STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245362	A. Building B. Wing	06/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mapleton Community Home	301 Troendle Street SW Mapleton, MN 56065

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and document review the facility failed to ensure the Minimum Data Set (MDS) accurately reflected the resident's fall history for 2 of 3 residents (R2 and R10) reviewed for falls. Findings include: R2's significant change Minimum Data Set (MDS) assessment dated [DATE], indicated impaired cognition, no behaviors or rejection of care, use of wheelchair, one fall with no injury, one fall with minor injury, and diagnoses of non-traumatic brain dysfunction, high blood pressure, and Alzheimer's disease. R2's care plan dated 11/2/23, indicated at risk for falls related to poor balance, assistive devices for mobility, psychotropic medication use, history of falls. Ensure non-slip footwear, follow facility fall protocol, if sitting on the edge of the bed to play cards, ensure that her bed is made or have her sit in the recliner. R2's facility progress notes reviewed on 6/29/26, indicated falls on 11/17/25, 1/7/26, 3/29/26, 3/30/26, 4/14/26, 4/18/26, 5/18/26, 5/23/26, and 6/15/26. R2's quarterly MDS assessment dated [DATE], indicated falls since the prior assessment that included one fall with no injury. Review of R2's falls during that assessment period indicated two falls had occurred. R2's significant change MDS dated [DATE], indicated falls since the prior assessment that included one fall with no injury and one fall with minor injury. Review of R2's falls during that assessment period indicated three falls had occurred. During interview on 6/30/26 at 10:20 a.m., assistant director of nursing (ADON) stated she was the MDS nurse for the facility and completed R2's MDS assessments. ADON stated she did not think the facility used point click care (PCC- facility electronic health record) to its full potential, still had a lot of paper charting, and it was likely falls could be missed when reviewing for assessments. ADON reviewed R2's falls and confirmed some falls were missed on her assessments. R10's quarterly MDS assessment dated [DATE] indicated R10 had no cognitive impairment, utilized a walker, was independent with walking, and had diagnoses that included non-Alzheimer's dementia, repeated falls, and chronic pain. Section J indicated R10 had experienced falls since admission or the prior assessment and was coded as having one fall with no injury and one fall with injury (except major). R10's care plan dated 4/29/26, identified R10 as being at risk for falls related to poor balance and a history of falls. Interventions included anticipating and meeting R10's needs, keeping the call light (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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	within reach and encouraging its use for assistance as needed, and following the facility's fall protocol. Review of R10's Accident Reports indicated R10 sustained falls on 2/14/26, 3/11/26, 3/24/26, and 4/30/26. On 6/30/26 at 8:47 a.m., the ADON, who also served as the facility's MDS nurse, stated they completed R10's MDS fall coding on 5/13/26. The ADON confirmed R10 experienced falls on 2/14/26, 3/11/26, 3/24/26, and 4/30/26, including two falls with injury (except major) and two falls with no injury during the applicable MDS look-back period. The ADON confirmed the MDS assessment was coded incorrectly and should have indicated two or more falls and two or more falls with injury (except major). On 6/30/26 at 11:18 a.m., the director of nursing (DON) stated they expected the MDS to accurately reflect residents' falls. Facility MDS Accuracy Policy, dated 3/2019, indicated the Resident Assessment Instrument (RAI) Manual would be followed to ensure accuracy in all coding areas.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, observation, and document review, the facility failed to revise and update the comprehensive care to include new fall interventions implemented for 3 of 3 residents (R2, R3, and R10) reviewed for falls. Findings include: R10's quarterly Minimum Data Set (MDS) assessment dated [DATE], indicated R10 had no cognitive impairment, utilized a walker, independent with walking, diagnoses included Non-Alzheimer's Dementia, repeated falls, chronic pain, had falls since admission or the prior assessment, one fall with no injury and one fall with injury (except major). R10's care plan dated 4/29/26, indicated R10 was at risk for falls r/t (related to) poor balance and history of falls and interventions included: anticipate and meet R10's needs, call light within reach and encourage her to use it for assistance as needed and follow facility fall protocol. R10's Accident Report documents which included interdisciplinary team review/investigation decision indicated: Review of R10's Accident Reports, including the interdisciplinary team (IDT) investigation and recommendations, identified the following falls and interventions: 12/5/25: Unwitnessed fall after bending to pick up a box of crackers. Intervention: remind R10 to have staff retrieve items from the floor. 2/14/26: Fell after attempting to sit on a walker without a seat. Intervention: use a chair when playing cards and move the walker aside before sitting. 3/11/26: Found sitting on the floor beside the bed. Intervention: call staff for assistance with transfers and incontinent care. 3/24/26: Found on the floor beside the bed with right hip and shoulder pain and transferred to the emergency department. Intervention: evaluate the need for a wider bed (determined not needed) and install a grab bar on the right side of the bed. 4/30/26: Fell while bending to pick up cigarette butts outside without her walker, resulting in a skin tear and superficial abrasions. Interventions: develop a smoking contract or revoke smoking privileges and have staff move her chair after smoking if desired. 6/8/26: Lost balance during dinner, fell backward, and struck the back of her head on another resident's chair before falling to the floor. Intervention: encourage R10 to slow down, stop and sit if feeling lightheaded, and provide smoking cessation education. Review of the comprehensive care plan failed to identify the interventions developed following the falls on 2/14/26, 3/11/26, 3/24/26, 4/30/26, and 6/8/26. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/29/26 at 10:33 a.m., R10 stated she had fallen approximately three weeks earlier because she lost her balance while walking without her walker. R10 stated staff reminded her to use her walker following the fall. On 6/29/26 at 2:41 p.m., licensed practical nurse (LPN)-B stated fall interventions were developed by the interdisciplinary team following falls, documented in the care plan, communicated to staff, and implemented. LPN-A was observed to review R10's electronic medical record (EMR) and confirmed interventions form R10's most recent fall on 6/8/26, were not added to the care plan. On 6/29/26 at 2:48 p.m., nursing assistant (NA)-A stated R10 was a fall risk and relied on the care plan to identify current fall interventions. On 6/29/26 at 2:59 p.m., registered nurse (RN)-B, known as the nurse manager, stated following a resident fall the nurse completes a fall report on paper and puts an immediate intervention in place and emails the nursing staff of the new interventions or writes a progress note. RN-B stated the the interdisciplinary team (IDT) meets and reviews the fall, and discusses interventions and the implemented interventions would be expected to appear in the resident's care plan. RN-B stated the IDT team consists of themselves, director of nursing (DON), assistant director of nursing (ADON), social worker, dietary, activities, business office, therapy and nursing floor staff. RN-B confirmed no new care plan interventions were documented following the 6/8/26, fall. RN-B stated DON or ADON updated resident care plans. On 6/29/26 at 3:09 p.m., the DON stated the IDT reviews each fall and attempts to implement a new intervention unless all appropriate interventions are already in place. The DON reviewed R10's fall investigation forms for the falls occurring on 2/14/26, 3/11/26, 3/24/26, 4/30/26, and 6/8/26 and confirmed the interventions developed following those falls had not been incorporated into the comprehensive care plan. The DON stated the paper fall investigation forms containing the interventions were maintained in the DON's office and acknowledged staff would not be able to readily identify the interventions from the care plan. The DON confirmed the DON and ADON were responsible for updating resident care plans. On 6/29/26 at 5:03 p.m., an LPN-C stated fall interventions are communicated during report or by email but should also be included in the care plan because staff rely on the care plan to identify resident-specific interventions. 6/29/26 at 5:57 p.m., R10 was observed ambulating independently in the hallway using a two-wheeled walker. On 6/29/26 at 6:06 p.m., R10 was seated on a bench outside the facility smoking a cigarette. On 6/30/26 at 7:58 a.m., a NA-B stated new fall interventions were communicated during shift report and would also be expected to be documented in the care plan. On 6/30/26 at 8:08 a.m., a RN-C stated following a fall, interventions should be updated in the resident's care plan and confirmed the DON and ADON were responsible for revising and upateing the care plan. R2's significant change MDS assessment dated [DATE], indicated impaired cognition, no behaviors or rejection of care, use of wheelchair, one fall with no injury, one fall with minor injury, and diagnoses (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	of non-traumatic brain dysfunction, high blood pressure, and Alzheimer's disease. R2's care plan dated 11/2/23, indicated at risk for falls related to poor balance, assistive devices for mobility, psychotropic medication use, history of falls. Ensure non-slip footwear, follow facility fall protocol, if sitting on the edge of the bed to play cards, ensure that her bed is made or have her sit in the recliner. R2's facility progress notes reviewed on 6/29/26, indicated falls on 11/17/25, 1/7/26, 3/29/26, 3/30/26, 4/14/26, 4/18/26, 5/18/26, 5/23/26, and 6/15/26. Review of R2's Accident Report documents which included interdisciplinary team review/investigation decision indicated the following interventions: 11/17/25: Wide bed 1/7/26: Clip call light to chest for easier access 3/29/26: Fall mat at bedside 3/30/26: Hospice referral 4/14/26: Medication change 5/18/26: Remove or flip out foot pedal if wheeling self 5/23/26: Medication change 6/15/26: Reviewed with hospice concern for adverse effect post administration of anxiety medication and discontinued medication R3's significant change MDS assessment dated [DATE], indicated impaired cognition, no behaviors or rejection of care, independent with ambulation with wheeled walker, one fall with injury, and diagnoses of anemia, atrial fibrillation (irregular heartbeat), high blood pressure, and hip fracture. R3's care plan dated 11/23/24, indicated moderate risk for falls related to confusion, deconditioning, gait/balance problems. Be sure call light is within reach to encourage her to use it for assistance as needed. Ensure appropriate footwear. Fall mat at bedside and bed at knee height. R3's facility progress notes reviewed on 6/29/26, indicated falls on 11/7/25, 5/18/26, and 5/28/26. Review of R3's Accident Report documents which included interdisciplinary team review/investigation decision indicated the following interventions: 11/7/25: decreased medication 5/18/26: Remind to wear shoes in room and let staff get large items and carry for her 5/28/26: Offer to move to room closer to nurses, discontinued medication (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 6/29/26 at 3:45 p.m., NA-C stated she did not know specific interventions for R2 but knew they tried to keep her out in the main area to keep an eye on her. NA-C further stated she did not know where she would find interventions, but they were usually passed down in report. NA-C stated she did not work every day, so could have missed hearing some interventions. NA-C stated she was not sure if interventions were on R2's care plan. During interview on 6/29/26 at 4:02 p.m., NA-D stated she did not have a list of interventions on the care plan for R2 or R3 and did not know if interventions were documented anywhere. NA-D stated interventions were talked about in report. During interview on 6/30/26 at 10:20 a.m., DON stated she reviewed all fall investigations for R2 and R3 and confirmed those interventions were not added to the comprehensive care plan. DON stated interventions were shared in verbal report with staff. DON further stated the investigation forms were kept in her office and not always available to staff, and it would be important for all staff working with R2 and R3 to be aware of their fall interventions to prevent falls. The facility Care Planning and Care Conference policy dated 8/28/17, indicated; The care plan will be reviewed quarterly with the IDT, resident and/or resident representative and staff. Corrections will be made to the plan of care as needed. Care plans are an on-going process and will have updates made on PRN basis with any changes. Auding will be done weekly on two random care plan by the Director of Nursing to endsure that care plans are up to date. The facility Falls Policy and Procedure dated 9/23, indicated A plan of care will be developed to include measures to aid in prevention of falls. Post fall: an accident report is filled up by the charge nurse following a fall. The charge nurse of each wing brings this report to the daily interdisciplinary team meeting. The team reviews the fall and determines if the current plan is adequate or other interventions should be put in place. The reports given to the DON to log for QAPI. Reassessment and reevaluation: residents who are at risk for falls will have their plan of care reassessed with each MDS assessment and reviewed at their resident care conference

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to comprehensively assess new bruises and abrasions for 1 of 2 residents (R3) reviewed for non-pressure skin conditions.Findings include:R3's significant change Minimum Data Set (MDS) assessment dated [DATE], indicated severely impaired cognition, no behaviors, diagnoses of arthritis, hip fracture, dementia, and use of anticoagulant (blood thinning medication).R3's care plan dated 11/23/24, indicated self-care performance deficit related to recent hip fracture and repair. Skin inspection: requires weekly skin inspection. Observe for redness, open areas, scratches, cuts, bruises and report changes to the nurse.During observation on 6/29/26 at 10:39 a.m., R3 was walking in the hallway independently with wheeled walker. R3 stated she fell about a month ago and broke her hip.R3's nursing admission/readmission evaluation completed by registered nurse (RN)-B dated 5/26/26, indicated skin issues present, right antecubital bruising from hospitalization, left antecubital bruising from hospitalization, coccyx blanchable redness, left hip known surgical incision covered with dressing, bruising present. There was no further information about the bruise sizes, shapes, dimensions, or coloring. The assessment indicated a care plan goal focus area: anticoagulation with goal of free from discomfort related to anticoagulant use and intervention of labs as ordered. There was no intervention to monitor/document/report signs or symptoms of anticoagulant complications, such as bruising.R3's nursing weekly skin check completed by licensed practical nurse (LPN)-B dated 5/29/26, indicated bruising related to fall, abrasion left forearm, redness to right knee from recent fall. See readmission assessment for skin concerns related to hospitalization/falls. New abrasion to left forearm and redness to right knee from fall sustained yesterday. No further information was on the assessment form. There was no further descriptive information about the new abrasion or knee redness.R3's nursing weekly skin check completed by RN-A dated 6/21/26, indicated new skin condition, injury or skin change noted. New bruise of unknown origin measuring three centimeters by two centimeters located on left knee (rear). No further information was on the assessment form. There was no further descriptive information about the new bruise.R3'S incident report for skin tears and bruises completed by RN-A dated 6/21/26, indicated new bruise to back of left leg below knee. No redness/warmth/swelling, pain with walking, scheduled Tylenol helps. Measurement three centimeters by two centimeters. There was no further description of the bruise.During interview on 6/30/26 at 2:06 p.m., RN-A stated she did not recall anything specific about R3's bruise, but she documented it in Point Click Care (PCC- facility electronic health record) and filled out the incident report provided by the facility. RN-A stated she was unsure if she should have done a focused assessment when finding the new bruise, and that she was unsure how other nurses would be able to tell if the bruise was worsening or healing.During interview on 6/30/26 at 10:12 a.m., director of nursing (DON) stated she was unaware nurses were not completing comprehensive, descriptive assessments of new non-pressure skin conditions. DON stated she thought the incident form they used covered everything. DON stated without comprehensive assessment of the skin conditions, other nurses would not be able to compare when monitoring for worsening of the skin condition and this could lead to something being missed for the resident. DON stated she expected comprehensive skin assessments with more detailed descriptions of bruises.Facility Skin Integrity Management Program provided 6/30/26, indicated the following:For new bruises, measure and document a skin progress note in PCC. Enter an order to measure bruises weekly until resolved into the treatment administration record (TAR) in PCC. Notify the family and provider within 24 hours. Complete an incident report and place in filing location at each nurse's station. For pre-existing bruises, measure bruise weekly and document a skin progress note in PCC until resolved. Notify provider if bruise worsens.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review the facility failed to ensure interventions developed following resident falls were implemented through a system that was available to staff to prevent further falls for 3 of 3 residents (R2, R3, R10) reviewed for accidents.Findings include:R10's quarterly Minimum Data Set (MDS) assessment dated [DATE], indicated R10 had no cognitive impairment, utilized a walker, independent with walking, diagnoses included Non-Alzheimer's Dementia, repeated falls, chronic pain, had falls since admission or the prior assessment, one fall with no injury and one fall with injury (except major).R10's care plan dated 4/29/26, indicated R10 was at risk for falls r/t (related to) poor balance and history of falls and interventions included: anticipate and meet R10's needs, call light within reach and encourage her to use it for assistance as needed and follow facility fall protocol.R10's Accident Report documents which included interdisciplinary team review/investigation decision indicated:Review of R10's Accident Reports, including the interdisciplinary team (IDT) investigation and recommendations, identified the following falls and interventions:12/5/25: Unwitnessed fall after bending to pick up a box of crackers. Intervention: remind R10 to have staff retrieve items from the floor.2/14/26: Fell after attempting to sit on a walker without a seat. Intervention: use a chair when playing cards and move the walker aside before sitting.3/11/26: Found sitting on the floor beside the bed. Intervention: call staff for assistance with transfers and incontinent care.3/24/26: Found on the floor beside the bed with right hip and shoulder pain and transferred to the emergency department. Intervention: evaluate the need for a wider bed (determined not needed) and install a grab bar on the right side of the bed.4/30/26: Fell while bending to pick up cigarette butts outside without her walker, resulting in a skin tear and superficial abrasions. Interventions: develop a smoking contract or revoke smoking privileges and have staff move her chair after smoking if desired.6/8/26: Lost balance during dinner, fell backward, and struck the back of her head on another resident's chair before falling to the floor. Intervention: encourage R10 to slow down, stop and sit if feeling lightheaded, and provide smoking cessation education.Review of the interventions on 2/14/26, 3/24/26, 4/30/26, and 6/8/26, were not present on the care plan. On 6/29/26 at 10:33 a.m., R10 stated she had fallen approximately three weeks earlier after walking without her walker because she lost her balance. R10 stated staff reminded her to use her walker following the fall.On 6/29/26 at 2:41 p.m., licensed practical nurse (LPN)-B stated fall interventions are developed by the interdisciplinary team following falls, documented in the care plan, communicated to staff, and implemented. After review of the electronic medical record, LPN-B confirmed interventions developed following the resident's 6/8/26 fall were not added to the care plan and stated she was not aware of all interventions in place to prevent R10's falls.On 6/29/26 at 2:48 p.m., nursing assistant (NA)-A stated R10 was a known fall risk and staff relied on the care plan to identify the resident's current fall prevention interventions and prevent further falls.On 6/29/26 at 2:59 p.m., registered nurse (RN)-B, the nurse manager, stated immediate interventions are implemented following a fall and later reviewed by the interdisciplinary team. RN-B stated IDT-developed interventions are expected to be incorporated into the care plan so staff were aware of and able to implement measures to prevent further falls. RN-B stated if fall interventions were not added to the care plan, staff may not be aware of interventions intended to prevent R10's falls. RN-B further stated she was not aware of all specific interventions in place following R10's falls.On 6/29/26 at 3:09 p.m., the director of nursing (DON) reviewed the post-fall investigations for R10's falls occurring on 2/14/26, 3/11/26, 3/24/26, 4/30/26, and 6/8/26 and confirmed the interventions developed following those falls had not been incorporated into the resident's comprehensive care plan. The DON stated the interventions remained on paper fall investigation forms maintained in the DON's office and acknowledged staff would not have a readily available method to identify the (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident's current fall interventions to further prevent falls.On 6/29/26 at 5:03 p.m., LPN-C stated staff rely on the resident's care plan to identify current fall prevention interventions and, if the care plan is not updated, staff would not be aware of the interventions to prevent further falls.On 6/30/26 at 7:58 a.m., nursing assistant (NA)-B stated new fall interventions were communicated during shift report but are also expected to be documented in the care plan so all staff know what interventions to implement to prevent falls.On 6/30/26 at 8:08 a.m., registered nurse (RN)-C stated resident care plans should be updated following a fall to include new interventions to prevent further falls.R2's significant change MDS assessment dated [DATE], indicated impaired cognition, no behaviors or rejection of care, use of wheelchair, one fall with no injury, one fall with minor injury, and diagnoses of non-traumatic brain dysfunction, high blood pressure, and Alzheimer's disease.R2's care plan dated 11/2/23, indicated at risk for falls related to poor balance, assistive devices for mobility, psychotropic medication use, history of falls. Ensure non-slip footwear, follow facility fall protocol, if sitting on the edge of the bed to play cards, ensure that her bed is made or have her sit in the recliner.R2's facility progress notes reviewed on 6/29/26, indicated falls on 11/17/25, 1/7/26, 3/29/26, 3/30/26, 4/14/26, 4/18/26, 5/18/26, 5/23/26, and 6/15/26.Review of R2's Accident Report documents which included interdisciplinary team review/investigation decision indicated the following interventions:11/17/25: Wide bed1/7/26: Clip call light to chest for easier access3/29/26: Fall mat at bedside3/30/26: Hospice referral4/14/26: Medication change5/18/26: Remove or flip out foot pedal if wheeling self5/23/26: Medication change6/15/26: Reviewed with hospice concern for adverse effect post administration of anxiety medication and discontinued medicationR3's significant change MDS assessment dated [DATE], indicated impaired cognition, no behaviors or rejection of care, independent with ambulation with wheeled walker, one fall with injury, and diagnoses of anemia, atrial fibrillation (irregular heartbeat), high blood pressure, and hip fracture.R3's care plan dated 11/23/24, indicated moderate risk for falls related to confusion, deconditioning, gait/balance problems. Be sure call light is within reach to encourage her to use it for assistance as needed. Ensure appropriate footwear. Fall mat at bedside and bed at knee height.R3's facility progress notes reviewed on 6/29/26, indicated falls on 11/7/25, 5/18/26, and 5/28/26.Review of R3's Accident Report documents which included interdisciplinary team review/investigation decision indicated the following interventions:11/7/25: decreased medication5/18/26: Remind to wear shoes in room and let staff get large items and carry for her5/28/26: Offer to move to room closer to nurses, discontinued medicationDuring interview on 6/29/26 at 3:45 p.m., NA-C stated she did not know specific interventions for R2 but knew they tried to keep her out in the main area to keep an eye on her. NA-C further stated she did not know where she would find interventions, but they were usually passed down in report. NA-C stated she did not work every day, so could have missed hearing some interventions. NA-C stated she was not sure if interventions were on R2's care plan.During interview on 6/29/26 at 4:02 p.m., NA-D stated she did not have a list of interventions on the care plan for R2 or R3 and did not know if interventions were documented anywhere. NA-D stated interventions were talked about in report.On 6/30/26 at 8:15 a.m., DON stated post-fall investigations had been completed and fall interventions had been decided for the above falls for R2 and R3. DON stated the interventions were passed on by word of mouth to the nurses in report. DON stated the interventions were not a part of the comprehensive care plan and were kept on paper in a binder in her office. DON further confirmed the interventions would not be available for staff if she were not there and it would be important for staff to know fall interventions to prevent future falls.Facility Falls Policy and Procedure dated 9/23, indicated; A plan of care will be developed to include measures to aid in prevention of falls.Post fall: an accident report is filled up by the charge nurse following a fall. The charge nurse of each wing brings this report to the daily interdisciplinary team meeting. The team reviews the fall and determines if the current plan is adequate or other interventions should be put in place. The reports given to the DON to log for QAPI.Reassessment and reevaluation: residents who are at risk for falls will have their plan of care reassessed with each MDS assessment and reviewed at their resident care conference.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review the facility failed to implement appropriate infection prevention and control practices by ensuring Enhanced Barrier Precautions (EBP), including gown and glove use during wound care, were implemented for 2 of 2 residents (R5 and R11) reviewed for skin conditions and by ensuring transmission-based contact precautions, including gown and glove use during direct personal care, were implemented for 1 of 1 resident (R58) reviewed for infection prevention. Findings include: R5's face sheet printed 6/30/26, indicated diagnoses of blister of left and right lower leg. R5's quarterly Minimum Data Set (MDS) assessment dated [DATE], indicated intact cognition, no rejection of care, use of wheelchair, dependent for dressing and hygiene, and application of ointments/medications and nonsurgical dressings. R5's care plan dated 9/28/23, indicated potential for pressure ulcer development, goal of skin remaining intact through review dates, and interventions of administering treatments as ordered and checking skin when assisting with toileting and dressing daily and also weekly in the bath. R5's physician's order dated 6/6/26, indicated left lower extremity (LLE) wound care: Cleanse leg, foot, toes, and between toes with normal saline or wound cleanser. Pat dry and dry well between toes. Moisturize intact skin, avoiding wounds and between toes. Right lower extremity (RLE) wound care: Cleanse leg, foot, toes, and between toes with normal saline or wound cleanser. Pat dry and dry well between toes. Moisturize intact skin, avoiding wounds and between toes. Apply skin prep to periwound skin and allow to dry. Apply a single layer cut-to-fit piece of foam over blisters. Cover with small pad, secure with wrap and tape from base of toes to just below the knee. R5's provider visit note dated 6/19/26 indicated RLE blister measuring 0.4 centimeters by 1.1 centimeters. Prep: cleansed with saline. Noted serosanguineous (thin fluid that is a mixture of water and blood) drainage. Surrounding skin noted to have tenderness. Patient tolerated procedure well. Moisturized and applied foam dressing. R5's progress note dated 6/29/26, indicated R5 had a hospice bath this shift. Wound continue to right lower extremity. Review of R5's treatment administration record (TAR) indicated licensed practical nurse (LPN)-A completed R5's RLE wound treatment on 6/29/26 and 6/30/26. During observation on 6/29/26 at 1:34 p.m., no enhanced barrier precaution (EBP) signs were noted on R5's room door. No personal protective equipment (PPE) for EBP was observed at his room entrance. During interview on 6/0/26 at 1:13 p.m., LPN-A state she completed R5's wound care for his RLE wound. LPN-A stated she did wear gloves but did not wear a gown. LPN-A stated she was not aware she needed to wear EBP PPE while taking care of R5's wound and he had not been placed on EBP as far as she knew. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 6/30/26 at 11:20 a.m., director of nursing (DON) also known as the infection preventionist, stated EBP should be used for R5 during cares and wound treatments due to his RLE wound with drainage. R11's significant change in status MDS assessment dated [DATE], indicated no cognitive impairment, independent with personal cares and transfers, and diagnoses included non-Alzheimer's dementia and cellulitis (bacterial infection of the skin) of left lower limb. R11's care plan dated 5/19/26, indicated impairment to skin integrity r/t (related to) cellulitis and monitor/document location, size and treatment of skin injury. R11's wound care provider note dated 6/19/26, identified two open ulcers to the left lower extremity requiring daily wound care, including cleansing, application of topical treatments, Xeroform (sterile, non-adherent medical dressing) dressing, ABD (absorbent medical dressing) pad, and Kerlix (gauze bandage) wrap. On 6/29/26 at 2:39 p.m., R11 was seated in a recliner in their room with a dressing to the left lower leg. R11 stated nursing staff performed daily dressing changes and wore gloves during wound care but did not wear gowns. R11's room identified no EBP signage or PPE cart outside or outside the room. On 6/30/26 at 10:00 a.m., RN-C performed R11's wound care, including removal of the dressing, cleansing the wound, application of prescribed treatments, and placement of a new dressing. RN-C performed hand hygiene and wore gloves throughout the dressing change; however, a gown was not worn. RN-C stated R11 would be expected to be on enhanced barrier precautions because of the wound requiring dressing changes. RN-C stated the director of nursing (DON) determined which residents were placed on EBP and was responsible for EBP signage and PPE carts. On 6/30/26 at 11:18 a.m., the DON stated residents with wounds requiring dressing changes would be expected to be on enhanced barrier precautions with gown and glove use during wound care. The DON stated she believed R11 only had a scratch and was unaware the resident had active wound care orders. The DON confirmed R11 should have been on EBP and stated any nurse could initiate EBP by posting signage and placing a PPE cart outside the resident's room. R58's entry MDS assessment dated [DATE], indicated reentry from short term hospital on 6/22/26. R58's treatment administration record (TAR) dated 6/1/26-6/30/26, indicated start date 6/22/26, contact precautions used as directed per CMS guidelines every shift for VRE in urine (Vancomycin-Resistant Enterococci- bacteria primarily spread through direct contact with contaminated hands or surfaces). R58's After Visit Summary dated 6/22/26, indicated skin care/pressure management instructions wound care: buttocks; pressure injury. R58's care plan dated revised on 6/22/26, indicated at risk of transmitting an infection, contact isolation: wear gowns and gloves when entering room. On 6/29/26 at 12:23 p.m., observation identified a PPE cart containing gowns and gloves and contact precaution signage posted outside R58's room. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/29/26 at 12:26 p.m. trained medication aide (TMA)-A was observed providing toileting assistance to R58 while wearing gloves but no gown. TMA-A exited the resident's bathroom without having a gown. TMA-A confirmed R11 was on contact precautions for VRE in the urine, and confirmed a gown and gloves were required during care, and stated they forgot to put on the gown. On 6/29/26 at 4:51 p.m., the DON confirmed R58 was on contact precautions for VRE in urine and stated staff should know to use gown and gloves when providing toileting assistance, due to the signage posted and the PPE cart outside of R58's room. Facility Infection Prevention and Control Manual Policy dated 2024, indicated; Enhanced Barrier Precautions: refer to 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. EBP are used in conjunction with standard precautions and expand the use of PPE to donning of gown and gloves during high-contact resident care activities that provide opportunities for transfer of MDROs to staff hands and clothing. EBP are indicated for residents with any of the following: Infection or colonization with a CDC-targeted MDRO when Contact Precautions do not otherwise apply; or Wounds and/or indwelling medical devices even if the resident is not known to be infected or colonized with a MDRO.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to offer the recommended update for pneumococcal immunizations for 2 of 5 residents (R1, R9), reviewed for immunizations. Findings include: R1's face sheet printed on 6/30/26, included diagnoses of dementia, chronic kidney disease, congestive heart failure (when the heart does not pump as well as it should) and chronic obstructive pulmonary disease (lung condition that obstructs airflow and causes breathing difficulty).R1's admission Minimum Data Set (MDS) assessment dated [DATE], indicated intact cognition, clear speech, could understand and be understood. R1 was dependent upon staff for activities of daily living (ADLs).R1's physician orders did not include vaccinations.R1's vaccine history indicated pneumococcal 23-valent vaccine was received in 2011.PneumoRecs VaxAdvisor application, a product created by the CDC (Centers for Disease Control and Prevention) for healthcare providers to determine which pneumococcal vaccines were needed, recommended to give one dose of PCV15, PCV20, PCV21 at least one year after the last dose of PPSV23.During an interview on 6/30/26 at 2:30 p.m., R1 had been sleeping in bed; family member FM-A stated she could not recall if the facility had talked to them about R1 receiving additional vaccinations, but stated if one were recommended, R1 would take it. FM-A stated she knew R1 had received pneumococcal, influenza and covid vaccines, but gave up trying to keep track.R9's face sheet received on 6/30/26, included primary and secondary diagnoses of hepatic encephalopathy (brain dysfunction caused by liver disease) and nonalcoholic steatohepatitis (aggressive form of fatty liver disease).R9's admission MDS assessment dated [DATE], indicated moderately impaired cognition, clear speech, could understand and be understood. R9 required substantial assistance or was dependent upon staff for ADLs.R9's physician orders did not include vaccines.R9's vaccine history indicated pneumococcal 23-valent vaccine in 2017, and PCV13 in 2020.PneumoRecs VaxAdvisor recommended to give one dose of PCV20 or PCV21 at least 5 years after the last pneumococcal vaccine dose.During an interview on 6/30/26 on 3:13 p.m., R9 stated if vaccines were recommended and offered, she would take them. R9 stated no vaccines had been offered or received since admission. During an interview on 6/30/26 at 12:44 p.m., the director of nursing (DON) who was also the infection preventionist, stated R1 had been admitted on [DATE], for short term rehabilitation, which was Medicare part A, so the facility would not automatically update any vaccines. Then on 4/17/26, R1 moved to long term care status, and missed the vaccine clinic held on 4/20/26. The next vaccine clinic would be held at the end of July. The DON stated the facility conducted quarterly vaccine clinics in conjunction with a pharmacy. Regarding R9, the DON stated vaccines would be recommended at end of her short-term stay. The DON stated the delay in R1 and R9 being offered to update their vaccine status while in short term stay, was due to billing. During an interview on 6/30/26 at 2:34 p.m., Doctor of Medicine (MD)-C had been informed some residents had not been offered pneumococcal vaccine updates on admission. MD-C stated pneumococcal would be important to have on admission and had been unaware of the process the facility utilized to determine which/when vaccines were offered.During an interview on 6/30/26 at 2:39 p.m., registered nurse (RN)-B who was also a nurse manager, stated her role in resident immunizations included looking up historical vaccinations, but did not assess vaccine status to determine if a resident was eligible for additional vaccines such as pneumococcal vaccines. RN-B stated that was handled by the DON and the pharmacy. RN-B stated immunization status was reviewed by pharmacy during vaccination clinics. Looking in the electronic medical record, RN-B stated both R1 and R9 had been eligible for PCV21 if a provider ordered it.Facility Standing Orders policy, undated, included per CDC guidelines, administer pneumococcal vaccines unless contraindicated.Facility Pneumococcal Vaccine Program policy dated 2024, indicated residents would be offered immunizations against pneumococcal disease in accordance with Advisory Committee on Immunization Practices (ACIP) recommendations. Pneumococcal disease was a serious illness that could cause sickness and even death. A physician (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	order for all pneumococcal vaccines was required. Pneumococcal vaccination guidance for pneumococcal vaccination can be determined at CDC PneumoRecs VaxAdvisor.

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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 required and accurate nursing staffing information was posted for residents and visitors. This had the potential to affect all 47 residents residing in the facility and their visitors.Findings include:During an observation on 6/29/26 at 2:17 p.m., observed the daily nursing staffing posting for 6/29/26, in an acrylic holder on the countertop at the nurses station inside the main entrance. The posting included all of the required information, including the number of staff on duty: RN (registered nurse), LPN (licensed practical nurse), TMA (trained medication aide), and CNA (certified nursing assistant). Postings for April through June were requested for review.For April, from 4/1/26 through 4/30/26, 16 shifts had been left blank (all night shifts). Further, a registered nurse had not been identified as having been scheduled/working five of the dates: 4/1/26, 4/10/26, 4/15/26, 4/24/26, and 4/29/26. For May, from 5/1/26 through 5/31/26, 12 shifts had been left blank (16 night shifts and one evening shift). Further, on 5/27/26, one shift identified an RN in training, but no other RN had been identified.For June, from 6/1/26 through 6/28/26, 16 shifts had been left blank (12 night shifts, three evening shifts and one day shift). Further, a registered nurse had not been identified as having been scheduled/working on four of the dates: 6/6/26, 6/7/26, 6/10/26, and 6/24/26.During an interview on 6/29/26, at 3:37 p.m., the director of nursing (DON) stated it was the responsibility of charge nurses to complete the staffing posting sheet at the start of their shift. The DON stated a minimum of one registered nurse was scheduled for eight consecutive hours every day. In addition, a nurse leader was scheduled to work the day shift, Monday through Friday, either the DON, assistant DON or nurse manager. According to the DON, the shifts where an RN had not been identified as scheduled/working, were primarily shifts worked by agency nurses who likely did not know they needed to complete the form. In addition, for nine of the 10 dates, an RN nurse leader had worked 8 consecutive hours too, except for Saturday 6/6/26, when the RN was an agency nurse. The agency nurses time card had been reviewed for verification. The DON stated she did not monitor the process to ensure nurses completed the form each shift/each day.During an interview on 6/29/26 at 6:08 p.m., registered nurse (RN)-A who was the charge nurse stated she had never filled out a staffing posting for a shift she worked, adding it was usually already filled out. During an interview on 6/30/26 at 8:39 a.m., licensed practical nurse (LPN-A) stated the charge nurse completed the daily staffing posting for that shift. LPN-A stated she looked at the online electronic scheduling system to determine who was scheduled to work, added it to the sheet and made changes to it if someone called in (not able to work). LPN-A stated there was at least one RN scheduled to work every day.Facility Posting Nursing Staffing Hours policy, undated, indicated early in the shift, the charge nurse would obtain a staffing hours form from the bottom file drawer located in the nurses station. The form would be completed with date, census, the type of nursing staff scheduled to work, and their scheduled hours. This would be done by the charge nurse on each shift.