STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245397	A. Building B. Wing	04/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Havenwood Care Center	1633 Delton Avenue NW Bemidji, MN 56601

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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 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to provide exercise programs as ordered for 6 of 6 residents (R14, R20, R32, R40, R53, R66) reviewed for restorative exercise program. This had the potential to affect all 38 residents who had exercise programs.Findings include: R20 R20's annual Minimum Data Set (MDS) dated [DATE], identified R20 had severe cognitive impairment and required moderate assistance with activities of daily living (ADLs), R20 was unable to ambulate. Diagnoses included osteoporosis, Alzheimer's disease, weakness and history of hand and hip fractures. R20's care plan reviewed 3/16/26, identified R20 had decreased physical mobility with a potential for falls due to a left hip fracture. Staff were directed to assist R20 to turn and reposition and transfer to her wheelchair. R20's care plan lacked documentation of a functional maintenance program (FMP). R20's undated Physician Orders identified an order for physical therapy FMP with a start date 10/1/25, and the end date was open ended. An order for physical and occupational therapy FMP was also listed with start date 9/26/25 with an open-ended end date. R20's Restorative Care Program identified the following: 9/19/25, identified R20 was discharged from occupational therapy (OT) and was to have a restorative program to maintain her upper extremity strength and range of motion of participation in self-care and functional tasks of choice. The restorative aide was directed to completed ten repetitions of shoulder flex, chest press and side to side with a two-pound weight, ten repetitions of elbow flexion and extension with a red TheraBand and ten repetitions of pro/supination with a yellow TheraBand. 10/1/25, identified R20 was discharged from physical therapy (PT) and was to have a restorative program to maintain lower extremity strength and range of motion for continued level of ambulation and transfers to decrease burden of care. The restorative aide was directed to complete 15 repetitions of marching, lower ankle and hip abduction, and leg curl with a two-pound ankle weight and ball squeezes and ball press. R20 was also to stand with her four wheeled walker for two, one-minute sets or as long as R20 tolerated. The Restorative Program logs dated 1/19/26 through 4/29/26, identified R20 in the list of residents who were to receive exercise one to two times per week. Next to each resident name was columns for each day of the week. The logs documented R20 had received restorative exercises one time and (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	refused three times during the 15-week time period. On 4/29/26, at 3:23 p.m. physical therapist (PT)-A and therapy director (TD) assisted R20 to complete the full OT and PT FMP program exercises in the therapy room. R20 became visibly weak, shaky toward the end of the exercises. PT-A and TD both stated R20 had no decline since P20 was last seen by therapy. R53 R53's quarterly MDS dated [DATE], identified R53 had intact cognition and was dependent on staff for most ADLs, mobility and transfers. R53 had impaired range of motion (ROM) to both lower extremities and was unable to ambulate. Diagnoses included paraplegia (paralysis lower half of body), spondylosis (degenerative spinal condition) and chronic pain. R53's care plan revised 3/16/26, identified R53 had decreased physical mobility with potentials for falls due to low back pain with bilateral sciatica, spinal stenosis, weakness and limited functional ROM. Staff were directed to assist R53 with mobility, transfers and repositioning. R53 was to participate in FMP per her plan of care. R53's undated Physician Orders report identified an order for FMP dated 9/4/25, with an open-ended end date. R53's Restorative Care Program identified the following: 9/4/25, identified R53 was discharged from OT, and an FMP program was setup with goals to maintain both upper extremity ROM in order to complete self-cares. The restorative aide was directed to perform active and passive ROM to all upper extremity wrist, shoulder, elbow planes as well as digit extension. 12/9/25, identified R53 was discharged from PT, and an FMP program was setup with goals to maintain lower extremity ROM, to prevent further contractures. The restorative aide was directed to complete passive ROM to R53's hips, knees and ankles in all planes. The restorative aide was also to assist R53 with two thirty second sets of hamstring and heel cord stretch. The Restorative Program logs dated 1/19/26 through 4/29/26, identified R53 in the list of residents who were to receive exercise one to two times per week. Next to each resident name was columns for each day of the week. The logs documented R53 had received restorative exercises five times and refused one time during the 15-week time period. On 4/29/26, at 4:02 p.m. R53 was seated in her room watching television. TD entered the room and received permission to assist R53 with her exercises. TD completed all exercises from the PT and OT FMP program. R53 was smiling and cooperative throughout the exercises. After completion of the exercises, TD stated she did not find a decline in R53's function since she was last seen by therapy. R53 stated she was unsure how often staff assisted her with her exercises or when they were last done. R53 stated she wished it were more often. R40 R40's quarterly MDS dated [DATE], identified R40 had moderately impaired cognition and was (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	independent with ADLs. R40 had full ROM of extremities and was able to ambulate independently. Diagnoses included dementia, traumatic subdural hemorrhage, repeated falls, dizziness and giddiness, disorder of the autonomic nervous system, and osteoarthritis of the knees. R40's undated Physician Orders report identified an order for PT and OT FMP one time per day with start date 12/5/25 and open-ended end date. R40's care plan revised 3/16/26, identified decreased physical mobility with potential for falls due to dementia, poor coordination and balance, history of falls, and poor sequencings skills. Staff were directed to provide limited assistance with transfer and ambulation and OT and PT FMP per plan of care. R40's Restorative Care Program identified the following: 12/3/25, identified R40 was discharged from OT, and an FMP program was setup with goals to maintain upper extremity strength and ROM in order to participate self-cares. The restorative aide was directed to perform upper extremity exercises for three minutes, use a two pound therapy bar for 15 repetitions for shoulder flexion, chest press, shoulder circumduction forward and backward, The restorative aide was to assist with elbow extensions using the green TheraBand for 15 repetitions two times as well as using the red flex bar for 10 repetitions of pronation, supination and wrist flexion and extensions. 12/9/25, identified R40 discharged from PT and an FMP program was setup with goals to maintain lower extremity strength and ROM to assist staff during her ADL's. The restorative aide was directed to assist R40 with seated exercises with ball presses, knee flexes, ankle pumps, hip abductions and adductions with small therapy ball and hip flexions. R40 was to stand with a four wheeled walker and march twenty times with two-pound ankle weights. The Restorative Program logs dated 1/19/26 through 4/29/26, identified R40 in the list of residents who were to receive exercise one to two times per week. Next to each resident name was columns for each day of the week. The logs documented R40 had not received restorative exercises at all and refused three times during the 15-week period. R14 R14's quarterly Minimum Data Set (MDS) dated [DATE], identified R14 had severe cognitive impairment and was non-ambulatory. A diagnosis of dementia was included. R14's Restorative Care Program dated 12/15/23, directed to maintain lower extremity range of motion/strength to assist staff during activities of daily living. Approaches/recommendations included: NuStep level 5, seat 9, arms at 8 for 5 minutes Seated exercises with 3-pound ankle weights for 15 repetitions. Left knee flex with geriatric Thera-band, Hip abduction with geriatric Thera-band, Hip adduction with small yellow t-ball, Ball presses and standing with front wheeled walker. Marching 20 times with contact guard assist R14's care plan revised 3/16/26, identified falls and alteration in skin related to poor coordination/balance, pain, dementia with cognitive losses and poor sequencing skills manifested by inability to transfer, always wheel self, always turn and reposition self, sit up, lie down or get feet and legs into bed independently. Unable to ambulate. Occupational therapy (OT) and physical therapy (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	(PT) functional maintenance program as ordered. R14's Restorative Program log dated 1/19/26 through 4/29/26, identified R14 had 105 opportunities to receive restorative exercises. R14 received the exercises 3 times and refused 3 times during the period reviewed. During an interview on 4/28/26 at 1:26 p.m., nursing assistant (NA)-H, who is also the restorative aide, stated R14 frequently refused to do restorative exercises, however, the documentation did not reflect R14 had refused or had been offered. R66 R66's MDS dated [DATE], identified R66 was cognitively intact and required substantial/maximal assistance with upper body dressing and personal hygiene, partial/moderate assistance with eating, and was dependent on staff for all other care areas. Diagnoses included dementia, anxiety and diabetes. R66's care plan revised 3/16/26, identified decreased physical mobility with potential for falls and alterations in skin r/t Diabetes, Dementia, Alzheimer's disease, Heart failure, poor balance at times and poor sequencing skills manifested by need for staff assist with mobility needs at times. R66 was to participate in a functional maintenance program as ordered by therapy. R66's Restorative Care Program dated 4/15/26, identified R66 was to maintain range of motion to decrease incidence of contractures and bedsores. Approach/recommendations included: Supine in bed: 2 sets of 15 repetitions of passive range of motion, SLR, hip abduction, hip flexion/extension, knee flexion/extension, ankle passive range of motion in all planes, hamstring stretch 2 x 15 repetitions, heel-cord strength 2 x 15 repetitions, and Encourage R66 to assist with movements if she is awake/alert. R66's Restorative Program log dated 4/15/26 through 4/29/26, identified there were 15 opportunities for R66 to receive the exercise. R66 received restorative exercises twice during the period reviewed During an interview on 4/28/26 at 1:26 p.m., nursing assistant (NA)-H, who is also the restorative aide, stated R66 frequently refused to do restorative exercises, however, the documentation did not reflect R66 had refused or had been offered. R32: R32's quarterly MDS dated [DATE], identified R32 was cognitively intact. R32 was substantial to maximal assist with bed mobility and transfers and did not walk. R32's had a diagnosis of joint replacement of left knee. R32's medical record contained the following information on the restorative program: R32's provider orders dated 11/19/25, identified Functional Maintenance Plan (FMP) was ordered with special instruction for walking program as part of FMP. R32's progress noted dated 11/19/25, identified R32 was discharged from PT services on 11/7/25. PT FMP in place with walking program apart of her FMP. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Restorative Care Program dated 11/7/25, identified R32 was placed on the program to maintain lower extremity (legs) strength and range of motion to decrease burden of care with transfers and ambulation (walking). The program identified which exercises to complete to help maintain R32's level of function. The exercises include doing them 15 times in a row once: Seated chair march, Long Arc Quad (big muscle on the front of the leg) stretch (sitting in a chair and lifting your foot straight out), Hip adduction with a ball. (squeezing your knees together with a ball between them), Hamstring (main muscle on back of leg) curls (the restorative aide would hold R32 up with a green TheraBand and would have to pull against it), Hip abduction with a green TheraBand (placing the band around both knees and spreading your knees apart), Hamstring and heel cord stretch (with leg straight out you would pull your toes back towards your body) and With a physical therapist, assist R32 to stand, and they may ambulate up to 100 feet or up to R32 tolerance using the front wheel walker and a gait belt (a belt to place around a resident to assist with standing and balance). R32's Restorative Program documentation identified from 1/29/26 through 4/26/26, R32 only received FMP exercises twice and did not include any ambulation services during period of time reviewed. During an interview on 4/28/26 at 12:26 p.m., nursing assistant (NA)-H stated they were only able to provide FMP services to R32 twice and that did not include ambulation services. The nursing assistants on the floor would be responsible for ambulation. During an interview on 4/29/26 at 9:49 a.m., TD stated the restorative aide would provide the exercise services and nursing and NAs provided ambulation services on the floor. R32's program for the exercises #1-6 (above) would be completed by the restorative aide and #7 would be completed by NAs on the floor. During an interview on 4/29/26 at 10:39 a.m., a trained medication aide (TMA)-C stated there was a list of residents who required ambulation and would be updated regularly by the nurse manager. If there were concerns on ability of the resident to continue walking, then we would let the nurse manager know and she would have ordered a screening from therapy to see if changes needed to be made with the program. I think there was a screening done for R32 that stated she was not to ambulate. During a follow up interview on 4/29/26 at 10:47 a.m., the TD stated when a request came in it would be charted and documented in their system. R36 had never received a request to rescreen her regarding ambulation. This was also verified by the physical therapist (PT)-A. During interview on 4/29/26, at 2:30 p.m. NA-H stated she had only been back working in the facility for the last two weeks and had been off for six months prior to that. NA-H stated she mainly worked restorative nursing but was pulled to the floor a lot to help with resident care due to short staffing and/or call ins. NA-H tried to document on the restorative logs when she was pulled off restorative to help on the floor. NA-H did not know if the nursing assistant who covered while she was gone was pulled off the restorative program as the aide had not documented, but few exercises had been documented in the logbook, prior to her return. NA-H stated even if she was not pulled off to work on the floor, it would be very difficult to see every resident on the FMP program. During an interview on 4/29/26 at 4:07 p.m., the director of nursing (DON) stated when residents were started on an FMP the restorative aide would work on the range of motion aspect of the plan and the NA's on the unit would do the ambulation portion of the plan. R36 should have received the ordered (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	FMP to maintain their level of function related to activities of daily living. During interview on 4/29/26, at 4:30 p.m. TD stated therapy completed the functional maintenance program form to initiate restorative nursing exercises when they discharged a resident from therapy. Therapy did not oversee the program. If a resident was not being seen or refusing restorative services, they would report to the charge nurse, and the charge nurse would notify therapy, if they needed to be re-evaluated. TD thought nursing oversaw the restorative program. When interviewed on 4/29/26, at 5:36 p.m. the interim DON stated she did not know if the previous restorative aide had documented her work correctly, but the facility did pull the restorative aide from time to time to work on the floor assisting with resident care. The facility had two restorative aides who each worked two days per week, and one worked every other weekend and the other, one weekend a month, for resident restorative program. The facility policy Quality of Care reviewed 10/2023, identified the facility would ensure a resident with limited range of motion or mobility would receive appropriate treatment and services to increase range of motion and mobility and/or prevent further decrease in range of motion or mobility. The facility policy Restorative Care dated 7/19/21, identified it was the intent of the restorative program to promote the resident's ability to adapt and adjust to living as independently and safely as possible. The resident would be assessed by physical therapy and recommendations for restorative care therapy were submitted on the restorative therapy form. A nursing assistant trained to perform restorative care therapy would complete 15 minutes daily with the resident. Time would be documented by the therapy aide. The restorative care lead nurse would maintain documentation of residents who received restorative care and would make progress notes on therapy, minutes of therapy provided and plan review.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. Based on observations, interviews and document review, the facility failed to provide sufficient staffing to provide exercise services for the restorative nursing program for 6 of 6 residents (R14, R20, R32, R40, R53, R66) reviewed for restorative exercise program. This had the potential to affect all 38 residents who had exercise programs. Findings include:See also F688: Based on observation, interview, and document review, the facility failed to provide exercise programs as ordered for 6 of 6 residents (R14, R20, R32, R40, R53, R66) reviewed for restorative exercise program. This had the potential to affect all 38 residents who had exercise programs. R20:R20's Restorative Care Program identified the following:9/19/25, identified R20 was discharged from occupational therapy (OT) and was to have a restorative program to maintain her upper extremity strength and range of motion of participation in self-care and functional tasks of choice. The restorative aide was directed to completed ten repetitions of shoulder flex, chest press and side to side with a two-pound weight, ten repetitions of elbow flexion and extension with a red TheraBand and ten repetitions of pro/supination with a yellow TheraBand. 10/1/25, identified R20 was discharged from physical therapy (PT) and was to have a restorative program to maintain lower extremity strength and range of motion for continued level of ambulation and transfers to decrease burden of care. The restorative aide was directed to complete 15 repetitions of marching, lower ankle and hip abduction, and leg curl with a two-pound ankle weight and ball squeezes and ball press. R20 was also to stand with her four wheeled walker for two, one-minute sets or as long as R20 tolerated. The Restorative Program logs dated 1/19/26 through 4/29/26, identified R20 in the list of residents who were to receive exercise one to two times per week. Next to each resident name was columns for each day of the week. The logs documented R20 had received restorative exercises one time and refused three times during the 15-week time period. R53:R53's Restorative Care Program identified the following:9/4/25, identified R53 was discharged from OT, and an FMP program was setup with goals to maintain both upper extremity ROM in order to complete self-cares. The restorative aide was directed to perform active and passive ROM to all upper extremity wrist, shoulder, elbow planes as well as digit extension. 12/9/25, identified R53 was discharged from PT, and an FMP program was setup with goals to maintain lower extremity ROM, to prevent further contractures. The restorative aide was directed to complete passive ROM to R53's hips, knees and ankles in all planes. The restorative aide was also to assist R53 with two thirty second sets of hamstring and heel cord stretch. The Restorative Program logs dated 1/19/26 through 4/29/26, identified R53 in the list of residents who were to receive exercise one to two times per week. Next to each resident name was columns for each day of the week. The logs documented R53 had received restorative exercises five times and refused one time during the 15-week time period. R40 R40's Restorative Care Program identified the following:12/3/25, identified R40 was discharged from OT, and an FMP program was setup with goals to maintain upper extremity strength and ROM in order to participate self-cares. The restorative aide was directed to perform upper extremity exercises for three minutes, use a two pound therapy bar for 15 repetitions for shoulder flexion, chest press, shoulder circumduction forward and backward, The restorative aide was to assist with elbow extensions using the green TheraBand for 15 repetitions two times as well as using the red flex bar for 10 repetitions of pronation, supination and wrist flexion and extensions. 12/9/25, identified R40 discharged from PT and an FMP program was setup with goals to maintain lower extremity strength and ROM to assist staff during her ADL's. The restorative aide was directed to assist R40 with seated exercises with ball presses, knee flexes, ankle pumps, hip abductions and adductions with small therapy ball and hip flexions. R40 was to stand with a four wheeled walker and march twenty times with two-pound ankle weights. The Restorative Program logs dated 1/19/26 through 4/29/26, identified R40 in the list of residents who were to receive exercise one to two times per week. Next to each resident name was columns for each day of the week. The logs documented R40 had not (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	received restorative exercises at all and refused three times during the 15-week period.R14 R14's Restorative Care Program dated 12/15/23, directed to maintain lower extremity range of motion/strength to assist staff during activities of daily living. Approaches/recommendations included: NuStep level 5, seat 9, arms at 8 for 5 minutes Seated exercises with 3-pound ankle weights for 15 repetitions. Left knee flex with geriatric Thera-band, Hip abduction with geriatric Thera-band, Hip adduction with small yellow t-ball, Ball presses and standing with front wheeled walker. Marching 20 times with contact guard assist R14's Restorative Program log dated 1/19/26 through 4/29/26, identified R14 had 105 opportunities to receive restorative exercises. R14 received the exercises 3 times and refused 3 times during the period reviewed.R66 R66's Restorative Care Program dated 4/15/26, identified R66 was to maintain range of motion to decrease incidence of contractures and bedsores. Approach/recommendations included: Supine in bed: 2 sets of 15 repetitions of passive range of motion, SLR, hip abduction, hip flexion/extension, knee flexion/extension, ankle passive range of motion in all planes, hamstring stretch 2 x 15 repetitions, heel-cord strength 2 x 15 repetitions, and Encourage R66 to assist with movements if she is awake/alert.R66's Restorative Program log dated 4/15/26 through 4/29/26, identified there were 15 opportunities for R66 to receive the exercise. R66 received restorative exercises twice during the period reviewed.R32:R32's Restorative Care Program dated 11/7/25, identified R32 was placed on the program to maintain lower extremity (legs) strength and range of motion to decrease burden of care with transfers and ambulation (walking). The program identified which exercises to complete to help maintain R32's level of function. The exercises include doing them 15 times in a row once: Seated chair march, Long Arc Quad (big muscle on the front of the leg) stretch (sitting in a chair and lifting your foot straight out), Hip adduction with a ball. (squeezing your knees together with a ball between them), Hamstring (main muscle on back of leg) curls (the restorative aide would hold R32 up with a green TheraBand and would have to pull against it), Hip abduction with a green TheraBand (placing the band around both knees and spreading your knees apart), Hamstring and heel cord stretch (with leg straight out you would pull your toes back towards your body) and With a physical therapist, assist R32 to stand, and they may ambulate up to 100 feet or up to R32 tolerance using the front wheel walker and a gait belt (a belt to place around a resident to assist with standing and balance). R32's Restorative Program documentation identified from 1/29/26 through 4/26/26, R32 only received FMP exercises twice and did not include any ambulation services during period of time reviewed.The restorative program documentation was reviewed and identified the following:1/19/26-1/25/16, 6 of 39 residents received services.1/26/26-2/1/26, 0 of 38 residents received services.2/2/26-2/8/26, 25 of 39 residents received services.2/9/26-2/15/26, 9 of 40 residents received services. 2/16/26-2/22/26, 28 of 38 residents received services.2/23/26-3/1/26, 6 of 39 residents received services.3/2/26-3/8/26, 2 of 38 residents received services.3/9/36-3/15/26, 0 of 38 residents received services.3/16/26-3/22/26, 0 of 37 residents received services.3/23/26-3/29/26, 1 of 37 residents received services.3/30/26-4/5/26, 3 of 40 residents received services.4/6/26-4/12/26, 0 of 40 residents received services.4/13/26-4/19/26, 27 of 40 residents received services.4/20/26-4/26/26, 26 of 41 residents received services.4/27/26-5/3/26, 30 of 38 residents received services.During an interview on 4/28/26 at 12:26 p.m., nursing assistant (NA)-H, who was a restorative aide, stated initially she was going to be just doing functional maintenance programs for the residents today (4/28/26) but was only able to work until about noon. She was then instructed to stop working on the FMP's and was pulled to the floor to work as a NA. NA-H stated being pulled to the floor happened a lot. There was another NA who would help with FMPs, but they also called to work as an NA on the floor. When NA-H is working as the restorative aide she reviewed the lists of residents and decide which ones could be done on that day. NA-H can't get through the list and there are residents who do not get the FMP services. Most of the residents on an FMP had not received services on a regular basis or not even at all. Most of the residents were not receiving their ordered FMP due to having to be pulled to the floor all the time and only working a couple of days a week. During a follow up (continued on next page)

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Havenwood Care Center	1633 Delton Avenue NW Bemidji, MN 56601

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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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	interview on 4/29/26, at 2:30 p.m. NA-H stated she had only been back working in the facility for the last two weeks and had been off for six months prior to that. NA-H stated she mainly worked restorative nursing but was pulled to the floor a lot to help with resident care due to short staffing and/or call ins. NA-H tried to document on the restorative logs when she was pulled off restorative to help on the floor. NA-H did not know if the nursing assistant who covered while she was gone was pulled off the restorative program as the aide had not documented, but few exercises had been documented in the logbook, prior to her return. NA-H stated even if she was not pulled off to work on the floor, it would be very difficult to see every resident on the FMP program. During an interview on 4/29/26 at 4:04 p.m. the director of nursing (DON) stated there are two aides who worked the restorative nursing program and they are both part time. For about 6 months the facility only had one part-time restorative aide. The restorative aides would start with the FMPs right away when they get to the facility, but they are frequently called out to floor to work as a NA. This is because of call-ins or short staffing on the floor. She stated it was not acceptable to be pulling the restorative aides to the floor all the time, because they have close to fifty residents to assist and are unable to get to all of them in a week and the residents go without their FMP.A staffing policy was not obtained.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 staff served meals while securing their hair with a hair covering on1 of 2 units Walnut Unit) . This had the potential to affect all 23 residents who ate meals on the Walnut Unit.Findings include:According to section 2-402.11 of the Food and Drug Administration (FDA) Food code dated 2017: A hair restraint keeps dislodged hair from ending up in the food and may deter employees from touching their hair. This is crucial to prevent cross-contamination. Staphylococcus aureus is an example of a common pathogen that is found on skin and hair. If enough of the bacteria is ingested, it could cause illness. Common symptoms of this illness include vomiting, nausea, and stomach cramps. During an observation on 4/28/26 at 12:06 p.m., dietary aide (DA)-A was serving meals from the Walnut Grove kitchenette. DA-A leaned over the steam table food containers while setting up the individual resident plates for the noon meal. DA-A was not wearing a hairnet. At 12:15 p.m., DA-A left the kitchenette to deliver food to a resident and then began to clean off tables where residents had finished.During an interview on 4/28/26 at 12:20 p.m., DA-A stated hairnets were required whenever in the kitchen and/or while serving food. DA-A touched her head and stated I don't have one on? Oh no, I thought I had one on. DA-A left the Walnut Grove kitchenette and went into the main kitchen. When DA-A returned a moment later, DA-A was wearing a hair net. During an interview on 4/29/26 at 3:17 p.m., the dietary manager (DM)-A stated staff should always wear a hairnet, especially while serving food to ensure hair does not get into the food to prevent illness and for palatability. The facility policy Employee Sanitary Practices dated 2019, identified all food and nutrition services employees will practice good personal hygiene and safe food handling procedures. All employees will: wear hair restraints (hairnet, hat, and/or beard restraint) to prevent hair from contacting exposed food

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review, the facility failed to ensure a report of missing personal property was followed up on for 1 of 3 residents (R14) reviewed for resident rights.Findings include:R14's quarterly Minimum Data Set (MDS) dated [DATE], identified R14 had severe cognitive impairment. Diagnoses included dementia, edema, restlessness and agitation. R14 required set up/clean up assistance with eating, maximal/substantial assistance with dressing, bathing and personal hygiene and was dependent on staff with toileting and putting on and taking off footwear. During an interview on 4/28/26 at 6:09 p.m., family member (FM)-A stated R14's wedding ring went missing a few months ago. FM-A reported the missing wedding ring to the nursing assistants, the cart nurses, registered nurse (RN)-A who was the unit manager and the previous director of nursing (DON) who was no longer at the facility. FM-A stated she was simply told no staff had seen the ring. After the wedding ring was missing for a week, FM-A reported the missing ring to the police. FM-A had received no further information about the missing ring. FM-A stated she was concerned a staff member had taken the ring and the facility was not investigating the concern. During an interview on 4/29/26 at 3:22 p.m., trained medication aide (TMA)-B stated she had heard something about R14 was missing a wedding ring a few months prior but really didn't recall anything else about it. During an interview on 4/29/26 at 3:22 p.m., RN-A stated she didn't recall anyone reporting R14 had a missing wedding ring.During an interview on 4/29/26 at 3:25 p.m., RN-C stated she was unaware of R14's missing wedding ring. Any missing item should be documented in a progress note, and it should be documented on the report sheet in the binder at the desk. The report sheet was kept in the binder for two weeks and then the report sheets were filed away by the director of nursing (DON). Then, an investigation would be done to try to find the missing item: laundry, housekeeping and nursing staff would be told to look for the item and be aware that it was missing.R14's medical record failed to identify R14 was missing a wedding ring.R14's Missing Item form was requested but not received. During an interview on 4/29/26 at 3:27 p.m., the social services (SS)-A stated she was unaware R14 was missing a wedding ring and there was no missing item report completed.During an interview on 4/29/26 at 3:28 p.m., licensed practical nurse (LPN)-A stated she didn't know anything about R14 missing a wedding ring. When a resident was admitted , staff really encouraged family to swap out any expensive or meaningful jewelry like a wedding for another ring, so the resident was still able to wear a ring but the likelihood of getting lost was not there. Staff report to social services and then an investigation was done to look in the room etc. During an interview on 4/29/26 at 3:31 p.m., the DON stated she was unaware R14 was missing a wedding ring. Staff were expected to complete a missing item report and, if possible, the resident was interviewed to determine when the item was last seen. Laundry, housekeeping, activities and nursing staff were informed to look for the item, and, on certain items, a police report may be filed. The DON stated she honestly did not know if a report had been filed for R14's missing ring because she was unaware it was missing. At 5:25 p.m., the DON stated R14's wedding ring had been found. It was found in laundry back in December 2025 and kept in the safe until 4/29/26 when the SA began asking about it. Staff did not complete a missing item report. The DON stated she expected staff to follow the procedure for a missing item and to report the concern to ensure all were aware of the missing item. If staff had been aware of R14's missing wedding ring, they would have known who the found wedding ring belonged to and R14 would have gotten it back sooner. The facility.The facility Missing Items Report revised 11/18/18, included information for staff to collect and identified the following: the resident's name, date, description of item(s) missing, date/time last seen, date/time noticed missing, thinks misplaced details, thinks taken and, if so, by whom, who it was reported to and who reported the missing item(s). Staff were instructed to complete the form immediately and give the report to the unit manager. The unit (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	manager would search probably places immediately and list the employee(s) assigned to search. If the item was not found, family would be contacted. If the family was unaware of the item(s) location, the item was to be treated as a misappropriated item and reported to law enforcement and the state agency (SA).

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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 and document review, the facility failed to revise the care plan to include ordered functional maintenance program (FMP) with goals and interventions for 2 of 6 residents (R20, R32) who received exercises, in addition, the facility include enhanced barrier precautions (EBP) including measurable goals and interventions for 1 of 6 residents (R66) whose care plans were reviewed for EBP. Findings include: R20: R20's annual Minimum Data Set (MDS) dated [DATE], identified R20 had severe cognitive impairment and required moderate assistance with activities of daily living (ADLs), R20 was unable to ambulate. Diagnoses included osteoporosis, Alzheimer's disease, anxiety, weakness and history of hand and hip fractures. R20's undated Physician Orders report identified an order for physical therapy FMP with a start date 10/1/25, and the end date was open ended. An order for physical and occupational therapy FMP was also listed with start date 9/26/25 with an open-ended end date. R20's Restorative Care Program identified the following: 9/19/25, identified R20 was discharged from occupational therapy (OT) and was to have a restorative program to maintain her upper extremity strength and range of motion of participation in self-care and functional tasks of choice. The restorative aide was directed to completed ten repetitions of shoulder flex, chest press and side to side with a two-pound weight, ten repetitions of elbow flexion and extension with a red TheraBand and ten repetitions of pro/supination with a yellow TheraBand. 10/1/25, identified R20 was discharged from physical therapy (PT) and was to have a restorative program to maintain lower extremity strength and range of motion for continued level of ambulation and transfers to decrease burden of care. The restorative aide was directed to complete 15 repetitions of marching, lower ankle and hip abduction, and leg curl with a two-pound ankle weight and ball squeezes and ball press. R20 was also to stand with her four wheeled walker for two, one-minute sets or as long as R20 tolerated. R20's care plan dated 3/16/26, identified R20 had decreased physical mobility with a potential for falls due to a left hip fracture. Staff were directed to assist R20 to turn and reposition and transfer to her wheelchair. R20's care plan lacked documentation of a functional maintenance program (FMP), with goals and staff interventions. During interview on 4/29/26, at 5:36 p.m. the director of nursing (DON) stated if a resident was being seen by the restorative aide for the FMP, that should be addressed in their plan of care. R32: R32's quarterly MDS dated [DATE], identified R32 was cognitively intact. R32 was substantial to maximal assistance with bed mobility and transfers and did not walk. R32's had a diagnosis of joint (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	replacement of left knee. R32's undated Physicians Orders report identified an order for a FMP with walking as part of the FMP with a start dated of 11/19/25, with no end date identified. R32's Restorative Care Program dated 11/7/25, identified R32 was discharged from PT and was to start a FMP to maintain lower extremity strength and range of motion to decrease the burden of care with transfers and ambulation. The FMP identified the resident was to do each exercise 15 times. The exercises included: Seated chair march Long Arc Quad (big muscle on the front of the leg) stretch (sitting in a chair and lifting your foot straight out) Hip adduction with a ball. (squeezing your knees together with a ball between them) Hamstring (main muscle on back of leg) curls (the restorative aide would hold R32 up with a green TheraBand and would have to pull against it) Hip abduction with a green TheraBand (placing the band around both knees and spreading your knees apart) Hamstring and heel cord stretch (with leg straight out you would pull your toes back towards your body) With a physical therapist, assist R32 to stand, and they may ambulate up to 100 feet or up to R32 tolerance using the front wheel walker and a gait belt (a belt to place around a resident to assist with standing and balance). R32's care plan with the last review date of 3/13/26, identified R32 had decreased physical mobility with potential for falls due to recent left knee replacement. Staff were directed to assist R32 to turn and reposition, pivot transfer and to assist with sit up and lay down in bed and get leg and feet in and out of bed. R32's care plan lacked any documentation related to a FMP with goals and interventions. During an interview on 4/29/26, registered nurse (RN)-B stated when a resident was started on an FMP the care plan for the resident should be updated. R32's care plan lacked any documentation of an FMP. During an interview on 4/29/26 at 4:07 p.m., the DON stated the FMP for a resident was ordered by PT and should be placed on the resident's care plan. R32's FMP lacked any documentation related to an FMP or ambulation. R66: R66's quarterly MDS dated [DATE], identified R66 required extensive assistance from staff for all activities of daily living (ADL's) and diagnoses included colostomy, diabetes, and Alzheimer's disease. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R66's care plan dated 8/27/21, identified R66 was at risk for alteration in nutrition due to gastrostomy tube (g-Tube), tube feedings and not taking nutrition by mouth. The care plan did not address what PPE staff should wear with cares. On 4/29/26 at 10:00 a.m., registered nurse (RN)-C stated R66 was at risk for infection because of her g-tube and staff wore PPE including a gown and gloves during direct patient cares. During interview on 4/29/26 at 5:26 p.m., DON stated staff were instructed to wear a gown and gloves when providing direct cares for a resident with indwelling tubes including catheters and tube feedings. Direct care included anytime staff touched the residents and included emptying a catheter and repositioning residents in bed. The facility policy Quality of Care dated 10/2023, identified the facility would strive to ensure residents received treatment and care in accordance with professional standards of practice, their comprehensive care plan and their personal preferences. A policy for resident care plan was not received.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review, the facility failed to provide timely cares to dependent residents for 2 of 7 residents (R14, R18) who's activities of daily living cares were observed. Findings include: R14: R14's quarterly Minimum Data Set (MDS) dated [DATE], identified R14 had severe cognitive impairment and was dependent on staff for toileting. R14 diagnoses included dementia, edema, restlessness and agitation. R14's Urinary Incontinence and Indwelling Catheter Care Area Assessment (CAA) dated 8/21/25, identified the CAA was triggered due to R14's needing extensive assistance with toileting and frequent incontinence of urine. Staff offer to assist R14 to the restroom or to use his urinal every 2-3 hours and as needed. R14 was at risk for alterations in skin, offensive body odor, falls and bladder infections. Complicated by history of falls, dementia, R14's care plan revised 4/29/26, identified R14 had an alteration in elimination related to dementia with cognitive losses, receiving diuretic, poor sequencing skills, history of retention of urine and constipation manifested by need for staff assistance with toileting, R14 was incontinent of bladder and bowel. Staff will check brief for incontinence q 2-3 hours and as needed, change brief as needed with incontinence. Provide total assistance of 1 staff to change brief. May require 2 staff to change brief at times. Provide total assistance of 1-2 staff to pull up/down pants and provide peri rectal care after elimination. A continuous observation of R14 was completed on 4/29/26 starting at 8:04 a.m., through 11:10 a.m. At 8:04 a.m. R14 was seated in his wheelchair and was pedaling himself with his feet up and down the hallway in front of the nurses' station. R14 was dressed and groomed for the day. R14 stated he didn't know if he had eaten breakfast yet and pointed at the other residents in the dining room through the dining room doors. [It was unknown what time R14 was placed in the wheelchair] At 8:40 a.m., nursing assistant (NA)-E stepped out of the dining room and told NA-F R14 still needed to eat breakfast. NA-F approached R14 and asked R14 if he was ready to eat breakfast, R14 nodded yes and NA-F wheeled R14 to his table in the dining room where NA-E assisted R14 to eat. At 8:51 a.m., R14 finished with his meal and was wheeled to the hallway in front of the nurses' station. R14 was not offered toileting. At 8:56 a.m., R14 began pulling himself down the hall using the handrail and his left hand while pedaling with his feet. staff including the director of nursing walked past R14 but did not greet or approach R14. At 9:01 a.m., R14 pulled himself along the handrail until R14 was blocked by the medication cart. Registered nurse (RN)-C assisted R14 to his room where RN-C applied a topical pain medication to R14's knees. RN-C asked R14 if he wanted to lie down and rest before the noon meal. R14 replied yes and smiled. RN-C provided R14 with his call light, tv remote, his overbed table then turned on R14's (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	call light. RN-C then requested staff to assist R14 to lie down over the walkie. RN-C told R14 I'll go let someone know you're ready to lie down for a rest, ok? and exited the room. At 9:15 a.m., housekeeping was vacuuming the hallway carpet outside R14's room. R14 backed his wheelchair to the doorway and sat with this back to the hallway. At 9:32 a.m., RN-C walked past R14 sitting in his doorway and, again, asked for staff to lie R14 down over the walkie. A response was heard of the walkie that it would be a few minutes. At 9:38 a.m., R14 wheeled himself to sit in front of his tv. R14's call light was still on. At 9:41 a.m., activity aide (AA)-A entered R14's room and offered the sing-along activity for R14. AA-A wheeled R14 to the activity room. R14 was not offered toileting. AA-A did not turn off R14's call light. At 10:54 a.m., the sing-along activity was done and trained medication aide (TMA)-A obtained R14's blood pressure while he was seated in his wheelchair in the activity office. R13 approached TMA-A and asked if R14 was going to stay for exercises and that staff usually toileted R14 before the noon meal. TMA-A stated she would talk to the nursing assistants and find out. At 11:02 a.m., TMA-A returned with R14's medications with RN-C. R14 was given his medications and RN-C wheeled R14 to his room. At 11:06 a.m., RN-A entered R14's room with the full body mechanical lift. RN-A and RN-C transferred R14 into his bed and told R14 he could rest for a while. R14 was not offered nor placed on the commode to attempt to void. At 11:10 a.m., trained medication aide (TMA)-B entered R14's room and RN-A exited. RN-C and TMA-B changed R14's incontinence brief which was saturated with urine and provided perineal care. During an interview on 4/29/26 at 11:20 a.m., RN-C stated she did bring R14 to his room at 10:00 a.m. and asked for him to be toileted but R14 went to activities instead. RN-C nor TMA-B knew what time R14 had been previously toileted that morning and would have to ask the nursing assistants. RN-C stated R14 was due to a bowel movement that morning and had received a laxative. When the laxative kicked in, staff would place R14 on the commode. However, when R14 was already incontinent staff laid him down and provided incontinence care. R14 was not placed on the commode every time he was toileted because staff did not want to cause R14 agitation. At 11:33 a.m., TMA-B stated she asked the nursing assistants when R14 was last toileted. TMA-B stated she was told R14 had been assisted with morning cares by the night shift staff and had toileted before day shift started at 6:00 a.m. The night shift staff had not reported the time of R14's toileting so staff really had no idea. R14 should have been toileted at 9:00 a.m. at the latest because R14 was care planned to be toileted every 2-3 hours. We try our best. TMA-B stated every staff person kept track of toileting times differently. TMA-B used her care sheet and wrote down the times and whether the resident was incontinent or had voided. Then, at the end of her shift she entered those times into the electronic system. However, TMA-B could not say what other staff did. During an interview on 4/29/26 at 2:48 p.m., NA-G stated the previous shift reported the residents' last toileting time and staff just kept a mental note when they resident was due again. Yea, some staff did write it down on the care sheet but to each his own I guess. NA-G was able to keep it in his (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	mind and kept track that way. During an interview on 4/29/26 at 2:51 p.m., licensed practical nurse (LPN)-A stated toileting times were given during shift report. For R14, staff should offer toileting every hour. During an interview on 4/29/26 at 2:54 p.m., RN-C stated she did speak with the nursing assistants to determine when R14 had been toileted that morning. R14 had been incontinent around midnight the night before and R14's morning cares were completed between 4:00 a.m. and 6:00 a.m. RN-C stated she did ask staff to toilet R14 at 10:00 a.m. and when RN-C saw it had not been done, she did it as observed. RN-C stated, if she had known R14 got up that morning between 4:00 a.m. and 6:00 a.m., RN-C would have expected R14 to be toileted between 6:00 a.m. and 7:00 a.m. to prevent skin breakdown. During an interview on 4/29/26 at 2:58 p.m., RN-A stated she did hear RN-C ask for R14 to be assisted with toileting over the walkie that morning. R14 should be toileted every 2-3 hours as care planned to prevent skin breakdown. RN-C stated there was no expectation on how staff tracked toileting times. Some staff wrote times on their care sheet, but others did not. Not keeping track could lead to prolonged toileting times which could lead to prolonged exposure to moisture and skin breakdown. If R14 was assisted with morning care between 4:00 a.m. and 6:00 a.m., R14 should have been toileted before 9:00 a.m. or earlier. During an interview on 4/29/26 at 3:31 p.m., the director of nursing (DON) stated R14 should have been toileted immediately after breakfast or within his care planned timeframe to prevent incontinence/skin breakdown and to lessen R14's behaviors/agitation. Additionally, staff should always offer R14 to sit on the commode even when R14 was incontinent as care planned. During an interview on 4/29/26 at 4:18 p.m., the assistant administrator stated staff were expected to follow the care plan as written and to document times and reapproach for refusals or resistance. R18: R18's five-day MDS dated [DATE], identified R18 had severe cognitive impairment and required maximum to total assistance with activities of daily living (ADLs). Diagnoses included dementia, kidney disease, cerebral infarction (stroke), anxiety and diabetes. R18's care plan dated 3/31/26, identified R18 had a self-care deficit with a goal to remain clean and free of odor daily. Staff were directed to comb R18's hair, brush his teeth and shave him. R18's Resident Care Sheet dated 4/22/26, directed staff in bold and capitalized text to shave daily, family request. During observation on 4/27/26, at 11:17 a.m. R18 was seated in his wheelchair in the Walnut Grove wing's television room. R18 had 1/4-inch grey whiskers scattered over his chin, cheeks, neck and below his nose. R18 was unable to recall if he had shaven that day. During observation on 4/28/26, at 10:38 a.m. R18 was seated in his wheelchair in the Walnut Grove wing's television room. R18 continued to have grey whiskers scattered over his face and neck and remained unshaven. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During observation on 4/29/26, at 8:59 a.m. R18 was seated in his wheelchair in the hallway. R18's was clean shaven. When interviewed on 4/29/26, at 9:00 a.m. LPN-B stated she was not sure why the aides would not have shaved R18 on 4/27/26, or 4/28/26, but he was shaved today. There were different nursing assistants on then there were the other two days. R18 was supposed to be shaved every day. When interviewed on 4/29/26, at 9:53 a.m. RN-B stated R18 should be shaven daily. RN-B was not sure why R18 was not shaved the other two days. RN-B was aware R18's shaver battery was very low when he was shaved that morning, so perhaps that was the reason, but the goal was to shave him every day. R18 could have refused, however the point of care documentation did not indicate R18 refused care. During interview on 4/29/26, at 9:54 a.m. NA-B stated she was not sure why R18 was not shaved the previous two days, but he was shaven now. R18 was supposed to be shaven every day. Some of the younger NA's just did not notice or didn't know better. R18 never refused assistance with cares and always allowed them to assist hiem to shave daily without any problems. During interview on 4/29/26, at 4:36 p.m. the DON stated she would have expected staff to shave R18 as care planned or document why it could not be completed. The facility Quality of Care Policy reviewed 10/2023, identified based on the comprehensive assessment of a resident the facility strove to ensure residents received treatment and care in accordance with professional standards of practice, their comprehensive care plan and their personal preferences. The facility provides the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with State and Federal Regulations.

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	245397	A. Building B. Wing	04/29/2026

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review, the facility failed to ensure residents received timely repositioning for 1 of 3 residents (R14) reviewed for pressure ulcers.Findings include:R14's quarterly Minimum Data Set (MDS) dated [DATE], identified R14 had severe cognitive impairment was dependent on staff for repositioning. Diagnoses included dementia, edema, restlessness and agitation. R14's Braden Scale (prediction for pressure ulcer scale) dated 2/13/26, identified R14 was a moderate risk for pressure injury/ulcer.R14's care plan revised 4/29/26, included an intervention to provide assist of one staff to turn and reposition every 2-3 hours.A continuous observation was conducted on 4/29/26 at starting at 8:04 a.m., R14 was seated in his wheelchair and was pedaling himself with his feet up and down the hallway in front of the nurses' station. R14 was dressed and groomed for the day. R14 stated he didn't know if he had eaten breakfast yet and pointed at the other residents in the dining room through the dining room doors. It was unknown when R14 was seated in his wheelchair.At 8:40 a.m., nursing assistant (NA)-E stepped out of the dining room and told NA-F R14 still needed to eat breakfast. NA-F approached R14 and asked R14 if he was ready to eat breakfast, R14 nodded yes and NA-F wheeled R14 to his table in the dining room where NA-E assisted R14 to eat.At 8:51 a.m., R14 finished with his meal and was wheeled to the hallway in front of the nurses' station. R14 was not offered repositioning.At 8:56 a.m., R14 began pulling himself down the hall using the handrail and his left hand while pedaling with his feet. Staff including the director of nursing walked past R14 but did not greet or approach R14. At 9:01 a.m., R14 pulled himself along the handrail until R14 was blocked by the medication cart. Registered nurse (RN)-C assisted R14 to his room where RN-C applied a topical pain medication to R14's knees. RN-C asked R14 if he wanted to lie down and rest before the noon meal. R14 replied yes and smiled. RN-C provided R14 with his call light, tv remote, his overbed table then turned on R14's call light. RN-C then requested staff to assist R14 to lie down over the walkie. RN-C told R14 I'll go let someone know you're ready to lie down for a rest, ok? and exited the room. RN-C did not offer to reposition R14.At 9:15 a.m., housekeeping was vacuuming the hallway carpet outside R14's room. R14 backed his wheelchair to the doorway and sat with this back to the hallway. At 9:32 a.m., RN-C walked past R14 sitting in his doorway and, again, asked for staff to lie R14 down over the walkie. A response was heard of the walkie that it would be a few minutes. At 9:38 a.m., R14 wheeled himself to sit in front of his tv. R14's call light was still on.At 9:41 a.m., activity aide (AA)-A entered R14's room and offered the sing-along activity for R14. AA-A wheeled R14 to the activity room. R14 was not offered toileting. AA-A did not turn off R14's call light.At 10:54 a.m., the sing-along activity was done and trained medication aide (TMA)-A obtained R14's blood pressure while he was seated in his wheelchair in the activity office. R13 approached TMA-A and asked if R14 was going to stay for exercises and that staff usually repositioned R14 before the noon meal. TMA-A stated she would talk to the nursing assistants and find out.At 11:02 a.m., TMA-A returned with R14's medications with RN-C. R14 was given his medications and RN-C wheeled R14 to his room.At 11:06 a.m., RN-A entered R14's room with the full body mechanical lift. RN-A and RN-C transferred R14 into his bed and told R14 he could rest for a while.At 11:10 a.m., trained medication aide (TMA)-B entered R14's room and RN-A exited. RN-C and TMA-B changed R14's incontinence brief which was saturated with urine and provided perineal care. R14's skin was pink, dry and intact.During an interview on 4/29/26 at 11:20 a.m., RN-C stated she did bring R14 to his room at 10:00 a.m. and asked for him to be toileted but R14 went to activities instead. RN-C nor TMA-B knew what time R14 had been previously repositioned that morning and would have to ask the nursing assistants.During an interview on 4/29/26 at 11:33 a.m., TMA-B stated she asked the nursing assistants when R14 was last repositioned. TMA-B was told R14 was assisted with morning cares by the night shift staff and had toileted before day shift started at 6:00 a.m. The night shift staff had not reported the time of R14's repositioning so staff really had no idea. R14 should have been repositioned (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	at 9:00 a.m. at the latest because R14 was care planned to be repositioned every 2-3 hours. We try our best. TMA-B stated every staff person kept track of repositioning times differently. TMA-B used her care sheet and wrote down the times. Then, at the end of her shift she entered those times into the electronic system. However, TMA-B could not say what other staff did. During an interview on 4/29/26 at 2:48 p.m., NA-G stated the previous shift reported the residents' last repositioning time and staff just kept a mental note when they resident was due again. Some staff wrote it down, but not everyone. NA-G was able to keep it in his mind and kept track that way. During an interview on 4/29/26 at 2:51 p.m., licensed practical nurse (LPN)-A stated repositioning times were given during shift report. For R14, staff should offer repositioning every hour. During an interview on 4/29/26 at 2:54 p.m., RN-C stated she did speak with the nursing assistants to determine when R14 had been repositioned that morning. R14's morning cares were completed between 4:00 a.m. and 6:00 a.m. RN-C stated she did ask staff to toilet R14 at 10:00 a.m. and when RN-C saw it had not been done. RN-C stated, if she had known R14 got up that morning between 4:00 a.m. and 6:00 a.m., RN-C would have expected R14 to be repositioned between 6:00 a.m. and 7:00 a.m. to prevent skin breakdown.During an interview on 4/29/26 at 2:58 p.m., RN-A stated she did hear RN-C ask for R14 to be assisted with toileting over the walkie that morning. R14 should be repositioned every 2-3 hours as care planned to prevent skin breakdown. RN-C stated there was no expectation of how staff tracked times. Some staff wrote times on their care sheet, but others did not. Not keeping track could lead to prolonged repositioning times which could lead to skin breakdown. If R14 was assisted with morning care between 4:00 a.m. and 6:00 a.m., R14 should have been repositioned before 9:00 a.m. or earlier. That is a large time span and, because it wasn't kept track of, staff don't know.During an interview on 4/29/26 at 3:31 p.m., the director of nursing (DON) stated R14 should have been repositioned immediately after breakfast or within his care planned timeframe to prevent skin breakdown and to lessen R14's behaviors/agitation.During an interview on 4/29/26 at 4:18 p.m., the assistant administrator stated staff were expected to follow the care plan as written and to document times and reapproach for refusals or resistance. The facility policy Skin Care reviewed 6/2023, identified staff would ensure proper identification of residents at risk for skin breakdown, prevention of development of pressure ulcers, and determining appropriate treatment of pressure ulcers and/or impaired skin for residents. Care plans will be individualized to address resident specific needs.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to ensure a stop date for medication was confirmed by the primary care provider for temporary medications that required an end date for 1 of 6 residents (R12) reviewed for medication management.Findings include:R12's five-day Minimum Data Set (MDS) dated [DATE], identified R12 had intact cognition. R12 received injectable medication for all seven days of the observation period and received anticoagulant medication. A complete drug regimen review was completed, and no potentially clinically significant medication issues were noted. Diagnoses included diabetes, fracture of the right femur, altered mental status, calculus of the kidney, hydronephrosis and metabolic encephalopathy.R12's Interagency Transfer Orders dated 4/15/26, identified an order for enoxaparin (a blood thinner) 40 milligram (mg) syringe, inject 0.4 millimeters (ml) under the skin every night to prevent deep vein thrombosis for diagnosis of total right hip arthroplasty. The quantity listed 13.6 ml with no refills. R12's Medication Administration Record (MAR) for April 2026, identified enoxaparin syringe 40 mg/0.4 ml: subcutaneous (SQ) at bedtime for fracture of right femur. Start/End date 4/15/26 to 5/18/26. Special Instructions were listed as RX for 13.6 ml/ 0.4 ml per dose=34 doses total. The medication was recorded as administered as ordered starting 4/15/26. When interviewed on 4/28/26, at 4:13 p.m. licensed practical nurse (LPN)-C stated the pharmacy had filled the enoxaparin in 40 mg / 0.4 ml prefilled single use syringes. Nursing staff administered the one prefilled syringe every evening. LPN-A was unsure what the special instructions on P12's MAR meant. During interview on 4/28/26, at 4:36 p.m. registered nurse (RN)-B stated the special instructions were to demonstrate how the end date of the medication was determined. The medication was filled for 13.6 ml quantity with no refills, so she did the math, versus contacting the medical provider, to determine 34 doses were ordered and figured out the end date from there. RN-B stated she had not contacted R12's primary care provider to verify the stop date of the medication and no verbal order had been obtained to stop the medication. During telephone interview on 4/29/26, at 9:06 a.m. the consulting pharmacist (CP)-D stated if a medication required an end date, either the pharmacist would call the provider to obtain it or nursing would do it. The quantity of medication with no refills could mean that the med should be stopped when ran out of medication, but not always. CP-D thought she would probably just check with the provider to make sure. It was better to double check with the provider rather than just assume. When interviewed on 4/29/26, at 4:27 p.m. the director of nursing (DON) stated usually medication orders such as enoxaparin had a stop date, especially when discharging from the hospital. She would expect staff to reach out to the provider to notify of the need for an end date to the enoxaparin and verification the dose was completed when the medication was gone. No refills on a medication did not always mean to discontinue the medication and needed to be verified by the primary care provider. The facility policy Pharmacy Services dated 10/2022, identified prescription medications were dispensed only upon receipt of clear, complete, and signed orders of a person lawfully authorized to prescribe. Any dose or order that appeared inappropriate, considering the resident's age, allergies, diagnosis or current medication regimen would be verified with the prescriber.

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review, the facility failed to ensure food was prepared and served to meet resident needs for 1 of 2 residents (R12) reviewed for nutrition. Findings include:R12's Speech Therapy Daily Note dated 3/16/25, recommended general precautions to include resident seated at 90 degrees for all oral intake, one to one assist to follow safe swallow strategies of small bites/sips, slow rate, alternate bites/sips and only feed resident when she is alert. R12's five-day Minimum Data Set (MDS) dated [DATE], identified R12 had intact cognition and required set up assistance with eating. R12's care plan dated 4/27/26, identified a potential for alteration in nutrition with a goal to maintain independence with eating after set up. Staff were directed to assist to setup meals as needed. R12 should be sitting upright as close to 90 degrees as possible when eating in bed. Staff were to encourage R12 to sit up in wheelchair with eating. R12's Physician Orders with print date 4/29/26, identified a dietary order 4/15/26, for a heart healthy/cardiac diet. Special instructions included to cut food into small bite size pieces, resident to sit at 90 degrees for all intake, slow rate of intake, small bites/sips, alternate bites/sips, assist of one and to only feed when alert. R12's Dietary Menu card,Tuesday dinner dated 4/28/26, identified a heart healthy diet and to cut P12's food into bite sized pieces. During observation on 4/28/26, at 12:19 p.m. R12 was in bed in her room, watching television and eating her lunch. R12's lunch tray was on her bedside table over her bed and R12 was in a semi upright position in bed, with the head of the bed raised to an approximately 75-degree angle. R12's lunch consisted of a half of a submarine sandwich on a white hoagie roll with lunch meat and cheese. Three large pieces of lettuce and a large slice of tomato was also on the plate. R12 had the half-consumed sandwich in her hand and was taking bites from it. No one was in the room with R12 as she ate. During interview on 4/28/26, at 12:28 p.m. trained medical assistant (TMA)-A entered R12's room and stated R12 was not positioned at a 90-degree angle as ordered and TMA-A stated she was not aware R12 had orders for her food to be cut into bite size pieces. TMA-A knew R12 had eaten a full sweet roll the day prior that had not been cut up for her. R12 should be seated at a 90-degree angle and food cut up in bite size pieces if that was what was ordered, as it would have been ordered to assist R12 to eat safely and prevent choking. TMA-A thought the order stemmed from when R12 had been more acutely ill and less alert. When interviewed on 4/28/26, at 12:33 a.m. nursing assistant (NA)-A stated the nurse aide care plan did identify R12's food was to be cut into bite size pieces but did not direct staff to ensure R12 was at a 90-degree angle to eat. NA-A stated R12's head of bed was elevated but was not fully at a 90-degree angle. NA-A stated usually the dietary staff was responsible to make sure resident food was cut up as ordered but if it wasn't, then the NA's should be doing it, kind of like a second check. During interview on 4/28/26, at 12:44 p.m. dietary aide (DA)-A stated dietary staff were supposed to cut up resident food when it was ordered, but if it wasn't, then the NA's should do it. DA-A felt sure she had cut up R12's sandwich into bite size pieces and thought maybe the NAs had given her the wrong tray instead, but she could not be entirely sure of that. DA-A stated R12's dietary slip identified her food needed to be cut up in small bite size pieces. During interview on 4/28/26, at 12:52 p.m. registered nurse (RN)-B stated it was not an official order to keep R12's diet as small bite size pieces and to be seated at a 90-degree angle when eating. RN-A left those special instructions on her chart as an additional note and R12's family had requested that as well. RN-A felt it was important to keep the special instructions listed when R12 had returned from the hospital on 4/15/26, but now R12's diet may need to be re-evaluated as she has improved since her return. The facility policy Diet Orders dated 2/2025, identified all meals provided to residents would have a written physician order. No further information was received.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review the facility failed to ensure staff wore the appropriate personal protective equipment (PPE) according to CDC guidelines during direct cares for 2 of 4 residents (R25, R66) reviewed who were on enhanced barrier precautions.Findings include:R25R25's annual Minimum Data Set (MDS) dated [DATE], identified R25 had an indwelling Foley catheter and was dependent on staff for activities of daily living (ADL's) including catheter care. R25's had a diagnosis of renal insufficiency.R25's care plan dated 3/6/25, identified R25 was at risk for infection due to his indwelling catheter and staff were to wear PPE, including gown and gloves, when caring for R25.On 4/27/26 at 1:45 p.m., nursing assistant (NA)-C exited R25's bathroom wearing gloves and was holding a urine collection graduate. NA-C bent down next to R25 and drained urine from the catheter drainage bag into the graduate. NA-C stood, walked into the bathroom and emptied the urine into the toilet. NA-C failed to wear a gown during catheter cares. During interview, NA-C stated when he emptied a resident's catheter, he always wore gloves and if there was a risk of infection then he would also wear a gown. NA-C stated he had worn gloves but not a gown when he emptied R25's catheter. NA-C stated there was a risk of splashing urine onto his clothes and potentially spreading bacteria to another resident. NA-C stated he should have worn a gown with R25's catheter cares.R66R66's quarterly Minimum Data Set (MDS) dated [DATE], identified R66 required extensive assistance from staff for all activities of daily living (ADL's) and diagnoses included colostomy, diabetes, and Alzheimer's disease.R66's care plan dated 8/27/21, identified R66 was at risk for alteration in nutrition due to gastric tube, tube feedings and not taking nutrition by mouth. The care plan did not address what PPE staff should where with cares. On 4/29/26 at 10:00 a.m., registered nurse (RN)-C was at R66's bedside and administering medication through the resident's gastrostomy tube (G-tube). Nursing assistant (NA)-D entered the room, put on a pair of gloves and walked to the resident's bedside. RN-C and NA-D were on either side of the bed. RN-C was wearing a gown and gloves. NA-D was wearing gloves, however, was not wearing a gown. R66's bed was thigh-height, and the resident was lying in bed with a lift sheet behind her hips and back, and her legs were resting on pillows behind her calves. RN-C and NA-D leaned over the bed and used the lift sheet to scoot the resident up towards the top of the bed. RN-C and NA-D walked to the foot of the bed and lifted and repositioned the pillows behind R66's lower legs. NA-D walked into the bathroom, removed her gloves, washed her hands and then exited the room. RN-C stated R66 was at risk for infection because of her g-tube and NA-D should have worn a gown and gloves while assisting with direct care.During interview on 4/29/26 at 10:35 a.m., NA-D stated she usually wears a gown when caring for residents with any type of tubes including g-tubes, although forgot to put on a gown when she repositioned R66. NA-D stated wearing a gown was important to prevent bringing in and spreading bacteria to R66, as well as to help prevent spreading bacteria to/from other residents.During interview on 4/29/26 at 5:26 p.m., director of nursing (DON) stated staff should wear a gown and gloves when providing direct cares for a resident with indwelling tubes including catheters and tube feedings. Direct care included anytime staff touched the residents and included emptying a catheter and repositioning residents in bed.The facility Enhanced Barrier Precautions policy dated 3/26, identified EBP expanded the use of PPE and referred to the use of gown and gloves during high-contact resident care activities that provided opportunities for transfer of multidrug-resistant organism (MDRO)'s to staff hands and clothing. MDRO's may indirectly be transferred from resident to resident during high contact care activities. Resident with wounds and indwelling medical devices are at an especially high risk of both acquisition of and colonization with MDRO's. The policy further identified EBP would be implemented for residents with wounds and/or indwelling medical devices during high-contact resident care activities regardless of MDRO infection or colonization. High risk care activities included device care or use.