. LPN-B acknowledged that nurses should contact a provider when insulin, diuretics, and blood pressure medications are missed so the provider can give orders if needed. During an interview on 7/17/26 at 10:42 a.m., the administrator confirmed that proper provider notifications did not go out until the morning of 7/16/26. The administrator acknowledged that provider notification, medication review, and resident assessments should have been completed immediately during the evening shift on 7/15/26. During an interview on 7/17/2026 at 11:21 a.m., the nurse practitioner (NP) confirmed they did not receive notification from the facility regarding the medication omissions until 7/17/26. The NP stated (continued on next page)		

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	and functions. Line item seven directed medications should be administered within one hour of prescribed times. Medications that are scheduled with liberated administration times will be administered during the documented time.		

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NAME OF PROVIDER OR SUPPLIER Edenbrook Pine Haven		STREET ADDRESS, CITY, STATE, ZIP CODE 210 Northwest 3rd Street Pine Island, MN 55963	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure residents were free from significant medication errors. Nursing staff administered medications up to 10 hours late or omitted them entirely, including critical medications such as insulin, anticoagulants, narcotics, and cardiovascular drugs. This affected 16 of 25 residents reviewed (R4, R7, R10, R12, R16, R18, R20, R23, R25, R27, R29, R30, R31, R37, R39, R46). Findings include: R4's comprehensive Minimum Data Set (MDS) assessment, dated 7/14/26 showed the resident was cognitively intact. R4's Face sheet diagnoses included congestive heart disease and obstructive pulmonary disease. R4's Medication Administration Audit Report showed the facility administered 6:30 a.m. scheduled medications late at 11:30 a.m. on 7/15/26. These late medications included budesonide inhalation suspension, gabapentin 300 mg, lisinopril 30 mg, apixaban 5 mg, torsemide 60 mg, and Anoro Ellipta inhalation. Staff also administered 7:00 a.m. scheduled pantoprazole 40 mg late at 11:31 a.m. R4's progress notes lacked documentation of nurse assessments or provider notifications regarding these delayed administrations. R7's annual MDS assessment, dated 7/3/26, showed the resident was severely cognitively impaired. R7's Face sheet diagnoses included neurocognitive disorder with Lewy bodies, hypertensive chronic kidney disease, chronic pain syndrome, and type 2 diabetes. R7's Medication Administration Audit Report and electronic medical record (EMR) entries by RN-A showed staff omitted the following ordered morning medications on 7/15/26: Dilaudid 6 mg, lorazepam 1 mg, lidocaine 4% patch, acetaminophen 650 mg, and diclofenac sodium 1% gel. R7's record noted RN-A documented the medications were not given due to time. Progress notes dated 7/15/26 lacked nurse assessments or provider notifications. A delayed entry on 7/16/26 at 12:26 p.m. later noted provider notification. R10's quarterly MDS assessment, dated 5/15/26, showed the resident was moderately cognitively impaired and received hospice services. R10's Face sheet diagnoses included dementia, kidney disease, non-pressure left foot ulcer, and reflux disease. R10's The Medication Administration Audit Report showed staff omitted the 12:00 p.m. dose of hydromorphone HCl 1 mg on 7/15/26. Staff administered the next 3:00 p.m. dose late at 5:00 p.m. Staff also omitted Ensure 8 ounces and diclofenac 1% gel. Staff failed to complete scheduled psychotropic monitoring, non-pharmacologic pain interventions, and wound dressing checks. R10's progress notes identified, on 7/16/26 at 12:27 p.m., the ADON documented the missed narcotic dose. EMR records lacked any provider notification or tracking on 7/15/26 or 7/16/26. R12's quarterly MDS assessment, dated 5/30/26, showed the resident was severely cognitively impaired. R12's Face sheet diagnoses included hypertensive chronic kidney disease, congestive heart failure, and venous insufficiency. R12's Medication Administration Report showed staff omitted the following ordered day-shift medications on 7/15/26: Vitamin B-12 1000 mcg, furosemide 20 mg, Fibercon 625 mg, Miralax 17g, senna, losartan potassium, calcium 500/D (8:00 a.m. and 2:00 p.m. doses), and acetaminophen 1000 mg (8:00 a.m. and 2:00 p.m. doses). R12's progress notes dated 7/15/26 and 7/16/26 lacked documentation of nurse actions, assessments, or provider notifications regarding the 10 missed medications. R16's quarterly MDS assessment showed the resident was cognitively intact. R16's Face sheet diagnoses included hypertension, chronic kidney disease, and dementia. R16's Medication Administration Audit Report showed staff omitted the following day-shift medications on 7/15/26: Acetaminophen 1000 mg (6:00 a.m. and 1:00 p.m. doses), Norvasc 5 mg, loratadine 10 mg, and calcium Vitamin D. Staff also failed to perform required WanderGuard placement checks, non-pharmacological pain interventions, and pain monitoring. RN-A documented that medications were not given due to time. R16's progress notes lacked provider notifications. R18's significant change (continued on next page)		

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	MDS assessment, dated 6/9/26, showed the resident was severely cognitively impaired.R18's Face sheet diagnoses included dementia, hypertensive heart disease with heart failure, cardiomyopathy, hemiplegia, type 2 diabetes, and atrial fibrillation.R18's Medication Administration Audit Report showed staff omitted the following day-shift orders on 7/15/26: Daily weight monitoring, metoprolol tartrate 25 mg, torsemide 40 mg, losartan potassium 50 mg, aspirin 81 mg, ascorbic acid 500 mg, cholecalciferol 50 mcg, metformin HCl ER 500 mg, and acetaminophen 1000 mg.R18's progress notes lacked records of resident clinical assessments, missing weight alerts, or provider notifications.R20R20's comprehensive MDS assessment, dated 7/2/26, showed the resident was cognitively intact.R20's Face sheet diagnoses included type 2 diabetes.R20's Medication Administration Audit Report showed staff administered 6:30 a.m. scheduled medications late at 10:00 a.m. on 7/15/26, including Lantus insulin 6 units, lisinopril 40 mg, and nifedipine ER.R20's progress notes lacked clinical assessments or provider notifications regarding the delayed long-acting insulin.R23R23's quarterly MDS showed the resident was severely cognitively impaired.R23's Face sheet diagnoses included hypertensive heart failure, mitral valve insufficiency, palliative care, and Alzheimer's disease.R23's Medication Administration Audit Report showed staff omitted scheduled morphine sulfate 5 mg, a scheduled pressure-relief lamb's wool application between the left toes, and a topical nystatin powder application under the breasts.R23's progress notes lacked documentation of clinical assessments or provider notifications for the omitted narcotic and treatments.R25R25's quarterly MDS dated [DATE] showed the resident was cognitively intact.R25 Face sheet diagnoses included diabetes, congestive heart failure, and chronic kidney disease.R25's Medication Administration Audit Report showed staff omitted the scheduled 6:30 a.m. blood glucose check. Staff administered 6:30 a.m. scheduled medications late on 7/15/26. Lantus insulin 6 units was given at 11:18 a.m., pantoprazole 40 mg was given at 9:49 a.m., torsemide 40 mg was given at 4:16 p.m. (nearly 10 hours late), and metoprolol succinate ER was given at 9:49 a.m.R25's progress notes lacked documentation of provider notifications regarding the missing blood sugar check or delayed insulin and diuretic doses.R27R27's quarterly MDS dated [DATE] showed the resident was cognitively intact. R27 Face sheet diagnoses included hypertensive heart, chronic kidney disease with heart failure, and diabetes type two. R27's The Medication Administration Audit Report dated 7/16/26 at 10:36 a.m. showed staff omitted multiple medications, assessments, and orders during the day shift on 7/15/26. Staff omitted a scheduled daily weight and required provider notification for parameters, iron-vitamin C 65-125 mg, acetaminophen 1000 mg scheduled at 1:00 p.m., sliding scale aspart insulin scheduled at 11:30 a.m., and aspart 12 units scheduled at 12:00 p.m. Additionally, staff omitted the scheduled 12:00 p.m. blood glucose check.R27's Medication Administration Record dated 7/17/26 showed the resident's subsequent blood sugar at 5:00 p.m. on 7/15/26 was elevated at 288. R27's progress notes dated 7/15 and 7/16/26 lacked documentation of nurse actions or provider notifications regarding the missing blood sugar monitoring or omitted insulin doses. R29 R29's quarterly MDS dated [DATE] showed a cognitive assessment could not be completed. R29's Face sheet diagnoses included unspecified Parkinsonism, apraxia, degenerative disease of the nervous system, and hypertension.R29's Medication Administration Audit Report dated 7/16/26 at 10:43 a.m. showed staff omitted multiple scheduled medications during the day shift on 7/15/26. Staff omitted carbidopa-levodopa 25-100 mg (3 tablets), hydroxyzine HCl 25 mg, lorazepam 0.5 mg, and eight ounces of Ensure. Staff also omitted scheduled doses of Dilaudid 2 mg (ordered every four hours for pain) at 6:30 a.m., 10:00 a.m., and 2:00 p.m. Staff administered the scheduled 6:00 p.m. Dilaudid 2 mg dose late at 8:26 p.m. R29's Progress notes dated 7/15 and 7/16/26 lacked documentation of nurse actions or provider notifications regarding the missing medications. Multiple progress notes entered (continued on next page)		

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	on 7/15/26 by RN-A indicated the identified medications were not given due to time. R30 R30's quarterly MDS assessment dated [DATE] indicated the resident was moderately cognitively impaired. Face sheet diagnoses included primary hypertension, depression, and cellulitis of the left lower leg. The Medication Administration Audit Report dated 7/16/26 at 10:39 a.m. showed staff omitted multiple medications and a scheduled skin treatment during the day shift on 7/15/26. Staff omitted morning artificial tears to both eyes, losartan potassium 100 mg, amlodipine besylate 10 mg, ipratropium-albuterol inhalation, sertraline 12.5 mg, pravastatin sodium 40 mg, and Senna S. Staff also omitted the scheduled 6:30 a.m. and 11:00 a.m. doses of cephalexin 500 mg. Additionally, staff omitted a scheduled skin treatment to the bilateral buttocks requiring cleansing with normal saline or wound cleanser and the application of a barrier cream. Progress notes dated 7/15 and 7/16/26 lacked documentation of nurse actions or provider notifications regarding the missing medications and skin treatment. R31 R31's annual MDS dated [DATE] showed the resident was cognitively intact. R31's Face sheet diagnoses included congestive heart failure, diabetes type 2, gastro-esophageal reflux, polyneuropathy, and fibromyalgia. R31's Medication Administration Audit Report dated 7/16/26 at 10:42 a.m. showed staff omitted multiple scheduled medications during the day shift on 7/15/26. Staff omitted metformin 500 mg, pantoprazole sodium delayed release 40 mg, iron slow release 45 mg, sennosides 8.6 mg, cyanocobalamin 1000 mcg, gabapentin 300 mg, and furosemide 40 mg. Staff also omitted the scheduled 6:00 a.m. and 1:00 p.m. doses of acetaminophen 1000 mg. R31's progress notes dated 7/15 and 7/16/26 lacked documentation of nurse actions or provider notifications regarding the missing medications. Multiple progress notes entered on 7/15/26 by RN-A indicated the identified medications were not given due to time. R37 R37's quarterly MDS dated [DATE] showed the resident was cognitively intact. R37's Face sheet diagnoses included pulmonary hypertension due to lung disease and hypoxia, chronic diastolic heart failure, diabetes type 2, and osteoarthritis. R37's Medication Administration Audit Report dated 7/16/26 at 10:41 a.m. showed staff omitted multiple medications, treatments, and assessments during the day shift on 7/15/26. Staff omitted Novolog sliding scale insulin, torsemide 40 mg, budesonide inhalation suspension 0.5/2ml, diclofenac sodium external gel to the knees, hydrocortisone topical cream, clotrimazole 1% topical cream, and miconazole nitrate topical powder. Staff failed to obtain a daily weight and provider notification if outside parameters. Staff also omitted scheduled wound care to the abdomen, groin, and breast crease, which required cleansing, application of antifungal cream, and a two-hour coverage with a moistened WypAll with 0.25% acetic acid. Additionally, staff omitted scheduled clinical assessments and treatments including monitoring for signs and symptoms of bleeding, pain assessment and non-pharmacological interventions, hypoglycemia/hyperglycemia monitoring, vital signs, oxygen saturation, and the morning application of compression wraps. R37's progress notes dated 7/15 and 7/16/26 lacked documentation of nurse actions or provider notifications regarding the missing medications, assessments, or treatments. R39 R39's quarterly MDS assessment dated [DATE] indicated the resident was cognitively intact. R39 Face sheet diagnoses included congestive heart failure and type 2 diabetes with a foot ulcer. R39's The Medication Administration Audit Report showed staff omitted the following ordered day-shift medications, treatments, and assessments on 7/15/26: an 8:30 a.m. blood glucose check, an 11:00 a.m. blood glucose check, a 7:30 a.m. dose of Novolog sliding scale aspart insulin, an 11:30 a.m. dose of Novolog sliding scale aspart insulin, and scheduled wound care to the third toe of the left foot. Staff also failed to complete multiple required shift-based clinical assessments, including taking a blood pressure reading, monitoring and recording fluid intake, tracking pain levels, applying non-pharmacological pain interventions, evaluating an alternating pressure mattress setting, checking for bleeding signs, checking for signs of congestive (continued on next page)		

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	heart failure, and tracking daily weight against ordered provider notification parameters.R39's progress notes dated 7/15/26 and 7/16/26 lacked documentation of nurse assessments, corrective clinical actions, or provider notifications regarding these missed orders.R46R46's comprehensive MDS assessment dated [DATE] indicated the resident was cognitively intact.R46's Face sheet diagnoses included congestive heart failure, unspecified polyneuropathy, a stage 4 heel pressure ulcer, emphysema, chronic pain syndrome, and type 2 diabetes.R46's Medication Administration Audit Report and Medication Administration Record showed staff omitted the following ordered day-shift medications, treatments, and assessments on 7/15/26: Cymbalta 60 mg, acetaminophen 1000 mg, iron-vitamin C 65-125 mg, a 1:30 p.m. dose of baclofen 5 mg, a 1:30 p.m. dose of gabapentin 600 mg, a 12:00 p.m. dose of insulin glargine 10 units, a 12:00 p.m. blood glucose check, a topical lidocaine HCl application, and two scheduled doses of topical Biofreeze gel at 6:30 a.m. and 11:00 a.m. Staff also failed to perform required clinical monitoring for hypoglycemia, hyperglycemia, psychotropic medication side effects, signs of congestive heart failure, daily weights with provider notification parameters, and shift-based heel skin evaluations.R46's record identified, RN-A entered multiple progress notes on 7/15/26 stating the items were not given due to time.R46's progress notes dated 7/15/26 and 7/16/26 lacked documentation of nurse actions, skin assessments, or provider notifications regarding these omissions.During the facility's Resident Council meeting on 7/15/26 from 10:00 a.m. to 10:40 a.m., multiple residents reported current, active medication delays. Resident R20 stated they were supposed to receive their oral medications and diabetes injections at 8:00 a.m. but did not receive them until just before 10:00 a.m. Resident R25 stated staff normally perform their blood sugar check, oral medications, and insulin administration early in the morning, but it was 10:30 a.m. and they had not yet received anything. Residents R4, R27, and R31 stated they were actively waiting for their morning medications to arrive. Resident R37 stated they were diabetic and a nurse checked their blood sugar after the resident requested it, but they had not received any of their morning medications.During an interview on 7/16/26 at 11:42 a.m., Licensed Practical Nurse (LPN)-C stated passing medications for the 28 residents in the front section was a difficult assignment due to the number of residents. LPN-C stated that if a nurse falls behind on a medication pass, they must inform management and ask for assistance. LPN-C stated providers must be notified about significant medication errors and missed or late medications that could negatively impact a resident, specifying insulin, diuretics, blood pressure medications, psychotropics, and anti-seizure medications as examples. LPN-C stated the Director of Nursing (DON) must also be notified.During an interview on 7/16/26 at 1:39 p.m., the DON stated a night shift nurse first notified them of the widespread day-shift omissions on the morning of 7/16/26. The DON stated this was a serious situation that could have resulted in harm to multiple residents. The DON confirmed the day, evening, and night shift nurses failed to notify a provider regarding the missed medications on 7/15/26, and that the DON finally notified the NP on the morning of 7/16/26. The DON stated RN-A should have used a walkie-talkie to ask for help and provider notification assistance. The DON stated LPN-B should have immediately notified a nurse manager or the DON upon discovering the situation so that staff could assess residents, contact providers, and administer the missed medications and treatments. The DON stated the provider required immediate notification on 7/15/26 regarding the late and missed insulin doses and other critical medications, and that residents who missed diuretics required additional monitoring. The DON confirmed RN-A's file contained no orientation competency checklists and that it was unclear who cleared the nurse from orientation status.During an interview on 7/16/26 at 3:13 p.m., RN-A stated they worked the day shift on 7/15/26, which was their first shift off orientation and their first time passing medications to the 28 residents in the front section. RN-A stated they were (continued on next page)		

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	unfamiliar with which residents received insulin or time-sensitive medications, and that it took them longer to verify identities, set up medications, and prioritize care because they were unfamiliar with the residents. RN-A stated that at 2:30 p.m., they had not completed the medication pass, treatments, or vital signs. RN-A stated LPN-B instructed them to stop passing the day medications, leave them unadministered, and document what was omitted. RN-A stated they did not contact a provider regarding the missed insulins or late medications because provider notification protocols were not covered during their orientation, and they did not notify the DON. During an interview on 7/16/26 at 4:50 p.m., LPN-B stated they worked the afternoon shift on 7/15/26. Before receiving report, RN-A stated they missed approximately 50 percent of the scheduled day-shift medications on their first day independent from orientation. LPN-B instructed RN-A to stop administering the day medications, leave them unadministered, and document the omissions in the chart. LPN-B stated multiple residents expressed concern over missing their medications. LPN-B did not contact medical providers or nursing leadership regarding the widespread day-shift medication omissions, nor did they review the specific omissions for each resident. LPN-B focused on the afternoon shift schedule and altered some medication administration times to space out the doses. Multiple residents experienced elevated blood sugars during the evening shift. LPN-B reported the facility Nurse Practitioner (NP) was on the floor, but LPN-B only notified the NP about one resident who had an elevated blood sugar reading. LPN-B stated that nurses must contact a provider when critical medications such as insulin, diuretics, and blood pressure medications are missed. During an interview on 7/17/26 at 10:42 a.m., the administrator confirmed they became aware of the multiple day-shift medication errors on the morning of 7/16/26. The administrator confirmed that multiple residents were involved, and that subsequent assessments showed no immediate negative effects. The administrator stated that notifications were sent to the providers, residents, and families. The facility suspended RN-A pending an investigation. The administrator stated that the evening shift staff should have conducted provider notifications, medication reviews, and resident assessments. The administrator stated that new graduates require more orientation and that a clear competency evaluation framework must be put in place going forward. During an interview on 7/17/26 at 11:21 a.m., the Nurse Practitioner (NP) stated the facility did not provide notification of the multiple missed medications and treatments until 7/17/26. The NP stated they had multiple resident-specific written notifications remaining in their inbox for review. The NP stated that omitting ordered treatments, assessments, and medications creates a potential for resident clinical decline. The NP specified that errors involving anticoagulants, antipsychotics, Parkinson's medications, anti-seizure medications, antibiotics, and insulin are concerning because they can cause resident decline if not addressed in a timely manner. The NP stated they require immediate notification for significant medication errors. For a missed insulin dose, the NP stated nursing staff must assess the resident, check the blood glucose level, and call the provider for corrective orders and monitoring parameters. Review of the facility policy Administering Medications showed in line item three that the DON is responsible for the supervision and direction of all personnel with medication administration duties and functions. Line item seven directed that medications must be administered within one hour of prescribed times. Review of the facility policy Change in Condition, dated 11/13/24, showed requirements to ensure provider and responsible party notification for any change in a resident's physical, psychosocial, or mental condition status. Line item two listed a medication error or an adverse reaction as an example requiring notification. Line item three instructed the nurse to complete and document assessment findings, including vital signs and respiratory or cardiac status, and to notify the provider. Review of the facility policy Care of the Diabetic Resident, dated 7/28/15, showed the policy lacked instructions or protocols regarding (continued on next page)		

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	missed insulin administrations. The surveyor requested a specific policy regarding insulin administration, but the facility failed to provide it.		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, and record review, the facility failed to ensure that discontinued and expired medications were locked and stored separately from active medications, and were disposed of in a timely manner, for 3 of 3 medication rooms reviewed (200/300-unit, 500-unit, and 600-unit medication storage rooms). Findings include: During a review of the 200/300-unit, 500-unit, and 600-unit medication storage rooms on 07/14/26, expired and discontinued medications were observed on the counters, unsecured and awaiting disposal. The medications belonged to residents who had been discharged between 05/04/26 and 07/03/26. The unsecured medications consisted of the following: Eliquis, Hydrochlorothiazide, Prochlorperazine, Nitroglycerin, and Naloxone. Also present were Enoxaparin syringes, Nasal saline solution, Mupirocin cream, Artificial tears, Zinc oxide, and Fluticasone inhalers. The inventory included bottles of Acetic Acid, containers of Nystatin powder, Fluorouracil cream, Lidocaine, Gabapentin, Haloperidol, and Acetaminophen. Additional items found were Docusate/senna, Phenytoin sodium capsules, Hyoscyamine, Glycerin suppositories, Proctozone-HC suppositories, Acetaminophen suppositories, and Pediapap liquid. Finally, the collection contained Trazodone, Vitamin D3, Eplerenone, Fluoxetine, Propranolol, Torsemide, Baclofen, Pantoprazole, Lantus SoloStar prefilled pens, Potassium Chloride, Clopidogrel, Mirtazapine, Mucus relief, Metoprolol, Olanzapine, Cetirizine, and several bottles of stock over-the-counter medications. During an interview on 07/14/26 at 1:56 p.m., Licensed Practical Nurse (LPN)-C stated that the discontinued and expired medications sitting on the counter of the 200/300-unit room were supposed to be transferred to the 600-unit medication room for final disposal. LPN-C stated they were unsure how long those medications had been left sitting out on the counter. During an interview on 07/14/26 at 1:44 p.m., the Director of Nursing (DON) confirmed that the medications left on the counters in all 3 medication storage rooms were expired or discontinued and required disposal. The DON stated that due to recent staffing challenges, the facility experienced a delay in disposing of medications in a timely manner. Facility policy titled Destruction and Disposal of Medications revised on 11/22/24 indicate, all expired and discontinued medication will be placed in a designated, secure location for medication needing destruction.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observation, interview, and record review, the facility failed to ensure proper personal protective equipment was used for 5 of 5 residents (R7, R17, R35, R59, R1) reviewed for enhanced barrier precautions (EBP). Findings include: R7's annual Minimum Data Set (MDS) assessment, dated 7/3/26 indicated R7 had severe cognitive impairment and was dependent on staff for bed to chair transfers as well as toilet hygiene. The MDS also indicated R7 had an indwelling urinary catheter and was frequently incontinent of bowel. R7 had a diagnosis of progressive neurologic disease, dementia, and had a stage 3 pressure injury (a deep wound in the skin that does not expose underlying structures). R7's diagnoses list included urinary retention, dementia, muscle weakness, and pressure injury of the sacrum (lower back). R7's provider orders included: change urinary catheter every 28 days, check to ensure dressing over sacral wound is clean and secured in place, sacral wound dressing changes, urinary catheter positioning instructions, and urinary output documentation. R7's care plans indicated R7 required assist of 1 staff for activities of daily living and assist of 2 with a mechanical lift for transfers. The care plan also indicated R7 was on enhanced barrier precautions due to urinary catheter use and provide personal protective equipment as needed. The care plan also indicated R7 had a stage 3 pressure injury to her sacrum. R7's nursing assistant care plan indicated R7 was on enhanced barrier precautions and provide personal protective equipment as needed. It also indicated R7 had a foley catheter and required 1 staff assist for ADL's and 2 staff with mechanical lift for transfers. During observation on 7/13/26 at 9:41 a.m., a sign titled Enhanced Barrier Precautions with instructions for PPE was on R7's door. The sign indicated staff must clean hands before entering and when leaving a resident's room. Providers and staff must wear gloves and a gown for high-contact resident care activities. The sign defines high-contact care activities as dressing, bathing, showering, transferring, changing linens, providing hygiene, changing briefs, assisting with toileting, device care, and wound care for wounds requiring a dressing. Gowns and gloves were located outside of R7's room. Nursing assistant (NA)-G and NA-H entered the room. NA-G did not don gloves or gown. NA-H donned gloves however no gown. R7 was laying in bed. A urinary drainage bag was attached to the side of R7's bed. Without donning gloves, NA-G pulled up R7's shorts and rolled R7 toward NA-H. NA-G's clothing came in contact with R7's bed. NA-G and NA-H positioning the mechanical lift sling under R7 and positioned the lift over R7. Wearing gloves but no gown, NA-H moved the urinary drainage bag from the side of the bed to the mechanical lift. NA-H then operated the mechanical lift while NA-G held on to the lift sling and R7's legs while R7 was lowered to the wheelchair. NA-G was not wearing gloves or a gown. Without donning a gown, NA-H reached to the opposite side of R7's bed to grab a blanket to cover R7's lap. NA-H's clothing came in contact with R7's sheets and blankets. NA-H then removed R7's urinary drainage bag from the mechanical lift and placed it under R7's wheelchair. NA-H removed gloves. NA-H and NA-G sanitized hands and left the room. (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Edenbrook Pine Haven		STREET ADDRESS, CITY, STATE, ZIP CODE 210 Northwest 3rd Street Pine Island, MN 55963	
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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 7/13/26 at 10:28 a.m., NA-H stated infection control training occurs during onboarding upon hire. NA-H stated if a resident is on EBP, staff are to wash hands and wear gloves anytime you do anything with the resident. Staff wear gowns when working with urine or bowel movements. When asked if staff are required to wear gowns for any other time, NA-H reiterated staff are only required to wear gowns when working directly with bodily fluids. During an interview on 7/14/26 at 4:16 p.m., registered nurse (RN)-C stated infection control training occurs during onboarding. The facility also provides monthly meetings with changes to infection control practices as well as infection control information posted at nurses stations that staff have to sign and acknowledge. RN-C stated residents are placed on EBP when residents have a bug they don't want. Staff wear gown and gloves anytime care involves bodily fluids. If a resident is on precautions related to urine, staff wear gowns when doing incontinence care. If a resident is on precautions related to catheter use, staff wear gown and gloves when doing catheter cares. If a resident is on EBP because a resident's immune system is suppressed, then staff wear gown and gloves all the time. During interview on 7/16/26 at 1:13 p.m., the facility infection preventionist (ADON/IP) stated residents are placed on EBP if they have an indwelling catheter, feeding tube, central IV line, or chronic wounds to prevent the development of infection. Gowns and gloves are required during any high-contact activity such as peri care, bathing, dressing changes, and medication administration via feeding tube. Staff must also wear gown and gloves during transfers and when contacting bed linens. During an interview on 7/17/26 at 8:52 a.m., the director of nurse stated residents with chronic wounds, catheters, feeding tubes, or any other device that could invite a multidrug resistant organism (MDRO). Staff should wear gown and gloves for any contact at all even if it is just to drain a catheter, boost in bed, or provide cares. The DON stated staff should absolutely wear gown and gloves when transferring from bed to chair and adjusting linens. R17 R17's quarterly Minimum Data Set (MDS) assessment, dated 6/129/26, identified R17 as cognitively intact. R17's diagnoses included resistance to multiple antimicrobial drugs, pneumonitis due to inhalation of food and vomit, encounter for attention to gastrostomy and type 2 diabetes mellitus. R17's current care plan indicated, R17's required a feeding tube due to history of oropharyngeal cancer, received all nutrition and fluids via PEG- TUBE (feeding device that delivers nutrition directly into a part of the small intestine while also allowing access to the stomach for drainage or medication), suprapubic catheter (a flexible tube inserted through a small abdominal incision to drain urine directly from the bladder) use related to diagnosis of urinary retention and enhanced barrier precaution. R 17's current provider orders indicated R17's was on amoxicillin 875-125 mg tablet, give 1 tablet by mouth 2 times a day for Pneumonia for 7 days (7/10/ 26 to 7/17/26) and R 17 on was EBP. (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During observations on 7/13/26 at 9:23a.m., R17's door had an isolation sign which indicated R17 was on droplet precautions, enhanced barrier precaution and had drawer containing PPE (protective personal equipment) next to the door. The EBP sign indicated gown, and gloves had to always be worn when staff provided high contact care activities. Licensed practical nurse (LPN)-A approached R17's room with donned mask, gloves, held 2 cups containing crushed medications and entered R17's room. LPN-A administered R 17's morning medications via PEG Tube, with no gown. While in R17's room, director of nursing (DON) stood in R17 entry way and communicated to LPN-A, R17's was off Droplet precaution due to negative COVID PCR result. During an interview on 07/14/26, at 3:12 p.m., DON confirmed R17's was on EBP and acknowledged had witnessed LPN-A providing high contact care without a gown. DON Stated, LPN- A will be provided with more education on infection control as it was LPN-A first week on the floor. R35 R35's comprehensive Minimum Data Set (MDS) assessment, dated 06/13/26, indicated intact cognition. R35's current provider orders indicated left buttock wound treatment daily and enhanced barrier precaution. During an observation on 07/14/26 at 10:08 a.m., nursing assistant (NA)-A, assisted R35 in bed with incontinent product change, gloves were in use and no gown in use. R35's door had an enhanced barrier precaution sign indicating, gown, and gloves had to always be worn when staff provided high contact care activities and had drawer containing PPE (protective personal equipment). NA-A came out of R35's room and asked licensed practical nurse (LPN)-B for assistance with 2 persons and a mechanical lift transfer. NA-A reentered R35's with no glove or gown and a mechanical lift. LPN-B arrived at R35's door, donned on a gown and gloves prior to entering R35's room. During an interview on 07/14/26 at 10:13 a.m., NA-A acknowledged, R35 was on EBP and acknowledged did not use proper PPE and stated, the nurse reminded me. During an interview on 07/14/26 10:13a.m., LPN-B acknowledged R35 was on EBP and confirmed NA-A did not wear proper PPE to provide high contact resident care activity. During an interview on 07/14/26, at 3:12 p.m., DON stated, staff was expected to use proper PPE when providing cares to residents on EBP. R59 R59's care plan revised on 07/09/26 indicated risk for infection as evidenced by chronic vascular wound to lower extremity, enhanced barrier precautions (EBP, an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and glove use during high contact resident care activities). (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R59's current provider order dated 07/09/26 indicated enhanced barrier precaution due to chronic wound and wound care dressing change to left ankle every evening. During an observation for medication administration on 07/14/26 at 7:31 a.m., licensed practical nurse (LPN)-A entered R 59's room with morning medications, no gloves or a gown was in use. R59's door had an enhanced barrier precaution sign indicating, gown, and gloves had to always be worn when staff provided high contact care activities and had drawer containing PPE (protective personal equipment). R59 requested assistance to put on socks and assistance into the bathroom after morning medications were administered. LPN-A assisted R59 to put socks on both feet, transferred R59 from the bed to the wheel chair, and from the wheel chair to the toilet. R1 R1's quarterly Minimum Data Set (MDS) assessment, dated 6/25/26, identified R1 was cognitively intact and was dependent on staff for mobility and required moderate to extensive assistance for activities of daily living. R1's care plan revised on 04/17/26 indicated risk for infection due to indwelling foley catheter use with history of neurogenic bladder, required PEG tube (feeding device that delivers nutrition directly into a part of the small intestine while also allowing access to the stomach for drainage or medication) due to Hernia Hiatal and EBP (enhanced barrier precaution). During medication administration observations on 7/15/26 7:50 a.m., NA-B, stated to LPN-A, R1's PEG tube had a kink, needed adjusting and NA-B also needed assistance to transfer R1 as R1 was a 2-persons assist with a mechanical lift. LPN-A followed NA-B, entered R 1's room with no gloves or gown. R1's door had an enhanced barrier precaution sign indicating, gown, and gloves had to always be worn when staff provided high contact care activities and had drawer containing PPE (protective personal equipment) next to the door. R1 was lying in bed, LPN-A leaned over R1, adjusted R1's PEG tube, removed a catheter secure tape next to PEG tube and sated the PEG tube was twisted and the catheter secure tape needed to be changed. LPN-A exited R 1's room, used hand sanitizer and returned to the medication administration cart. During observation on 07/15/26 at 8:01 a.m., LPN-A prepared 13 medications for R1 and reentered R1's room with no gloves or gown. R1 was lying on the bed, being attached/hooked to the mechanical lift with a sling by NA- B. NA -B had on gloves and no gowns. LPN-A directed the mechanical lift, NA-B directed R1 in the sling and managed R1's foley catheter bag. Once R1 was placed in the power chair, NA-B removed the slings, adjusted R1 in a comfortable sitting position while LPN-A (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	administered morning medications. During an Interview on 7/15/2026 8:39 a.m., NA-B indicated was aware of EBP precautions as indicated by the sign and PPE equipment present at R1's door. NA-B stated, had been unable to put on a gown consistently due to time constraint. NA-B stated, there are too many call lights, I sometimes do not even look at the door, I just go in. During an interview on 07/15/2026 at 8:32 a.m., LPN-A indicated had been instructed during the orientation process by 3 different staff members, donning a gown was only required for wound care when a resident was on EBP. A policy titled Enhanced Barrier Precautions issued 3/26/24 indicated It is the policy of this facility that Enhanced Barrier Precautions, in addition to Standard and Contact Precautions will be implemented during high-contact resident care activities when caring for residents that have an increased risk for acquiring a multidrug-resistant organism such as a resident with chronic wounds requiring a dressing, indwelling medical devices or residents with 'infection or colonization with an MDRO' EBP is defined as an infection control intervention designed to reduce transmission of MDRO that employees targeted gown and glove use during high contact resident care activities. The policy indicated the purpose of EBP is to prevent opportunities for transfer of MDROs to employee's hands and clothing during cares, beyond situations in which staff anticipate exposure to blood or body fluids. High-contact resident care activities include dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, devices care, wound care.		

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observation, interview, and record review, the facility failed to ensure a dignified dining experience was provided when staff stood assisting with meals for 3 of 3 residents (R29 ,R43, R37) reviewed for dignity. Findings include:R29's electronic medical review (EMR) indicated dependence with activities of daily living and enrolled in a hospice program (a specialized model of end-of-life medical care of people with terminal illness and life expectancy of about six months or less, focusing on comfort, symptoms relief, and quality of life).R43's EMR reviewed indicated dependence on staff for activities of daily living and enrolled in a hospice program.During an observation on 07/14/26 at 12:35 p.m., 4 residents were seated at a table in the dining room, 3 of the residents were in Broda chair (high back positioning chair) and nursing assistant (NA)-C in a standing position, assisted all 3 residents simultaneously with eating.During an interview on 7/14/26 at 2:15 p.m., (NA)- C confirmed R 29, R43, R37 needed assistance with meals. NA-C confirmed, had assisted all 3 residents with eating simultaneously while in a standing position. NA-C stated, I made sure 1 resident swallowed before I moved to the next.During an interview on 7/14/26 2:25 p.m., licensed practical nurse (LPN)-C confirmed, R29, R37, R43, needed assistance with meals and expected any staff member aiding with feeding to be in a sitting position.During an interview on 7/15/26 at 2:27 p.m., assistant director of nursing/infection preventionist (ADON/IP) verified all staff assisting a resident to eat should be seated for face-to-face contact. ADON/IP stated that it was not dignified to stand over a resident while helping them with their meal.Facility policy titled Dinning and Food Service revised on 2/15/25 indicated, when feeding a resident remember to sit down next to resident, and feed resident one resident at a time. Do not stand while feeding a resident.		

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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. Based on observation, interview, and record review, the facility failed to ensure care was provided in accordance with a resident's care plan for 1 of 1 residents (R22) reviewed for activities of daily living. Findings include: R22's quarterly Minimum Data Set (MDS) assessment, dated 4/20/26, indicated R22 had severe cognitive impairment, no psychosis, and no history of rejection of care. R22 was also dependent on staff for toilet hygiene and required substantial assist for toilet transfers. The MDS also indicated R22 was frequently incontinent of bowel and bladder. R22 had a history of non-traumatic brain dysfunction, and dementia. R22 was also at risk for developing pressure injuries and received antipsychotic (used to treat behavioral and disturbances), antianxiety (used to treat anxiety), and antidepressant (used to treat depression) medications. R22 had a history of falls, and received hospice care. R22's diagnoses list included dementia with psychotic disturbances, restlessness and agitation, repeated falls, history of femur fracture, and chronic kidney disease. R22's careplan indicated R22 had poor safety awareness and required 1 staff to assist with toileting. It also indicated R22 had urinary urgency and would often transfer without staff assistance. Staff should offer toileting upon awakening, after each meal, and every 2 hours after R22 goes to bed. The careplan also indicated toileting might relieve agitation. R22 also has a history of incontinence and is a high risk for falls. R22's fall careplan indicated, when [R22] is asking where bathroom is, accompany to the room and assist if she allows. Notify nurse if refusing assistance. R22's physical mobility careplan indicated R22 had poor safety awareness, reduced mobility and a history of femur fracture. It also indicated R22 required 1 staff assist for transfers however often refuses assistance or use of call light. R22's July medication administration record (MAR) indicated R22 has scheduled toileting due to frequent falls. Please assure staff are both assisting with encouraging R22 to use toilet upon awakening in the morning, after each meal, and every 2 hours after going to bed for safety. R22's nursing assistant (NA) kardex (careplan used by NA staff instructing care for the resident) indicated if 22 asks where the bathroom is, accompany her to her room and assist if she allows. Notify nurse if refusing assistance. It also indicated R22 was a staff assist of 1 and R22 has urgency and will often transfer without putting on the call light. Offer toileting upon awakening in the morning, after each meal, then every 2 hours after going to bed. The Kardex also indicated attempt toileting if able, as being able to urinate sometimes help relieve agitation. During interview on 7/13/26 at 3:20 p.m., family member (FM)-A stated R22 can be stubborn and has a strong sense of independence and does not always allow staff to assist. FM-A stated most of R22's falls are related to needing to use the bathroom. During interview on 7/15/26 at 11:09 a.m., NA-F stated R22 can be feisty. R22 will occasionally tell staff she does not have to use the bathroom and then attempt to toilet herself when staff walk away. Occasionally R22 will agree to use the bathroom. During continuous observation on 7/15/26 from 12:36 p.m.-1:43 p.m.,-at 12:36 p.m., NA-E was seated in the dining room assisting residents with eating. R22 was sitting in wheelchair across the dining room. An unidentified dietary staff member asked R22 if she was finished with her meal. R22 told the dietary staff member she needed to go to the restroom. The staff member replied let me go call someone. At that time the dietary staff member walked toward the kitchen and used a walkie talkie to state R22 needed to use the bathroom. Message was heard coming from the walkie talkies in the area. At that time, R22 started independently leaving the dining room. -at 12:41 p.m., R22 was observed wheeling passed the nurses station toward the 300 hall. NA-D and another unidentified nursing assistant were sitting at the nurses station. The floor nurse was standing at the medication cart. -at 12:44 p.m., NA-D was (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	observed walking down a hall to answer call lights. A message over the walkie talkie it would be nice if someone could help in the dining room because there are a lot of call lights going off down 2, 3, and 400 halls. R22 wheeled back into the dining room. NA-E remained in the dining room assisting resident's with eating. NA-E looked towards R22 and made conversation about her stuffed animal. R22 then wheeled toward the dining room window.-at 12:55 pm., R22 remained in the dining room dozing off. -at 1:00 pm., NA-E took a resident who was being assisted out of the dining room. R22 remained in the dining room sleeping. Other NA's were observed answering call lights down the hall. -at 1:08 p.m., NA-E returned to the dining room to retrieve another resident then stopped to speak to a resident who was sitting on a bench near the door. -at 1:17 p.m., R22 remained in the dining room sleeping. -at 1:24 pm., resident remained in the dining room. NA staff were answering call lights down the 300 hall. The floor nurse was at the medication cart passing medications. -at 1:31 pm., R22 continued to be sitting in the dining room sleeping. One other resident was in the dining room. Dietary staff were observed in the kitchen. -at 1:43 p.m., 1 hour and 7 minutes after first informing staff she needed to use the restroom, R22 as awake in the dining room. R22 stated she was not tired, just bored and doesn't have anything to do. R22 told surveyor she does have to go to the bathroom but it's not that big of a deal. At that time, the surveyor updated NA-D and NA-E, R22 had to use the restroom. R22 was taken to her room. NA-D and NA-E attempted multiple times to encourage R22 to go to the bathroom, however R22 started becoming frustrated and headed for the bedroom door. At that time, NA-D and NA-E decided to allow R22 to leave her room to prevent R22 from becoming more agitated. During an interview on 7/15/26 at 1:48 p.m., NA-D stated R22 was toileted before lunch and did not hear the request over the walkie talkie R22 needed to use the restroom. During an interview on 7/15/26 at 1:55 p.m., NA-E stated R22 was toileted at 10:45 a.m., when R22 got up for the morning. NA-E stated staff try to assist residents within 5 minutes of calling for help however residents have had to wait a lot longer today due to staffing issues. NA-E stated floor nurses do not always assist with answering call lights or toileting. During an interview on 7/15/26 at 11:06 a.m., licensed practical nurse (LPN)-C stated staff try to keep R22 close due to R22's history of self transferring. R22 has a history of agitation requiring as needed medication at times. LPN-C stated when R22 states she needs to use the restroom, she must be taken immediately due to her history of self transferring. R22 continues to have behaviors at times however it is not common for R22 to refuse toileting. During an interview on 7/17/26 at 8:52 a.m., the director of nursing (DON) stated she would expect staff to toilet a resident within 2-5 minutes of a resident's request. The DON stated a 1 hour wait would be absolutely too long to wait to use the bathroom. A policy titled Activities of Daily Living dated 2/25/25 indicated the facility will assist residents with using the bathroom and maintaining cleanliness based on the residents' careplan.		

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the past 3 years of survey results were readily available and accessible to residents and visitors. This affected 9 of 9 residents reviewed for survey accessibility. Findings include: During an observation on 7/15/26 at 7:20 a.m., a survey results binder was located inside a wall-mounted holder between the oxygen storage room and storage room [ROOM NUMBER]A. The binder contained the recertification survey results dated 10/17/23. The binder contained no recertification or complaint survey results for the years 2024 or 2025. During an interview on 7/15/26 at 9:43 a.m., the administrator reviewed the binder and stated the 2024 and 2025 survey results should be inside. The administrator stated staff might have removed the 2024 and 2025 binders for use. During a Resident Council meeting on 7/15/26 at 10:00 a.m., Residents R1, R4, R8, R20, R21, R25, R27, R31, and R37 stated they did not know past survey results were available for review. No residents recalled facility staff informing them that the results existed or where they were located. During a follow-up interview on 7/15/26 at 11:03 a.m., the administrator had three survey binders on their desk. The administrator stated they retrieved the binders from the opposite side of the building. During an interview on 7/15/26 at 1:41 p.m., the facility Scheduler stated the facility kept survey results at both building entrances. The Scheduler showed an empty holder outside their office. The Scheduler stated they gave the 2023 and 2024 binders to the Administrator earlier that day. The Scheduler stated they never had the 2025 results on their hallway.		

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. Based on observation, interview, and document review, the facility failed to ensure daily nurse staffing hours were consistently posted at the start of each shift. This had the potential to affect all residents, families, and visitors. Findings include: During observations on consecutive survey days, the facility failed to update and post current daily staffing hours: On 7/13/26, the facility posted the daily staffing list. On 7/14/26 at 10:00 a.m., the facility posted the daily staffing list. On 7/15/26 at 7:23 a.m., the staffing list from the previous day (7/14/26) remained posted. The facility did not post the current staffing list for 7/15/26. During an interview on 7/15/26 at 12:43 p.m., the Administrator confirmed the staffing hours for 7/15/26 were not posted. The Administrator confirmed the posted list was from 7/14/26. The Administrator stated they expected staff to post the current staffing hours every morning. The surveyor requested the facility policy regarding posted nursing hours, but the facility failed to provide it.		