STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245366	A. Building B. Wing	05/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hilltop Healthcare Rehabilitation and Skilled Nurs	2501 Rice Lake Road Duluth, MN 55811

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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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47263 Based on record review and interview, the facility failed to ensure psychotropic medication orders had an indication for use for 1 of 5 residents (R29) reviewed for unnecessary medications. Findings include: R29's quarterly Minimum Data Set (MDS) dated [DATE], indicated R29 was cognitively intact and identified diagnoses of secondary polycythemia (increased amount of red cells due to another medical condition), depression, anxiety, polyneuropathy (disease affecting peripheral nerves throughout the body), hypertension, acquired absence of foot, sleep apnea, and amputation of lower left leg. R29's provider orders reviewed on 4/30/25, included the following medication orders: -duloxetine oral capsule delayed release sprinkle 60 milligrams (mg), give one capsule by mouth one time a day for 'no indication listed' -pristiq oral tablet extended release 24 hour 25mg- give 25mg by mouth one time a day for 'no indication listed' During interview on 5/1/25 at 8:51 a.m., registered nurse (RN)-D reviewed medication orders for R29 and confirmed no indication listed for duloxetine and pristiq medications. RN-D stated expectation for every medication order to have an indication or diagnosis listed. During interview on 5/2/25 at 1:05 p.m., director of nursing (DON) stated expectation for every medication order to have an indication for use listed. Medication Administration policy last reviewed 4/1/24, explained facility's policy to administer all medications and treatments in a safe and effective manner. Included in the procedure for administering medications was 'able to state indication.'

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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** 47263 Based on record review and interview the facility failed to ensure accurate coding of the Minimum Data Set (MDS) for 3 of 5 residents (R26, R30, R29) reviewed for MDS completion. Findings include: R26: R26's admit MDS dated [DATE], indicated R26 was cognitively intact with the diagnosis of COPD. MDS Section O., was coded incorrectly and indicated R26 was not receiving hospice. R26's Census documentation showed R26 was admitted on [DATE], with hospice services. R26's care plan with the admitted [DATE], included care planning for hospice services. During an interview on 5/1/25 at 3:06 PM both registered nurse (RN-A) and the director of nursing (DON) were present and confirmed R26's admission MDS should have been coded to show that R26 was receiving hospice services. The facility policy Accuracy of Assessments dated 3/15/24, indicated the policy was created to ensure each resident received an accurate assessment reflective of the resident status at the time of assessment and staff were to follow the RAI manual. 48109 R30: R30's quarterly MDS dated [DATE], identified intact cognition and diagnoses of kidney failure and malignant neoplasm of the prostate. Section H, which covers bowel and bladder, identified R30 had a colostomy. During an interview on 5/2/25 at 10:21 a.m., RN-F confirmed R30 didn't have a colostomy. During an interview on 5/2/25 at 2:55 p.m., the MDS nurse stated section H of R30's MDS was marked in error. The MDS nurse stated accurate MDS' were important because it reflects how they should plan and care for him. 49878 R29: R29's quarterly MDS dated [DATE], indicated R29 was cognitively intact and with a functional limitation in movement on one side of the lower body. The MDS further indicated R29 did not use any mobility devices. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R29's facesheet reviewed on 5/2/25, indicated diagnoses of secondary polycythemia (increased amount of red cells due to another medical condition), depression, anxiety, polyneuropathy (disease affecting peripheral nerves throughout the body), hypertension, acquired absence of foot, sleep apnea, and amputation of lower left leg. During observation on 4/30/25 at 10:20 a.m., R29 observed in bed with a wheelchair and prosthetic leg in resident's room. R29 confirmed using mobility devices when out of bed. During interview on 5/1/25 at 11:02 a.m., MDS coordinator explained MDS reports were done on a schedule dictated by regulations. MDS coordinator stated reports were based on documentation from nursing staff, and providers involved in the resident's care. MDS coordinator further explained parts of the MDS were done in-person with the resident. MDS coordinator reviewed R29's quarterly MDS from 4/8/25, and confirmed MDS indicated R29 did not use mobility devices. MDS coordinator stated the MDS was incorrect and R29 does use mobility devices including a wheelchair and prosthetic limb. During interview on 5/2/25 at 1:05 p.m., director of nursing (DON) stated expectation that MDS reports should accurately reflect the resident's status. DON confirmed R29's MDS from 4/8/25 was not accurate concerning mobility devices.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49878 Based on record review and interview, the facility failed to ensure a Level II Pre-Admission Screening and Resident Review (PASARR) reassessment after 30 days was conducted, documented, and retained to ensure mental health needs were appropriately addressed or provided for 1 of 1 residents (R22) reviewed for PASARR. Findings include: R22's significant change Minimum Data Set (MDS) dated [DATE], identified R22 had severely impaired cognition and required substantial assistance with most activities of daily living (ADLs). R22's admission record, reviewed 5/2/24, identified diagnoses including dementia with agitation, delusional disorder, bipolar disorder, morbid obesity, essential tremor (neurological disorder characterized by uncontrolled shaking movements), bilateral hearing loss, depression, and schizophrenia. R22's pre-admission screening (PAS) dated 2/4/23, indicated R22 required a Level II assessment for mental illness to be done before admission to a nursing home. PAS further indicated R22 was in assisted living with an admission to the nursing home on 2/3/23 with an anticipated length of stay listed, Less than 30 Days. R22 was also noted to have a diagnosis of schizophrenia. R22's Level II Preadmission Screening for Persons with Mental Illness Determination for Nursing Facility Admission completed on 2/7/23, indicated admission is approved for post-hospital rehabilitative services for 30 days. This person may have a mental illness and may need specialized services, by [but] meets the requirements for post hospital rehabilitation. Further assessment and service plan changes must be documented upon at change in the resident's condition or when the nursing facility (NF) stay is anticipated to exceed 30 days. The NF is responsible for alerting LMHA to such changes. During interview on 5/1/25 at 11:19 a.m., admissions clerk (AC) stated PAS and PASARR were done before a resident's admission, and coordinated with Senior LinkAge Line (responsible for PAS in Minnesota). AC reported being unaware of R22's Level II assessment being limited to a 30 day admission and needed a reassessment after that point. During interview on 5/1/25 at 11:25 a.m., social services director (SSD) stated being unaware of R22's Level II assessment being limited to a 30 day admission. SSD reviewed R22's Level II assessment and confirmed it was limited to a 30 day admission. SSD stated Senior LinkAge Line should have been contacted when R22 stayed in the nursing home past 30 days. During interview on 5/2/25 at 1:06 p.m., director of nursing (DON) stated being unaware of R22's Level II assessment being limited to a 30 day admission. DON stated expectation for all PAS and PASARR assessments to be completed with required timeframes.

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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** 48109 Based on interview and document review, the facility failed to develop individualized and comprehensive care plans for for 2 of 2 residents (R30, R101) reviewed for pain and wound management. Findings include: R30: R30's quarterly Minimum Data Set (MDS) dated [DATE], identified intact cognition and diagnoses of malignant neoplasm of prostate, chronic pain syndrome, and anxiety. Section J of the MDS, which looks at health conditions impacting the resident's functional status and quality of life, identified R30 had pain, scheduled and as-needed pain medications, and had pain that frequently affected sleep, therapy, and day-to-day activities. R30's provider orders dated 4/30/25, identified an order for morphine sulfate every two hours as needed for pain, and morphine sulfate (MS) extended release 15 mg tablet two times per day for pain. Orders for non-pharmacologic interventions were not found. R30's care plan dated 4/24/25, identified R30 had a diagnosis which can or may affect pain status. R30's care plan didn't clearly identify actual pain and lacked individualized details for R30's pain, how to assess or rate pain, a goal rating for pain tolerance, how the pain impacted sleep, ADLs, activities of leisure, mood, or behavior. During an interview on 4/28/25 at 7:24 p.m., R30 stated they didn't do a good job with pain medication, but he had signed up for hospice now. During an interview on 5/2/25 at 2:15 p.m., registered nurse (RN)-F stated the non-pharmacologic interventions in place were to try to get R30 to reposition, but he won't always do that and to encourage rest and assist to rest as able. RN-F stated R30 was a smoker and it was sometimes hard to get him to rest because he wanted to be outside. RN-F indicated she would be updating R30's care plan to be more specific about his pain, symptoms and interventions. R101: R101's admission Minimum Data Set, dated dated dated [DATE], identified intact cognition and diagnoses of bilateral lower extremity cellulitis, pain in the thoracic spine, and chronic pulmonary edema. R101's MDS identified two venous stasis ulcers, a risk for pressure ulcers but no actual pressure ulcer, and limited range of motion in both lower extremities. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R101's care plan dated 2/11/25, identified a problem statement for skin integrity, but didn't clearly identify actual venous stasis and pressure ulcers. Interventions for R101 included meds/labs/treatments as ordered, incontinent care with incontinent brief changes, observe skin with AM and PM cares and report to team leader, weekly skin checks, pressure reduction cushion in wheelchair and bed, Circaid Velcro (compression wrap) to both lower extremities. The care plan lacked instruction for positioning in consideration of R101's posture, lacked a turning and repositioning program, and didn't include coordination with the outside wound care provider. R101's provider orders identified the following: -2/12/25 Elevate legs off and on throughout the day, try to keep pressure off spine as much as possible - recommend to closely monitor this area for breakdown and protect with padded foam like dressing - keep pressure off as able every shift. -2/19/25 Foam border to mid spine for protection, change every three days and as needed. -4/18/25 Wound care to mid spine: acetic wash, apply a thin layer Mupirocin (antibiotic ointment) to wound bed only, cover with Allevyn (brand name foam dressing) gentle border or equivalent, change every other day. -4/18/25 Turn and reposition every two hours - She is to stay off her back R30's Weekly Wound Round Documentation dated 4/8/25, identified an abrasion to lower back which had been slow to heal, so weekly measurements would be started. The document indicated there was a positioning plan, but didn't indicate what the plan was. During an interview on 5/2/25 at 2:28 p.m., RN-F stated turning and repositioning were important, but especially for R101 because her back is shaped differently. During an interview on 5/2/25 at 3:31 p.m., the director of nursing (DON) stated care planning was important so they can meet the needs of the residents. A policy, Comprehensive Person-Centered Care Planning Policy and Procedure dated 3/14/25, identified the facility will develop and implement a comprehensive person-centered care plan for each resident that includes measurable objectives and timeframes to meet each resident's medical, nursing, mental and psychosocial needs that are identified in the comprehensive assessment.

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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** 49036 Based on interview and document review, the facility failed to ensure that quarterly care conferences were completed for 1 of 1 resident (R17) reviewed for care conferences. Findings include: R17's quarterly Minimum Data Set (MDS) dated [DATE], identified diagnoses of chronic obstructive pulmonary disease (COPD), depression, and pressure ulcers. During interview on 4/28/25 at 12:50 p.m., R17 stated that he had only had one care conference since he admitted that he could remember. Care plan documentation notes, undated, identified that R17 had care conferences on 8/23/24 and 11/21/24. No further care conferences were documented. During interview on 5/1/25 at 8:22 a.m., social services director (SSD) stated that the last care conference for R17 would have been on 11/21/24. I believe the last couple of times we had scheduled care conferences, R17 was in the hospital. We typically schedule care conferences every three months and it looks like R17 is due for one. Care conferences are important to address any concerns, whether it be nursing, social services, or other concerns. Missing care conferences could cause resident concerns to be missed. During interview on 5/1/25 at 11:39 a.m., the director of nursing (DON) stated care conferences should occur quarterly and following a change in condition. Care conference are important in developing an individualized plan of care and allowing the patient to have involvement in their plan of care. Care Plan - Reviews/Conferences policy last reviewed 3/6/24, identified that the community will conduct a care plan review/conference at least quarterly, and as needed, that is interdisciplinary, provides an in-depth review of the resident's plan of care, and provides an opportunity for resident and resident representative and/or family discussion/input.

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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** 48109 Based on observation, interview and document review, the facility failed to ensure weights were completed as ordered and failed to provide assessment and documentation before a visit to the emergency department for 1 of 2 residents (R3) reviewed for quality of care. Findings include: R3's quarterly Minimum Data Set (MDS) dated [DATE], identified intact cognition and diagnoses of congestive heart failure (CHF), chronic obstructive pulmonary disease (COPD), morbid obesity, obstructive sleep apnea, hypertension (HTN), and chronic kidney disease (CKD) stage 3. R3's care plan dated 2/4/25, identified R3 had a risk for, or actual, heart and circulation concerns related to diagnoses of hypertension and heart failure. Interventions included medications, treatments and labs per provider order and to monitor and document signs and symptoms of adverse side effects related to diagnosis and medication use. R3's provider orders identified: -4/2/24 an order for weights twice weekly. -5/6/24 an order for a 2000 milliliter (mL) fluid restriction daily. -7/16/24 an order for furosemide (a diuretic, or water pill) 120 milligrams (mg) on Mondays, Wednesdays, Fridays, and 80 mg on Tuesdays, Thursdays, Saturdays and Sundays. -4/25/25 an order for metolazone (a diuretic, or water pill) 2.5 mg, and Spironolactone (a diuretic, or water pill) 25 mg daily for CHF. -4/26/25 an order for daily weights. R3's EMR identified the following weight records for April 2025: -4/7 216.6 -4/21 223.7 -4/26 220 Review of R3's electronic medical record (EMR) for April 2025 didn't identify progress notes with R3's refusal of having weight taken, didn't identify an assessment or progress note for R3's symptoms prior to going to the emergency room the afternoon of 4/29/25. During an observation on 4/28/25 at 5:15 p.m., R3 was observed sleeping on her bed with her bare legs visible. Both of R3's lower extremities had tight, shiny skin and were reddish-purple in color from about mid-calf down. There were compression socks laying on the bed inside out. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/29/25 at 2:39 p.m., R3 stated her legs were hurting so bad and this happened sometimes, the nurse took her vitals, and she was going to the emergency room . At 2:42 p.m., an ambulance arrived and took R3 via stretcher. During an interview on 4/29/25 at 3:02 p.m., nursing assistant (NA)-A stated the resident weights were done by the NAs, but the nurse will tell them who needs to be done, then they get it and report back to the nurse. During an interview on 4/30/25 at 7:19 a.m., R3 was back in the facility and stated the ER treated her for pain in her legs. R3 was wearing compression socks. During an interview on 5/2/25 at 1:57 p.m., registered nurse (RN)-F stated she would expect some kind of assessment and documentation when a resident is sent to the ER. RN-F would also expect daily weights to be taken as ordered and for refusals to be documented for R3. RN-F added R3 was known to refuse weights, and they would encourage her by educating her because she had heart problems, edema and leg pain so it would be important for her to have her weight taken. During an interview on 5/2/25 at 3:31 p.m., the director of nursing (DON) stated her expectation would be for daily weights to be done as ordered. The DON would also expect documentation in the medical record when a resident went to the ER.

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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** 49036 Based on observation, interview, and document review the facility failed to ensure that vitals were performed pre and post dialysis for 1 of 1 resident (R19) reviewed for dialysis care. R19's admission Minimum Data Set (MDS) dated [DATE], identified diagnoses of chronic kidney disease, atrial fibrillation, coronary artery disease, diabetes mellitus, and hypertension. Resident was cognitively intact. R19's care plan, undated, identified that R19 received dialysis and interventions included to check access site every shift to ensure dressing is clean, dry and intact, resident exhibits no signs/symptoms of infection, patency of access site palpating pulse of extremity, and checking for warmth and color of extremity. Meds/labs/treatments as ordered/accepted. The care plan did not address assessment of vitals pre or post dialysis. R19's April 2025, Weights and Vitals charting failed to show vitals assessments pre and post dialysis. During interview on 4/28/25 at 6:36 p.m., R19 stated that the facility does not check her vitals or do any type of assessment after dialysis. On 4/30/25 at 12:10 p.m., trained medication aid (TMA)-A was in room with R19 upon her return from dailysis. TMA-A had not taken resident vitals. TMA-A stated that she belived that there is not any type of assessment for R19 when she returns from dialysis. During interview on 4/30/25 at 12:21 p.m., registered nurse (RN)-D stated that the staff assesses the dialysis site for redness, infection, and/or swelling upon return from dialysis and receives a post run report from the dialysis facility. Vitals are completed at the dialysis facility. During interview on 5/1/25 at 11:44 a.m., the director of nursing (DON) stated that there should be pre and post dialysis vitals taken for dialysis residents. It is important to ensure there are no complications from dialysis and ensure that R19 is returning in a better state than what she left us in. During interview on 5/1/25 at 12:01 p.m., RN-D looked at R19's vitals assessments and stated that he did not see post dialysis visit vital signs, only documentation of signs and symptoms. Facility policy, Dialysis, last reviewed 6/7/24, failed to address vitals assessments pre and post dialysis.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47263 Based on interview, observation, and record review the facility failed to ensure competent administration of insulin occurred for 1 of 1 resident (R60) who was reviewed for insulin administration. Findings include: R60's quarterly Minimum Data Set (MDS) dated [DATE], indicated R60 was cognitively intact with the diagnosis of diabetes. R60's undated Care Plan indicated R60 had diabetes type II and instructed staff to administer medication and treatments as ordered. R60's Medication Review Report on or After 5/5/25, Orders included the following orders: Lantus Solostar inject subcutaneous 72 units at bedtime. Humalog Lispro insulin inject per sliding scale at bedtime. Blood sugars before meals and at bedtime R60's Medication Administration Record for April 2025, included the following insulin administrations: 4/25/25 Humalog scheduled time 2000 administered time at 2126 by registered nurse (RN-C), dose 1 unit. 4/25/25 Lantus scheduled time 2000 administered time at 2127 by RN-C, dose 72 units. R60's Weights and Vitals Summary 4/1/25 to 4/30/25 did not show R60 had experienced a low blood sugar the evening of 4/25/25, into the morning of 4/26/25. A progress note entered on 4/29/25, showed that R60 had reported concerns regarding an insulin administration that had occurred on 4/25/25. Note indicated an investigation had been started. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility provided video clip dated 4/25/25, of a medication administration performed by RN-C on the evening of 4/25/25, was reviewed. The clip started with RN-C wearing gloves and handing R60 a snack at the left side of the nurse's station desk. RN-C moved to the right side of the desk, then went back to the left side, grabbed a computer mouse, returned to the right side of the desk and stood at the computer on the nurse station desk edge. With the same gloves on, RN-C opened the medication cart, removed a baggie with insulin pen(s) from medication cart, did not close the medication drawer, returned to end of nurse station, (same gloves on) removed the insulin pens from the baggie, and set them on the counter. (Same gloves on) RN-C went back to medication cart, opened the top right medication drawer and proceeded to enter both drawers with gloved hands. RN-C left both drawers open and moved out of the camera frame towards the nurse manager's office. RN-C returned in the frame wearing gloves with supplies in hand, stopped at the medication cart, partially closed the right drawer and then went back to R60 at the nurse station desk. RN-C removed what appeared to be a syringe from a wrapper and then drew insulin out of what appeared to be an insulin pen via the syringe. RN-C kept the syringe in hand, set down the pen and then grabbed a different pen and appeared to draw insulin from the 2nd pen. (Wear the same gloves) RN-C then set the pen down and administered the contents of the syringe to R60. With the same gloves on RN-C went between the medication cart and the administration area a few times and then returned to R60 at the desk with another baggie containing an insulin pen. RN-C set the pen down, can be seen putting hand in pocket and doing other actions at the desk. (With same gloves on) RN-C entered the open top left medication drawer, returned to R60 and then got a second dose of insulin ready to administer to R60. RN-C proceeded to administer a second injection of insulin to R60 (wearing the same gloves). RN-C returned items to the medication cart and touched several surface area while still wearing the same gloves. At the end of the video clip R60 wheeled away from the desk and RN-C can be seen at a computer, wearing the same gloves. During an interview on 4/28/25 at 7:16 p.m., R60 stated they were worried they had received the wrong dose of Lantus insulin over the weekend because the nurse seemed unsure of what they were doing. The nurse had drawn their insulin into a syringe from insulin pens, and R60 suspected nurse had gotten the math wrong and given them too much insulin because they had experienced a low blood sugar that night. During a follow-up interview on 4/30/25 at 1:17 p.m., R60 stated the insulin administration they were concerned with had occurred on Friday 5/25/25. R60 reported the nurse had taken a BD syringe and drawn two doses of insulin out of insulin pens, and given it to them instead of administering the insulin with the pen. R60 stated they didn't think it was okay for the nurse to draw insulin from a pen, and they were concerned the nurse had done the math wrong and given them too much insulin because of the low blood sugar they had in the middle of the night. R60 was not able to pull up the low blood sugar value on their dexacom unit (which continuously monitored blood sugar). R60 indicated they had reported the events to the nurse manager yesterday (4/29/25). During an interview on 4/30/25 at 3:54 p.m., RN-C stated they could not recall all the details from the 5/25/25 evening shift, however they did remember they had given R60 two injections of Lantus insulin to equal the ordered bedtime dose of 72 units. They had explained to R60 the two doses would not be equal amounts, but the total dose would equal 72 units, so they were not sure why R60 thought they had received too much Lantus insulin. RN-C felt they had administered the correct amount because they had also had a second staff check the total dose prior to administration. RN-C confirmed they had administered R60's insulin via a syringe after they had drawn the insulin out of R60's old and new insulin pens. (continued on next page)

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Hilltop Healthcare Rehabilitation and Skilled Nurs	2501 Rice Lake Road Duluth, MN 55811

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/30/25 at 4:43 p.m., the director of nursing (DON) stated they had talked with RN-C, and RN-C had confirmed they had drawn insulin out of insulin pens with a syringe and administered it to R60 via the syringe. During an interview on 5/1/25 at 8:03 a.m., RN-G stated they had been working the night shift on 5/25/25, into 5/26/25, and they had not been called to address a low blood sugar for R60. During an interview with the DON on 5/2/25 at 10:47 a.m., the video footage from 5/25/25, of R60's bedtime insulin administration was reviewed. The DON confirmed RN-C and R60's were the subjects being viewed in the video. The DON confirmed RN-C had opened the medication cart, removed insulin, and then had left the cart open, unlocked, and unattended during the course of the video. In addition, RN-C had also left insulin pens unattended at the desk. The DON stated the medication cart should not be left unlocked once medication is removed, and the cart and or medications should never be left unattended. The DON confirmed it appeared RN-C had not sanitized their hands or changed gloves at any point during the video and they had touched multiple surfaces, entered the medication cart and administered medications wearing the same gloves. The DON stated they expected infection prevention measures to be followed which included hand sanitization after touching dirty surfaces and sanitization and glove changes before and after insulin administrations. The DON confirmed RN-C had drawn insulin from insulin pens and indicated this was not an acceptable medication administration practice. The DON stated they were in the process of addressing identified concerns with RN-C along with the additional concern that it was likely R60 had not received their bedtime Humalog insulin dose on 5/2/25. During an interview on 5/2/25 at 1:38 p.m., the consulting pharmacist stated it was not an acceptable practice to draw insulin from an insulin pen and indicated they believed manufacturers recommend against this practice either. Insulin pens are specifically designed to administer insulin directly to a person. Pens are also designed to hold insulin for priming, so a pen may show it is empty but there may still be insulin left in the pen that was intended for priming. The excess insulin is intended to be disposed of when the pen is empty, it should not be removed from the pen with a syringe. There really is not an acceptable reason to pull insulin from an insulin pen. During a follow up interview on 5/2/25 at 2:45 p.m., RN-C stated they had given R60 their Lantus insulin at the desk so they could verify with another nurse what dose to give R60. RN-C remembered giving R60 two injections of Lantus at the nursing station desk that night and stated they should not have drawn insulin from the insulin pens into syringes, they should have administered the insulin directly from the pen. RN-C's personnel file included a completed Skills Check Off form dated 9/27/18. The insulin administration check off included insulin administration by insulin pen. The competency did not include drawing insulin from an insulin pen for administration. Hand sanitization before and after medication administration was included in administration steps. An additional interview document dated 4/30/25, indicated RN-C had confirmed they had drawn insulin out of an insulin pen for administration to R60. RN-C had also acknowledged infection prevention concerns that had occurred during R60's insulin administration. The facility policy Insulin Administration from Pen dated 6/7/24 included hand sanitization before and after administration of insulin. The policy did not include drawing insulin from an insulin pen for administration via a syringe. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility policy Hand Washing dated 6/8/22, indicated the facility would follow CDC recommendations for handwashing the policy identified the following hand sanitization events: before and after glove use, after touching contaminated surfaces, before/after touching residents. The facility policy Medication - Storage dated 3/12/24, indicated all medications were to be stored in accordance with manufacturers recommendations and according to state and federal laws. All drugs and Biologics should be stored in locked compartments, and controlled substances should be stored with two locks.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49878 Based on record review and interview, the facility failed to ensure an indication for use was connected to ordered medications for 2 of 5 residents (R88, R407) reviewed for unnecessary medications. Findings include: R88: R88's quarterly Minimum Data Set (MDS) dated [DATE], identified R88 was severely cognitively impaired, required partial to substantial assistance with activities of daily living (ADLs), and had diagnoses of cerebrovascular disease (condition that affects blood vessels supplying blood to the brain), dementia, hypertension, depression, hyperlipidemia, and a history of transient ischemic attack (temporary stroke). R88's provider orders reviewed on 4/30/25, included the following orders: -aspirin oral capsule 81 milligrams (mg), give one tablet by mouth one time a day for salicylate -atorvastatin calcium oral tablet 80mg, give on tablet by mouth one time a day for antihyperlipidemic -clopidogrel bisulfate oral tablet 75mg, give one tablet by mouth one time a day for platelet aggregation inhibitors -losartan potassium oral tablet 100mg, give one tablet by mouth one time a day for ARBs -pantoprazole sodium oral tablet 40mg, give one tablet by mouth one time a day for PPIs During interview on 5/1/25 at 10:05 a.m., registered nurse (RN)-B reviewed ordered medications in R88's chart. RN-B confirmed R88's listed medications did not have a proper indication or diagnosis for use. RN-B stated expectation of all medication orders to have an indication for use or diagnosis attached. During interview on 5/2/25 at 1:05 p.m., director of nursing (DON) stated expectation for all medication orders to have an indication for use or diagnosis attached. 49036 R407: R407's admission MDS dated [DATE], identified diagnoses of bipolar disorder, post-traumatic stress disorder (PTSD), and chronic pancreatitis. R407 was cognitively intact. R407's provider orders reviewed on 4/29/25, included the following order: (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-valacyclovir HCl Oral Tablet 1 gram (GM), give 1000 mg by mouth in the evening for x During interview on 5/1/25 at 11:41 a.m., the DON stated it was important and the expectation would be that there is a diagnosis for the use of R407's valyclovir. Medication Administration policy last reviewed 4/1/24, explained facility's policy to administer all medications and treatments in a safe and effective manner. Included in the procedure for administering medications was 'able to state indication.'

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 47263 Based observation, interview, and document review the facility failed to ensure medications were not left unsecured in resident accessible areas. In addition, the facility failed to ensure medications and biologics were properly stored in locked medication carts. Findings include: During an observation on 4/30/25 at 3:12 p.m., the Cedar medication cart was noted to be unlocked and unattended. The director of nursing (DON) confirmed the cart was not locked and when the trained medication administrator (TMA)-A returned to the cart, the DON informed TMA-A they had found the cart unlocked, and that was unacceptable. TMA-A acknowledged they had left the medication cart unlocked and unattended. During an interview on 5/1/25 at 2:13 p.m., TMA-A confirmed they had left the medication cart unlocked and unattended on 3/30/25 and indicated the DON had addressed it with them. TMA-A stated the medication cart should always be locked because it held narcotic medications and resident prescriptions medications. It was important to keep the cart locked to prevent others/residents from accessing resident medications, and to prevent diversion of medications like gabapentin and muscle relaxants that are more likely to be abused. During an interview on 5/02/25 at 10:47 a.m., the DON reviewed video footage of R60's bedtime insulin administration on 4/25/25. The DON confirmed RN-C and R60 were the subjects in the video. The DON confirmed RN-C had opened the medication cart, removed insulin, and then had left the cart open and unlocked, while attending to R60's insulin administration. In addition, the DON noted RN-C had also left insulin pens at the desk and the medication cart open when they had stepped away from the area. The DON stated they expected nurses to lock the medication cart each time they were done pulling medications and before they left the medication cart. RN-C should not have left medications on the desk unattended. The facility policy Medication - Storage dated 3/12/24, indicated all medications were to be stored in accordance with manufacturers recommendations and according to state and federal laws. All drugs and Biologics should be stored in locked compartments, and controlled substances should be stored with two locks.

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure meals and snacks are served at times in accordance with resident's needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49878 Based on interview and document review, the facility failed to consistently offer and provide a nutrient and/or calorie substantive snack after the dinner meal and before bedtime, leaving 15 hours between the evening and morning meals. This had the potential to affect all 107 residents at the facility. Findings include: During interview on 4/28/25 at 7:13 p.m., R60, whose quarterly Minimum Data Set (MDS) dated [DATE] identified intact cognition, stated the facility staff do not come and deliver a bedtime snack. During interview on 4/28/25 at 1:12 p.m., R5, whose quarterly MDS dated [DATE] identified intact cognition, stated no snacks were offered in the evening. During resident council meeting on 4/30/25 at 1:30 p.m., the following residents voiced concerns about snacks: -R9, whose quarterly MDS dated [DATE] identified intact cognition, stated staff never bring snacks around to residents. R9 also stated the snacks residents have received were not substantial enough. -R39, whose quarterly MDS dated [DATE] identified intact cognition, stated staff do not bring snack around to residents. R39 also stated there was not enough snack at times, and there was not a good variety of snacks. During interview on 5/1/25 at 2:09 p.m., registered nurse (RN)-E stated snacks were available on the unit and residents have to ask for a snack. RN-E stated being unaware if there were snack carts. During interview on 5/1/25 at 2:15 p.m., certified nursing assistant (CNA)-B stated there were a good variety of snacks available to the residents at any time, and residents needed to ask for a snack. CNA-B further stated there were no snack carts brought to the residents. During interview on 5/2/25 at 10:09 a.m., licensed practical nurse (LPN)-A stated residents were able to get a snack anytime. LPN-A further identified residents would ask staff for a snack, and was not sure if there were snack carts. During interview on 5/2/25 at 1:06 p.m., director of nursing (DON) stated expectation that snacks were offered to residents before bedtime. Hilltop Healthcare Meal Cart Delivery Times undated, identified the following times for meal cart delivery on different units: CEDAR (continued on next page)

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	BREAKFAST- 7:45 AM- 8:05 AM LUNCH- 11:45 PM-12:05PM DINNER 4:45 PM-5:05 PM WILLOW BREAKFAST- 8:05 AM-8:25 AM LUNCH- 12:05 PM- 12:25PM DINNER- 5:05 PM- 5:25 PM SPRUCE BREAKFAST-8:25 AM- 8:45 AM LUNCH- 12:25 PM- 12:45 PM DINNER-5:25 PM- 5:45 PM ELM BREAKFAST 8:45 AM-9:00 AM LUNCH 12:45 PM- 1:00 PM DINNER 5:45PM- 6:00PM Snack Availability policy, last reviewed 6/7/24, identified the purpose of the policy was to ensure that residents have access to nourishing snacks. Policy defined a nourishing snack as a verbal offering of items, single or in combination from the basic food groups.