STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245363	A. Building B. Wing	01/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aicota Health Care Center	850 Second Street Northwest Aitkin, MN 56431

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and document review the facility failed to ensure milk products were served to residents at safe temperatures for consumption. This deficient practice had the potential to affect 5 residents (R8, R11, R17, R20, R38) who were served milk at unsafe temperatures. In addition, the facility failed to ensure staff preparing food had proper hair restraints in place. This deficient practice had the potential to affect any person consuming food prepared by the facility.R8's admission Record dated 1/9/26, identified an admission date of 10/30/25 and diagnoses of malignant neoplasm of part of the left bronchus or lung, and chronic kidney disease.R11's admission Record dated 1/9/26, identified an admission date of 3/21/22 and diagnoses of chronic atrial fibrillation, vascular dementia, hypertension and diabetes.R17's admission Record dated 1/9/26, identified an admission date of 5/5/25 and diagnoses of hypertensive heart disease, and rheumatoid arthritis.R20's admission Record dated 1/9/26, identified an admission date of 12/18/25 and diagnoses of chronic obstructive pulmonary disease (COPD), and anemia.R38's admission Record dated 1/9/26, identified an admission date of 4/18/23 and diagnoses of late onset Alzheimer's disease, atrial fibrillation and chronic kidney disease.During an observation and interview on 1/7/26 at 8:49 a.m., dietary aid (DA)-A was standing at a serving table in the dining room with breakfast items including a partially full gallon of milk and a quart of half and half which were not on ice. There were five residents still eating, and two unidentified nursing assistants (NA)s. At 9:04 a.m., one NA poured a glass of milk from the jug sitting on the table as DA-A was standing by watching. The NA didn't serve the glass of milk, and DA-A got a thermometer and checked the temperature of the milk at 42 degrees Fahrenheit (F). DA-A then poured what was left in the half and half container into a glass and checked the temperature at 64 degrees F. DA-A stated the milk and half and half should be at 41 degrees F or lower and the risk to someone drinking this would be food poisoning or something. DA-A stated his normal practice would be to put the milk and creamer in the fridge, which was right by the serving table, between uses.During an observation on 1/7/26 at 11:18 a.m., cook (CK)-A had placed the hot food in the steam table, then proceeded to dish up plates. CK-A was not wearing a hair net. At 11:23 a.m., there was noted to be a half-full, clear gallon container of milk on the serving table and not on ice. At 11:34 a.m., the milk was still on serving table. At 11:45 a.m., culinary supervisor (CS)-E was behind the steamtable dishing up plates. CS-E has a full beard of about one inch in length and was not wearing a beard net. The milk was still on the serving table with unidentified staff pouring beverages. An unidentified dietary aid (DA) made chocolate milk with the milk from the gallon jug on the serving table and brought it to R20. At 11:53 a.m., CS-E poured milk from the jug on the serving table into a glass and used a thermometer to get a temperature of 55 degrees F. CS-E stated it was too warm so it should be thrown out, he stated the risk to residents would be listeria. CS-E got the help of other staff to collect the glasses of milk served from this gallon to R8, R11, R17, R20, and R38.During an interview on 1/7/26 at 12:06 p.m., CD-B stated he would expect the milk to be on ice or only pulled out briefly for use. CD-B stated Listeria would be the risk of serving milk out of safe temperatures. CD-B observed CK-A behind the steam table working with food without a hair net and stated he would expect CK-A to have a hair net on then went and grabbed her one.During an interview on 1/7/26 at 12:20 p.m., CS-E stated he (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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	thought he would need a beard net if the beard was an inch or longer, which he stated he thought his was close to and he would wear a beard net if it was needed.During an interview on 1/8/26 at 10:18 a.m., the administrator stated her expectation would be that they follow regulation and have protective gear on which included hair and beard nets. The administrator also stated she would expect milk products to be served in range for safe consumption.During an interview on 1/9/26 at 10:52 a.m., CD-B stated he would expect a beard net to be worn if the beard was one-eight inch or longer.

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F 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. Based on interview and document review, the facility failed to accurately submit the payroll-based journal system (PB&J) staffing data to Centers for Medicare and Medicaid Services (CMS). This had the potential to affect all 53 residents residing in the facility.Findings include:The facility's PB&J data submitted to CMS for 7/1/25, through 9/30/25, identified the facility was triggered for no registered nurse hours on the following days: 7/1/25, 7/2/25, 7/8/25, 7/9/25, 7/14/25, 7/15/25, 7/16/25, 7/23/25, 7/24/25, 7/26/25, 7/27/25, 8/10/25, 8/14/25, 8/21/25, 8/22/25, 8/23/25, 8/25/25, 8/28/25, 9/1/25, 9/4/25, 9/5/25, 9/6/25, 9/7/25, 9/8/25, 9/11/25, 9/12/25, 9/15/25, 9/19/25, 9/25/25, 9/26/25, 9/27/25, 9/28/25, 9/30/25.In addition, the facility's PB&J data submitted to CMS for 7/1/25, through 9/30/25, identified the facility was triggered for failure to have licensed nursing coverage 24-hours a day on the following days: 7/1/25, 7/2/25, 7/3/25, 7/8/25, 7/9/25, 7/10/25, 7/11/25, 7/12/25, 7/13/25, 7/15/25, 7/16/25, 7/17/25, 7/24/25, 7/26/25, 7/27/25, 7/28/25, 7/29/25, 7/30/25, 7/31/25, 8/3/25, 8/6/25, 8/9/25, 8/10/25, 8/13/25, 8/16/25, 8/23/25, 8/28/25, 9/4/25, 9/5/25, 9/6/25, 9/7/25, 9/9/25, 9/10/25, 9/11/25, 9/17/25, 9/18/25, 9/19/25, 9/20/25, 9/21/25, 9/23/25, 9/24/25, 9/25/25.The facility was able to provide payroll documentation identifying there was a registered nurse on the above listed days and licensed nursing coverage 24-hours a day on the above listed days.During an interview on 1/9/26 at 11:23 a.m., the director of nursing (DON) stated they were not able to get into the program, they finally received a username, but when they submitted the file, it was formatted incorrectly. The DON stated they worked on trying to submit data up until the deadline but missed the deadline because of the time difference (the program was based on the Eastern time zone).Compliance with CMS Payroll Based Journal Reporting dated 7/1/19, identified the facility would comply with the CMS PBJ policy by reporting to electronically submit direct care staffing information (including agency and contract staff) based on payroll and other auditable data. The quarters were listed as well as the dates the information was due.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 agency nursing staff received appropriate orientation, training and supervision. This had the potential to affect all 53 residents who resided in the facility. Findings include:A review of agency orientation paper work identified the following sections: HR (human resources) and HR paper work, orientation tour, safety, other (care plans in closet, bath schedule, point click care log in and documentation, dining room cards, walking expectations, linen rooms/hopper, barrel empty, lift training total lift, daily routines, lift training sit to stand), changes in physical and mental condition changes, breaks, daily routines am (day), daily routines pm (evening), daily routines noc (night). The orientation paperwork included employee name, date task completed, and completed by initials. A spot for agency staff printed name, signature and date, and orientation leader signature.A review of agency staff members orientation paperwork identified the following:Anonymous staff member (ASM)-P, nothing filled out except agency staff signature and date.ASM- N, nothing filled out except agency staff printed name, signature and date.ASM-M, completed by column completed thru XXXX, printed name, signature and no date.ASM-I, date task completed line drawn through, completed by no initials but line drawn through no dates. Printed name, signature and date.ASM-K, completed by initials of agency staff, printed name, signature and date.ASM-G, completed by initials of agency staff, printed name, signature and date.ASM-O, date task completed line drawn through, completed by no initials but line drawn through no dates. Printed name, signature and date.ASM-J, date task completed line drawn through, completed by no initials but line drawn through no dates. Printed name, signature and date.ASM-Q, date task completed filled out with line drawn through, completed by initials of agency staff member. Printed name, signature and date.ASM-H, date task completed had agency staff member initials, nothing in completed by column. Printed name, signature and date.ASM-C, date task completed date filled in, completed by agency staff initials. Printed name, signature and date.ASM-L, completed by agency staff initials. Printed name, signature and date.Did not receive orientation paperwork for five staff hired between October and December of 2025. None of the orientation paperwork had the signature of the orientation leader.During an interview during the course of the survey 1/5/26-1/9/26, anonymous staff member (ASM)-C stated there was no training or orientation to the facility. Just given an assignment and told to go. ASM-C feared there would be retaliation for talking with surveyors.During an interview during the course of the survey ASM-F stated agency staff had no training when they started at the facility but were currently being told they must sign and back date their orientation sheets. ASM-F stated agency staff were told if they did not do this, they would have their contracts cancelled.During an interview during the course of the survey 1/5/26-1/9/26, ASM-G stated they did not receive an orientation to the facility. ASM-G stated they were concerned about retaliation from the facility by being interviewed. ASM-G stated they were made to sign orientation papers with a fake dated. ASM-G stated other agency staff were asked to do the same.During an interview during the course of the survey 1/5/26-1/9/26, ASM-J stated they signed their orientation paperwork on 1/7/26, they were told they couldn't find the original paperwork.During an interview during the course of the survey 1/5/26-1/9/26, ASM-N reviewed their orientation paperwork and verified it had not been filled out, only signed. During an interview during the course of the survey 1/5/26-1/9/26, ASM-P reviewed their orientation paperwork and verified it had not been filled out, only signed. During an interview on 1/9/26 at 10:37 a.m., scheduling coordinator (SC)-R stated she was in charge of orientation for agency staff. SC-R stated when agency staff started on an off shift or a weekend, she would leave a note for a staff person to sign the agency orientation paperwork. SC-R stated agency staff were expected to be competent and ready to start work. SC-R stated for Grapetree staff they were supposed to receive an hour of orientation and for Shift key no orientation they would receive a tour of the building. SC-R stated human resources had no involvement at the (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	facility, she was in charge of ensuring the check list was completed. SC-R was not sure who the orientation leader was for signature on the paperwork. SC-R expected the columns to be completed and signed off. SC-R stated she was unable to find all of the agency staff paperwork.During an interview on 1/9/26 at 9:08 a.m., registered nurse (RN)-A stated they had no official role in the process. RN-A stated they expected agency staff to come prepared to take care of residents.During an interview on 1/9/26 at 11:09 a.m., the director of nursing (DON) stated agency staff were expected to complete the paperwork. The DON stated ideally, she would expect the paperwork to be completed. The DON identified the orientation leader as a nursing assistant, a nurse, or SC-R. The DON verified she was ultimately responsible for agency staff orientation.A policy on agency staff orientation was requested but not provided.

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review the facility failed to facilitate resident preferences for meals for 1 of 1 resident (R27) reviewed for choices.Findings include:R27'S annual Minimum Data Set (MDS) dated [DATE], identified R27 had diagnoses which included atrial fibrillation (an irregular and often very rapid heart rhythm), heart failure (when the heart muscle doesn't pump blood as well as it should), gastroesophageal disease (when stomach acid flows back up into the esophagus and causes heartburn), depression, and chronic obstructive pulmonary disease (lung and airway diseases that restrict breathing). In addition, R27's MDS identified R27 was cognitively intact and was able to understand and be understood. R27's care plan was requested but not provided. R27's care plan, unable to provide a date, identified nutrition as care plan concern. Staff were directed to provide her diet as ordered, her dislikes were listed, staff were to encourage R27 to make food choices at all meals and to provide snacks and supplements.R27's nursing assistant Kardex dated 8/28/25, had a section titled Eating, the information provided was R27 was independent for eating. It did not include likes or dislikes.R27's meal ticket identified texture was regular and regular house diet. The section Dislikes was blank.The kitchen's Meal Distribution Report, no date, listed the resident's name, whether they ate in their room, allergies, texture/special diets, dislikes, notes, standing orders. Information in the book identified R27 ate in her room, had a regular diet and regular texture. The section for dislikes was left blank.During an observation on 1/7/26 at 11:31 a.m., the menu was posted outside of the dining room. For week three, lunch was listed as a hot turkey sandwich on white, garlic mashed potatoes, brussel sprouts and pineapple angel cake. Dinner was listed. No alternatives were listed.During an observation on 1/7/26 at 11:48 a.m., a staff entered R27's room with her lunch tray.During an observation on 1/7/26 at 11:51 a.m., R27 verified her meal ticket was titled breakfast and had no dislikes listed. R27 verified she received brussel sprouts and didn't like them, she also stated she did not have an opportunity to order her lunch (she wasn't told what was for lunch and/or offered the alternative). There was not a ticket on the tray for the evening meal.During an interview on 1/5/26 at 4:38 p.m., R37 stated she didn't get to make choices about the food she was served, she said it would just arrive. R37 stated she would periodically receive a questionnaire about food, and she would tell them she didn't like vegetables like broccoli and cauliflower but would still get them.During an interview on 1/7/26 at 12:39 p.m., cook (C)-A stated there was an always available menu and the kitchen needed to know by 10:00 a.m., to get the alternative. C-A stated the menu was posted in the hallway by the dining room. C-A stated residents needed to tell the nursing staff about preferences and dislikes, she said they did not go out and meet the residents. C-A brought out the book (meal distribution) she verified there were not dislikes noted for R27 in the book.During an interview on 1/7/26 at 1:00 p.m., nursing assistant (NA)-A stated the care plan for a resident would be found in the closet. NA-A provided the care plan for R27, there was nothing to identify likes or dislikes on the care plan. NA-A stated the process was to go around and ask residents if they wanted what was on the menu or the alternative. NA-A verified the menu was posted outside of the dining room and a resident would need to go and look at it to know what would be served for lunch and dinner. After looking about the room, NA-A was able to find the laminated always offered menu. NA-A verified she had not had time to ask R27 if she wanted what was on the menu for lunch or the alternative.During an interview on 1/7/26 at 1:17 p.m., the director of nursing (DON) stated the unit nurse manager would be the person to ensure the care plan was updated and current and that the likes and dislikes were noted. The DON verified it would be important to know a resident's food preferences to provide individualized care. The DON also verified the residents were not provided with a copy of the menu daily, weekly, or monthly. The DON stated they would need to go and look at the posted menu outside of the dining room.During an interview on 1/8/26 at 10:47 a.m., (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	anonymous staff member (ASM)-D stated they needed to collect lunch tickets, when asked if they needed to be collected by 10:00 a.m., ASM-D stated that was correct, but it has been too busy to collect them timely. During an interview on 1/8/26 at 2:55 p.m., registered nurse (RN)-A verified resident autonomy was important. RN-A verified the menu was posted in the hallway by the dining room and not delivered to residents. RN-A stated it was the expectation that the staff would tell residents what was for lunch and dinner and ask if they wanted an alternative meal. RN-A stated they were not sure how the kitchen was notified of preferences and dislikes.During an interview on 1/9/26 at 10:18 a.m., the culinary director (CD)-B verified the menu was posted outside the dining room. CD-B stated the nursing staff were supposed to be asking residents what they wanted for lunch and dinner. CD-B stated the kitchen needed the meal tickets around 11:30 a.m., to receive the alternative. CD-B stated they would get the preferences and the dislikes from nursing staff. CD-B reviewed the meal distribution book and verified R27 did not have anything listed for dislikes. CD-B verified it was important for residents to receive what they wanted for meals as their needs should come first.During an interview on 1/9/25 at 10:59 a.m., the DON verified resident should have choices about everything from getting up to going to bed, what they eat and how often they want to eat.The Combined Federal and State [NAME] of Rights dated 12/22/25, identified the resident had the right to be informed of, and participate in, his or her treatment.The policy Resident Rights dated 10/15/24, identified Residents shall have the right to appropriate medical and personal care based on individual needs. Appropriate care for residents means care designed to enable residents to achieve their highest level of physical and mental functioning.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to develop a person-centered care plan to include necessary post-treatment assessments and documentation needs for 1 of 2 residents (R42) reviewed for care planning. R42's admission minimum data set (MDS) dated [DATE], identified intact cognition and diagnoses of acute and chronic respiratory failure with hypoxia, kidney transplant rejection, end-stage-renal-disease (ESRD), and dependence on renal dialysis. R42's care plan dated 1/6/26, identified a focus statement for a high risk of complications related to on-going dialysis treatments. Interventions didn't include instructions to assess R42 upon return from a dialysis treatment for his overall condition and status, vital signs, presence of thrill or bruit in fistula, or status of dressings on the fistula. R42's provider orders dated 12/23/25, identified an order to check AVS fistula every shift, every day, and an order for dialysis treatments on Mondays, Wednesdays, and Fridays and R42 was to be ready at 7 a.m. R42 also had an order for weight to be taken on bath day. R42's electronic medical record (EMR) lacked documentation of R42's return from and assessment after returning from dialysis treatments. During an interview on 1/8/26 at 1:11 p.m., registered nurse (RN)-A, who identified as being a nurse manager for R42, stated she would want the care plan to include post-dialysis assessments because it could help with early intervention for potential blood pressure issues. RN-A confirmed the current care plan didn't include this.

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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 interview and document review, the facility failed to follow bowel protocols for 1 of 3 residents (R3) reviewed for quality of care.R3's significant change in status assessment (SCSA) minimum data set (MDS), dated [DATE], identified severely impaired cognition and diagnoses of Alzheimer's dementia, anxiety disorder, major depressive disorder, uterovaginal prolapse and constipation. R3's MDS also indicated moderate assistance needed for bed mobility, transfers, and toilet hygiene. The MDS also identified R3 was occasionally incontinent of bowel and bladder and was on a toileting program, R3 needed moderate assist for transferring and toilet hygiene. R3's care plan, dated 8/18/21, identified R3 was incontinent of bowel and bladder and needed an assist of one to bring her to the toilet and provide incontinent care as needed. The care plan didn't address constipation. R3's provider orders, dated 11/17/24, for bowel movement (BM) protocol: -Give four ounces (oz) of prune juice after five shifts of no BM as needed (PRN) for constipation.-Senna 8.6 milligrams (mg) PRN for constipation, if no BM after 24 hours give senna and prune juice together (if milk of magnesia contraindicated).-Milk of magnesia (MOM) give 30 milliliters (mL) PRN for constipation mix with four ounces of prune juice. Give after 24 hours of no results of plain prune juice.-Dulcolax rectal suppository, give one suppository rectally PRN for constipation.-Fleet enema rectally as needed for constipation if no BM 24 hours after Dulcolax suppository.-1/9/24, give MiraLAX 17 grams every other day. R3's electronic medical record (EMR) identified the following: -a bowel report, dated 1/3 to 1/9/26, with no bowel movement documented from 1/4 through 1/7/26.-progress notes for the dates of 1/4 to 1/7/26 do not have notes regarding bowels.-medication administration record (MAR) for January 2026 didn't identify an as needed (PRN) bowel medication given until after the interview below with RN-B and was given on 1/7/26 at 3:38 p.m., when Senna was given and recorded as ineffective. And on 1/8/26 at 1:49 p.m., MOM 30 mL was given and recorded as effective. An untitled facility-submitted worksheet, dated 1/5/26, had a list of residents including R3. Next to R3 was a hand-written time of 9:52 a.m. and the letter m circled. During an interview on 1/7/26 at 2:30 p.m., nursing assistant (NA)-B stated she would be responsible for documenting BMs. She will also let the nurses know if they haven't had one for a while.During an interview on 1/7/26 at 2:53 p.m., registered nurse (RN)-B stated they ran a bowel report every day on the afternoon shift, and that shift would then give the PRN medication. RN-B checked R3's EMR and stated there wasn't a BM documented since 1/3/25. RN-B stated she usually started with giving R3 Senna, or any of them if that one had already been used.During an interview on 1/8/26 at 9:19 a.m., RN-C stated BMs were documented by the nursing assistants. On afternoon shift they look for when the last BM was, if it was so many shifts then they use a PRN. Can try whatever they have under the orders. During an interview on 1/8/26 at 11:08 a.m., the director of nursing (DON) stated alerts would show up in the EMR if a resident hadn't had a BM in more than 48 or 72 hours. The PM shift runs a bowel report every day. The DON stated she would expect an assessment be completed if the resident had gone without for a few days. They follow MAGIC standing orders. The risk could be an obstruction, and before that them just being ill. An undated document, Aicota Bowel Protocol, identified bowel lists should be run on the PM shift and provided directions for how to run this list. An example bowel report is provided, with five consecutive shifts of no BM documented and highlighted with a line drawn after the fifth shift indicating when an intervention would be started.

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	245363	A. Building B. Wing	01/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aicota Health Care Center	850 Second Street Northwest Aitkin, MN 56431

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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review the facility failed to ensure a resident was toileted timely to prevent an incontinence accident for 1 of 1 resident (R27) reviewed for bowel and bladder.Findings include:R27'S annual Minimum Data Set (MDS) dated [DATE], identified R27 had diagnoses which included atrial fibrillation (an irregular and often very rapid heart rhythm), heart failure (when the heart muscle doesn't pump blood as well as it should), gastroesophageal disease (when stomach acid flows back up into the esophagus and causes heartburn), depression, and chronic obstructive pulmonary disease (lung and airway diseases that restrict breathing). In addition, R27's MDS identified R27 was cognitively intact and was able to understand and be understood. R27's MDS identified she was frequently incontinent of bladder and occasionally incontinent of bowel. In addition, R27's MDS identified she was dependent on staff for toileting hygiene.R27's care plan, undated, identified R27 was continent of bladder with episodes of incontinence and required an assist of two for toilet use.R27's nursing assistant Kardex dated 8/28/25, had a section titled Toileting, the information provided included Resident is continent with episodes of incontinence. The information also identified R27 was an assist of two for transfers/adjust clothing/change incontinent product. R27's Kardex identified R27 was a two-assist with Hoyer lift and medium sling transfer.During an observation and interview on 1/5/26 at 4:36 p.m., R27 stated she was currently wet, she stated she had told a male staff member, and he said he would get help. R27 stated she would often sit wet several times a day. R27 stated staff did not come in every few hours and offer to take her to the bathroom. R27 stated it could take up to 30 minutes to get her call light answered and it had been on since 4:30 p.m., R27 turned her call light back on during the interview.On 1/5/26 at 4:53 p.m., a male staff member answered her call light. R27 asked him to get the girls because she was wet and still waiting for help.On 1/5/26 at 4:57 p.m., two unidentified female staff entered R27's room to assist her to the commode. One of the staff remarked it was often difficult to find two female staff for assistance with toileting.On 1/6/26 at 1:53 p.m., R27 was brought back to her room by an unidentified staff, she had been in the activity. The staff member was heard to say, I'll be right back.On 1/6/25 at 2:16 p.m., staff entered R27's room and asked her what she needed, at that time a second staff entered the room with the mechanical lift.On 1/8/26 at 12:54 p.m., R27 stated she had just been gotten up for the day. She stated they were late getting her up and that she preferred to be up between 10:00 a.m. and 10:30 a.m.During an interview during the course of the survey between 1/5/26-1/9/26, an anonymous staff member (ASM)-C stated they took care of about 27 residents with a partner, sometimes the partner was a nurse. ASM-C stated they were able to complete tasks, just not always timely.During an interview during the course of the survey between 1/5/26-1/9/25, ASM-G stated they were concerned about retaliation from the facility by being interviewed. ASM-G stated they took care of 25-27 residents alone. ASM-G stated they were unable to perform tasks timely (toileting, getting residents up timely [sometimes after 10:30 a.m.]).During an interview on 1/9/26 at 10:59 a.m., the director of nursing (DON) stated she would expect a resident who was identified as wet should receive toileting assistance in about 10 minutes. The DON identified the concerns as dignity and skin breakdown and irritation. The DON identified two nursing assistants for 27 residents would be bare staffing and it would be better to have three.The policy Call light dated 11/12/12, identified the expectation was to respond promptly to resident's calls for assistance.The policy Resident Rights dated 10/15/24, identified Residents shall have the right to appropriate medical and personal care based on individual needs. Appropriate care for residents means care designed to enable residents to achieve their highest level of physical and mental functioning.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to perform vital sign monitoring, assessment, and documentation of resident's condition and fistula status (also called a shunt, a connection made between a vein and an artery for the necessary blood flow to facilitate a machine to remove the excess waste and water from the person's blood which the kidneys are not able to) after returning from a renal dialysis treatment at an offsite dialysis facility for 1 of 1 (R42) resident reviewed for dialysis care. R42's admission minimum data set (MDS), dated [DATE], identified intact cognition and diagnoses of acute and chronic respiratory failure with hypoxia, kidney transplant rejection, end-stage-renal-disease (ESRD), and dependence on renal dialysis. R42's care plan, dated 1/6/26, identified a problem statement for a high risk of complications related to on-going dialysis with a goal for R42 to attend dialysis appointments as scheduled. Interventions included avoiding lotion on dialysis site, check for bruit and thrill every shift and to notify provider and dialysis of any concerns, to coordinate services with dialysis center, and for a dialysis binder to go to/from appointments for coordination of care. R42's provider orders, dated 12/23/25, identified an order to check AVS fistula every shift, every day, and an order for dialysis treatments on Mondays, Wednesdays, and Fridays and R42 was to be ready at 7 a.m. R42 also had an order for weight to be taken on bath day. R42's electronic medical record (EMR), for the dialysis treatment dates of 1/5 and 1/7/26, didn't identify vital sign values, progress note, or assessment for R42's return from a dialysis treatment. During an interview on 1/5/26 at 6:16 p.m., R42 stated the facility didn't do anything for him after dialysis. R42 explained the dialysis center took his vital signs and bandaged his fistula prior to him leaving the center, and he brought that binder back to the facility. At this time, R42's fistula is covered with gauze dressings and tape, he stated he had dialysis this morning and will take it off tomorrow. During an interview on 1/7/26 at 3:03 p.m., licensed practical nurse (LPN)-A stated they made sure to provide R42 with a meal and ask how it went. LPN-A demonstrated the dialysis communication book they used to communicate with the dialysis center. Prior to dialysis they took R42's weight and vitals and checked for a thrill on the fistula, and when R42 came back they checked the book to see how it went for him and the vitals dialysis recorded before he left there. During an interview on 1/8/26 at 9:54 a.m., LPN-B stated for R42 there wasn't a whole lot to do unless he was feeling dizzy or something. They have a communication book that goes back and forth with dialysis. LPN-B added R42 was cognitively intact and would tell them if something was wrong. During an interview on 1/8/26 at 11:00 a.m., the director of nursing (DON) stated vitals and site check were done on return, the dialysis center did the pre- and post-weight and share information with a binder that went back and forth with R42. The DON stated her expectation would be for these things to be charted. The DON also stated the risks for a person after dialysis could be bleeding or blood pressure issues. The DON stated the nurses got some dialysis education upon hire but thought they should be reeducating when they got a new dialysis resident as they didn't take dialysis residents very often. During an interview on 1/8/26 at 1:11 p.m., registered nurse (RN)-A and nurse manager for R42 stated she would want the care plan to include the post-dialysis assessments, which it didn't right now. A dialysis policy was requested on 1/8/26 at 10:04 a.m. but was not received.

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. Based on record review and interviews, the facility failed to ensure the information on the daily nurse staffing was in a format that was clear to residents and visitors. This had the potential to affect all 53 residents who resided in the facility and their families and visitors. Findings include: On 1/8/26, the Daily Staffing Posting was reviewed. The posting included the following: Date, facility name, census. Shift category identified registered nurse (RN), nursing assistant (NAR), licensed practical nurse (LPN), and nursing assistant in training (NAIT). The first column was titled Shift Category second column titled Shift Time was listed as follows: RN - Skilled 2:00 PM-10:30 PMNAR 6:00 AM-6:30 PMNAR 10:00 PM-6:30 AMNAR 6:00 AM-2:30 PMLPN - Skilled 6:00 AM-2:30 PMNAR 2:00 PM-10:30 PMLPN - Skilled 10:00 PM-6:30 AMLPN - Skilled 6:00 PM-6:30 AMNAR 6:00PM-6:30 AMNAR 11:30 PM-8:00 AMRN - Skilled 6:00 AM-2:30 PMNAIT 6:00 AM-2:30 PMLPN - Skilled 6:00 AM-6:30 PM The totals for each skill category were not totaled per shift but rather for the 24-hour period. Residents, visitors and families were not able to see who was working by shift. The nursing assistants in training were included in the totals for staff working. During an interview on 1/8/26 at 11:01 a.m., visitor (V)-S and R49 reviewed the staff posting, V-S read it to R49 and they discussed it. V-S said they didn't understand what NAR or NAIT meant, they thought maybe a nurse assistant. V-S stated they could see there were different shifts all mixed together but said would not be able to tell how many or what staff were working on each shift without getting another piece of paper to figure it out. During an interview on 1/9/26 at 11:23 a.m., the director of nursing (DON) stated the posting for nursing staff had all of the required elements. A policy on staffing was requested but not provided.