

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245405	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/05/2026
NAME OF PROVIDER OR SUPPLIER Heritage Living Center		STREET ADDRESS, CITY, STATE, ZIP CODE 619 West Sixth Street Park Rapids, MN 56470	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to ensure a resident received ongoing nursing assessment and monitoring following an acute change in condition for 1 of 2 residents (R5) reviewed for changes in condition. Findings include: R5's significant change Minimum Data Set (MDS) dated [DATE] identified the assessment was completed due to R5's admission to hospice care. R5 had intact cognition and was dependent with most activities of daily living (ADLs), including dressing, grooming, and toileting. R5 was dependent with transfers and unable to ambulate. R5 had an indwelling Foley catheter and was always incontinent of bowel. R5 did not exhibit rejection of care or other behaviors during the assessment period. Diagnoses included right above-the-knee amputation, heart failure, chronic obstructive pulmonary disease (COPD), diabetes, anxiety, and a history of transient ischemic attack and cerebral infarction (stroke). R5's care plan, revised 7/13/26, identified R5 had altered respiratory status related to heart disease, asthma, anemia, COPD, and a history of tuberculosis. Goals included maintaining a normal breathing pattern and pulse oximetry above 90 percent. Staff were directed to monitor, document, and report breathing abnormalities to the physician, administer nebulizers and inhalers as ordered, and obtain vital signs weekly and as needed. The care plan identified R5 had altered elimination related to bowel incontinence and an indwelling urinary catheter. Staff were directed to provide perineal care after each incontinent episode and record the amount and consistency of bowel movements. The care plan identified R5 had diabetes with a goal to experience no complications related to diabetes. Interventions directed staff to administer medications as ordered, monitor for side effects, and monitor, document, and report to the physician as needed symptoms of hypoglycemia or hyperglycemia, increased thirst and appetite, weight loss, and fatigue. R5's progress notes identified the following: On 6/28/26, R5 woke early and ordered four ice creams for breakfast and stated they were for his diarrhea. Later, R5 was heard shouting for help and was seated in his wheelchair at the end of the bed. R5 denied pain, breathing difficulty, or chest pain and refused to allow staff to obtain his vital signs. R5 stated he did not know what was going on with him. Staff notified the on-call physician, who ordered laboratory testing, which R5 initially refused. Later during the day shift, R5 allowed staff to attempt to obtain blood for the ordered laboratory testing twice; however, the samples hemolyzed and could not be used. R5 was confused and hallucinating. Staff updated the on-call physician, who stated another provider would see R5 the following day. On 6/28/26 at 10:34 p.m., staff documented R5 had been incontinent of seven large, loose, tarry stools. Staff made several attempts to convince R5 to go to the emergency room for evaluation; however, R5 refused. R5 also refused all oral intake during the evening shift. On 6/29/26 at 10:07 a.m., R5 was transferred to the hospital due to increased stools and hypotension. R5's blood pressure was 55/36, pulse was 53 beats per minute, and temperature was 99.2 degrees Fahrenheit. R5's medical record lacked evidence a licensed nurse assessed R5 or that staff monitored (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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: 245405	If continuation sheet Page 1 of 14

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R5's vital signs and clinical condition during the evening and night shifts following his acute change in condition, which included seven large, loose, tarry stools and refusal of oral intake. R5's Blood Pressure Summary identified staff recorded R5's blood pressure two to three times per day from 6/16/26 through 6/27/26; however, no blood pressure was recorded on 6/28/26 or prior to R5's assessment and transfer to the hospital on 6/29/26. During an interview on 8/4/26 at 2:43 p.m., licensed practical nurse (LPN)-B stated the second floor was usually staffed with a trained medication assistant (TMA) and a nursing assistant (NA). If the TMA needed assistance, such as when a resident experienced a change in condition or required insulin administration, a nurse from the first floor would go to the second floor and provide the necessary nursing services. If an LPN or registered nurse (RN) was scheduled on the second floor, the nurse completed their own assessments. LPN-B stated assessments were documented in the resident's progress notes. During an interview on 8/4/26 at 2:47 p.m., RN-A stated when she began her shift on 6/29/26, she reviewed the shift report and went to assess R5. RN-A stated she first obtained R5's vital signs because R5 was sweaty and did not feel well. RN-A discussed R5's condition with him, and R5 agreed to go to the emergency room for evaluation. RN-A stated she had been informed R5 previously refused hospital evaluation. RN-A stated she would have expected increased monitoring and vital sign assessments during the previous shifts due to R5's change in condition. RN-A was unable to locate evidence staff monitored R5's condition and stated it appeared staff did not obtain R5's vital signs during the evening or night shift. During a telephone interview on 8/4/26 at 3:42 p.m., LPN-C stated she worked the evening shift on 6/28/26 and remembered R5 repeatedly refused to go to the emergency department for evaluation. LPN-C thought the TMAs obtained R5's vital signs twice during the shift. LPN-C stated she did not document the vital signs in R5's medical record and acknowledged the vital signs should have been documented. LPN-C stated she knew the on-call provider had been notified during the day shift; therefore, staff did not update the provider during the evening shift because R5 continued to refuse transfer to the emergency department for evaluation. During an interview on 8/4/26 at 5:40 p.m., RN-D stated she worked the day shift on 6/28/26 and remembered R5 experienced significant hallucinations. RN-D stated she was told R5 wanted four cups of ice cream for breakfast and wondered whether R5's symptoms were related to his blood glucose because he had diabetes. RN-D contacted the on-call provider because of R5's confusion and attempted to obtain blood for the ordered laboratory testing; however, the samples clotted and could not be used. RN-D stated she attempted to obtain R5's blood pressure, but the machine repeatedly displayed an error. RN-D then attempted to palpate R5's pulse and blood pressure but was unable to obtain them. R5 would not allow staff to place a blood pressure cuff on him, and when staff were able to attempt it, the machine continued to display an error. RN-D stated the on-call provider said R5 needed to go to the emergency room; however, R5 was his own person and refused to go. RN-D stated R5 was sweating but would not allow staff to touch him to obtain his vital signs or blood glucose. R5 hollered for help throughout the shift, but when staff entered his room, R5 stated he had not asked for help and directed staff to leave. RN-D stated R5 became more like himself toward the end of the day shift, which was when staff were able to attempt obtaining the blood samples; however, R5 allowed staff to provide care for only a short time before he again refused to be touched. During an interview on 8/4/26 at 5:33 p.m., TMA-A stated she worked the evening shift on 6/28/26. Staff offered R5 several opportunities to go to the emergency room because of his condition. R5 was not eating or drinking but repeatedly stated he wanted to wait. TMA-A thought her coworker had obtained R5's vital signs but was unsure where they would have been documented. TMA-A stated R5 appeared grayish, and staff offered him everything they could offer. TMA-A stated TMAs and NAs were trained to obtain vital (continued on next page)		

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to consistently implement and evaluate individualized interventions to address persistent expressions of distress for 1 of 1 resident (R31) reviewed for dementia care. This resulted in prolonged periods of R31 hollering without staff intervention and contributed to distress for another resident (R7), who had a known history of post-traumatic stress disorder (PTSD) with loud noises identified as a trigger. Findings include: R31's quarterly Minimum Data Set (MDS) dated [DATE], identified R31 had a severe cognitive impairment and had diagnoses that included Alzheimer's disease, dementia, delusional disorders, and depression. R31 exhibited facial expressions (e.g. grimaces, wincing, wrinkled forehead, furrowed brow, clenched teeth or jaw) as indicators of pain or possible pain and received scheduled pain medication and non-medication interventions for pain. R31's Cognitive Loss/Dementia Care Area Assessment (CAA) dated 2/23/26, identified R31's goal was to maintain by management of symptoms and behaviors. Staff would encourage R31 to make as many choices as possible, needs anticipated by staff when needed. R31's Behavioral Symptoms CAA dated 2/23/26, identified R31's goal was to improve by utilizing behavioral interventions. Medications administered to manage depression and behavioral symptoms, monitored routinely. R31's Pain CAA dated 2/23/26, identified R31's goal was to maintain with current pain management regimen effective. R31 had scheduled medications, non-medication interventions, and as needed (PRN) medications available. R31's care plan revised 5/6/26, identified R31 had behaviors of yelling out, grabbing at staff, and swearing related to dementia, and Alzheimer's disease, delusional disorder, and depression. Interventions included: Intervene as necessary to protect the rights and safety of others. Approach/Speak in a calm manner. Divert attention. Remove the situation and take R31 to alternate location as needed. Monitor behavior episodes and attempt to determine underlying causes. Consider location, time of day, people involved, and situations. Document behavior and potential causes. When R31 was exhibiting verbal/physical behaviors (yelling out; declining cares; grabbing; swearing) leave R31 in a safe space and return later to provide task. R7's Trauma Informed Care dated 11/25/24, identified R7 had a history of childhood neglect and abuse which can make R7 feel angry/irritable, anxious and distraught. There was no pattern to how often the feeling related to the situation occurred. Loud noises were a trigger for R7. A close relationship with siblings and other family members helped make R7 feel better. Preference for private room and R7 used tv or a white noise machine to block out neighboring sounds. R7's quarterly MDS dated [DATE], identified R7 had severe cognitive impairment and diagnoses included Post-Traumatic Stress Disorder (PTSD), depression, migraine and cirrhosis of the liver. R7 required cleanup/set up assistance with eating but was independent with all other care areas. R7 exhibited no behaviors R7's care plan revised 7/22/26, identified R7 had actual or potential for post-traumatic stress disorder related to childhood neglect and abuse. Interventions included the following: observe for changes in mood/behavior/sleep/eating and side effects of medications. During an observation on 8/3/26 at 11:04 a.m., R31 was sitting in her wheelchair in the common area in front of the tv. R31 was hollering incoherently and loudly. R31 could be heard throughout the wing. Licensed practical nurse (LPN)- stated R31 was having mouth pain, and staff were trying to figure out what to do. R31 had been given pain medication. At 11:16 a.m., R31 continued to holler out. R31's eyes were closed and she was sitting with her feet elevated and a pillow behind her head. At 11:38 a.m., R31 was assisted to the dining room for her noon meal. R31 continued to holler out loudly but the (continued on next page)		

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	other residents weren't acknowledging her hollering. LPN-A, R31 and two other residents were in the dining room. At 11:48 a.m., R31 continued to holler out incoherently. R31's tablemates joined her at the table but neither said anything when R31 hollered out. The other residents quietly sat with their eyes closed waiting for the meal to start. At 12:01 p.m., R31 continued to holler uhhhhh loudly. Nursing assistant (NA)-B stated R31 hollered a lot like that. R31 was in a lot of pain. It's been going on a while now. During an interview on 8/3/26 at 1:39 p.m., family member (FM)-A stated R31 did have problems with her teeth and staff had been working with insurance to get R31 to an oral surgeon because R31 would not open her mouth for the regular dentist and R31 ground her teeth. FM-A stated he was told staff could feel where R31's teeth were broken off. Staff applied a numbing gel to R31's gums/teeth and R31 had pain medications as well. However, FM- stated the doctor said it shouldn't hurt R31. R31 did the hollering. FM-A wasn't sure if it was pain or if R31 had a behavior. FM-A knew if you held R31's hand or rubbed her feet, R31 calmed down. During an observation on 8/3/26 at 5:58 p.m., NA-A assisted R31 to the common area and stated, you probably don't want to sit here because she's going to be noisy. R31 was hollering loudly until registered nurse (RN)-A brought an oral soothing device. The oral soothing device was a fabric pouch with a plastic handle that could be filled with ice. RN-A stated R31 ground her teeth, and the facility has been unable to get her a mouth guard. The oral soothing device was filled with lemon flavored icy to help soothe R31's oral pain. R31 did suck and chew on the oral soothing device but continued to holler out around it. At 6:01 p.m., R31 opened her mouth and RN-A removed the oral soothing device. RN-A went down the hall and R31 began hollering again. At 6:06 p.m., R31 continually hollered loudly. RN-A returned with an ice pack and held it against R31's cheek. R31 continued hollering and RN-A asked if it was too cold. R31's hollering remained unchanged. RN-A asked R31 if she wanted to go for a walk. R31 continued hollering and kicked her feet into the air. RN-A told R31 to squeeze RN-A's hand if the ice pack was too cold. R31 lightly held RN-A's hand. At 6:10 p.m., R31 had continually hollered. RN-A pushed R31's wheelchair past the nursing assistants and asked if it was normal for R31 to holler like this. The nursing assistants nodded and said yes. At 6:14 p.m., RN-A and the director of nursing (DON) brought R31 to her room. The DON stated hollering was R31's norm and left the room. At 6:17 p.m., RN-A brought R31 back to the common area in front of the tv. RN-A then left the area. At 6:24 p.m., R31 hollered non-stop. R7 was inside her room, which is adjacent and shared a wall the tv area, with the door shut and could be heard clearly yelling shut up! through the shut door. R31 continued hollering. At 6:26 p.m., R31 continued hollering. R7 was sitting in her recliner and was trying to watch tv. R7 is scowling and shaking her head and yelled Shut up! It's just nonstop. Day and night. It drives me nuts! R7 stated it didn't do any good to say anything to the staff, but seriously can't they just move her somewhere else? R7 stated she understood R31 lived at the facility but R31 didn't have to sit right outside R7's room. At 6:32 p.m., R31 hollered nonstop with tone and intensity increased. Staff did not move R31 or approach R31 or R7 to attempt redirection. During an interview on 8/4/26 at 10:12 activity aide (AA)-A sat next to R31 talking softly and assisted R31 to eat an icy while holding/stroking R31's hands. R31 occasionally made sound, but the sound had decreased in tone and intensity significantly. At 10:33 a.m., AA-A told R31 AA-A needed to go chart and would see R31 later. During an interview 8/4/26 at 10:37 a.m., AA-A stated R31 had hollering behaviors for quite a while now. AA-A stated the nurses were working with R31's insurance to get an oral procedure approved. AA-A stated R31's hollering lessened when some sat with R31 and held her hands. It also increased when R31's family had visited and had to leave. AA-A stated R31 had the behavior prior to the dental problem being identified. AA-A stated she was unsure if it was pain or did the pain increase the behavior and the behavior just continued. The other residents did complain. Another resident recently moved upstairs so she (continued on next page)		

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	wouldn't have to listen to it anymore. R7 complained as well. Sometimes staff tried to move R31 to the dining room because there was a tv there too when R7 complained. AA-A stated she did not know if there was anything else the staff could do. During an observation on 8/4/26 at 10:44 a.m., R31 started hollering again. NA-C was sitting at the desk, and housekeeping was going room to room. No staff approached R31. At 10:51 a.m., R31 hollered nonstop. NA-C left the desk but never approached R31. Housekeeping continued going room to room. At 11:09 a.m., NA-C approached R31 and placed a wedge cushion between R31 and R31's left wheelchair armrest. NA-C told R31 she would be back to get her for lunch shortly. At 11:11 a.m., RN-A approached R31, put on a pair of gloves and applied essential oils to R31's neck. RN-A stated sometimes the essential oils and neck rub helped R31. R31 did stop hollering while R31 rubbed R31's neck. At 11:19 a.m., RN-A walked away from R31 and R31 began hollering. At 11:21 a.m., RN-A returned with a nutritional shake and R31 drank the shake using a straw. R31 stopped hollering. During an interview on 8/4/26 at 2:17 p.m., NA-D stated R31 screamed all the time, every day. R31 was in a lot of pain, and the hollering was the only way for R31 to communicate. R31 had an oral soothing device that R31 could chew on that helped. When R31's family was there, that helped too. Staff believed R31 was scared to be alone and hollered because of that as well. Other residents did complain about R31's hollering. R7 complained but was usually good about it. R7 just shut her door and tried to ignore it. At 2:21 p.m., NA-D returned with the oral soothing device and a towel. NA-D stated R31 would not always open her mouth and rubbed R31's lips with the device telling R31 that it would feel good. NA-D placed the device in R31's mouth, placed the towel in R31's lap and walked away. Let's see if that helps for a little bit. R31 continued to holler around the device. At 2:28 p.m., R31's hollering increased in tone and loudness, yelling approximately every 15 seconds. R7 was in her room with the door shut and can be heard clearly yelling Shut up! Just shut up! There were 5 staff sitting at the desk for afternoon report. No staff approached either resident. R31 and R7 continued hollering. At 2:31 p.m., NA-D approached R31 and placed the oral soothing device back into R31's mouth. You just have to keep sticking it in her mouth. R31 chewed on the device but continued hollering in a muffled hum. NA-D went back to the desk. At 2:36 p.m., the oral soothing device fell out of R31's mouth and R31 is screaming incoherently. R7 screamed Shut up! behind her closed door but could be clearly heard. Staff continued to sit at the desk without approaching R31 or R7. At 2:40 p.m., shift report was done and staff stood up from the desk. R31 and R7 were hollering. NA-E approached R31 and assisted R31 to an upright position. R31 continued to scream. No staff checked on R7. NA-E walked away from R31 with R31's oral soothing device and walked with the other 4 staff down the hall. R31 and R7 continued hollering. At 2:44 p.m., NA-E brought R31's oral soothing device to R31 and placed it in R31's mouth. R31 chewed and sucked on the device. NA-E stated R31 hollered every day, all day. Sometimes rubbing R31's legs helped because R31's muscles would get stiff. Sometimes the chewing ice helped. That was all staff usually did. NA-E then stated staff didn't always have to hold R31's device for R31 but NA-E chose to at that time to prevent R31 from spitting it out. R7 did get really upset about R31's hollering. R7 had behaviors too and screamed at R7 which wasn't right either. R31 couldn't help it. Staff were supposed to go in and talk to R7 and just try to calm her down. At 2:50 p.m., NA-E placed the oral soothing device in R31's mouth, removed her gloves and walked away from R31. R7 hollered shut up but NA-E did not go in and talk to R7. At 2:53 p.m., R31 spit out the oral soothing device and was hollering again. R7 repeatedly hollered in her room. At 2:57 p.m., NA-E sat down at the desk, didn't approach either resident and was working on the electronic tablet. R31 and R7 continued hollering. During an interview on 8/4/26 at 3:07 p.m., NA-A stated R31 yelled and screamed all day, every day. Sometimes R31 was quiet in the mornings but by 2:00-3:00 p.m., R31 hollered until she went to bed at 7:00 p.m. After that, R31 tended to be (continued on next page)		

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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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to ensure a resident was free from a significant medication error when a registered nurse (RN) administered 5 milligrams (mg) of morphine sulfate instead of the prescribed 2 mg dose for 1 of 1 resident (R43) reviewed for medication administration. Findings include: R43's significant change Minimum Data Set (MDS) dated [DATE] identified R43 had severe cognitive impairment and diagnoses that included Alzheimer's disease, coronary artery disease, and dementia. R43's physician orders dated 7/30/26 identified the following: morphine sulfate concentrate oral solution 100 mg/5 milliliters (mL): place and dissolve 2 mg (0.1 mL) buccally (between the gum and inner lining of the cheek) every four hours for pain. morphine sulfate concentrate oral solution 100 mg/5 mL: place and dissolve 5 mg (0.25 mL) buccally every hour as needed (PRN) for breakthrough moderate to severe pain rated 4-10 out of 10 or shortness of breath. R43's electronic medication administration record (EMAR), reviewed on 8/5/26, identified R43 received the scheduled 2 mg (0.1 mL) dose of morphine sulfate at 4:00 p.m. The EMAR further identified R43 had not received a PRN dose of 5 mg (0.25 mL). During an observation on 8/3/26 at 4:04 p.m., RN-B withdrew 0.25 mL (5 mg) of morphine sulfate concentrate 100 mg/5 mL using the syringe provided with the medication. RN-B brought the medication into R43's room and administered the medication buccally. RN-B returned to the medication cart, removed the narcotic record book from the drawer, and documented that 0.1 mL of morphine sulfate had been administered. RN-B stated she administered 0.25 mL to R43 because the medication box label identified 0.25 mL. RN-A stated she was the unit manager and R43's medication order had recently changed. RN-A stated 0.1 mL was the correct dose. However, RN-B explained and confirmed to RN-A that she had administered 0.25 mL. RN-A stated, That's an error, and asked whether R43 was okay. RN-A and RN-B assessed R43 following the medication error. R43's vital signs and condition were unchanged. RN-A stated when a medication dose changed, a sticker should have been applied to the medication label to ensure staff double-checked the dose. RN-A stated a medication error report would be completed and the director of nursing (DON) would be notified. During a telephone interview on 8/5/26 at 10:54 a.m., RN-E stated she was notified of R43's medication error on 8/3/26 at approximately 4:45 p.m. RN-E stated because R43 had been routinely receiving morphine sulfate, the medication error was not a concern that required further evaluation. During an interview on 8/5/26 at 11:52 a.m., the DON stated RN-A reported the medication error immediately after it occurred. The DON spoke with RN-B, who acknowledged the error. RN-B received education regarding the importance of completing the five rights of medication administration: right resident, right medication, right dose, right route, and right time. The DON stated RN-B followed the directions on the medication label; however, facility policy required staff to follow the EMAR. The DON sent an alert to all trained medication aides (TMAs) and nursing staff and provided facility-wide education. The DON stated she expected staff to follow facility policy to ensure resident safety. During a telephone interview on 8/5/26 at 12:36 p.m., the administrator stated she expected staff to follow facility policy for medication administration to ensure resident safety. During a telephone interview on 8/5/26 at 1:11 p.m., the consultant pharmacist stated R43 could have experienced increased drowsiness from the medication error but did not expect adverse effects because R43 had already been receiving morphine sulfate. The consultant pharmacist stated staff were expected to follow facility policy to ensure medications were administered safely. The facility's Liquid Narcotic Administration Policy, revised 1/2025, identified the purpose of the procedure was to provide guidelines for the safe administration of oral liquid narcotic medications. The policy directed (continued on next page)		

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	staff to:Verify there was a physician's order for the medication to be administered.Review the resident's care plan for special needs.Assemble necessary equipment and supplies.Place the EMAR within easy viewing distance.Unlock the medication cart and narcotic drawer.Select the medication from the medication cart.Check the medication label and confirm the medication and dose with the EMAR.Prepare the correct dose of medication. When using a syringe, staff were required to use the syringe provided with the medication and draw up the correct amount. An ordered amount of less than 5 cubic centimeters (cc) required use of a syringe.Contact hospice for approval of an initial hospice medication dose; subsequent doses did not require approval unless otherwise indicated.Check the narcotic record against the previous drug count and medication supply and report discrepancies to the DON and complete an incident report for errors.		

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to ensure a medication label accurately reflected the current physician-ordered dose for 1 of 1 resident (R43) reviewed for medication labeling. The incorrect label contributed to R43 receiving 5 milligrams (mg) of morphine sulfate instead of the prescribed 2 mg dose. Findings include: R43's significant change Minimum Data Set (MDS) dated [DATE] identified R43 had severe cognitive impairment and diagnoses that included Alzheimer's disease, coronary artery disease, and dementia. R43's physician orders dated 7/30/26 identified the following: morphine sulfate concentrate oral solution 100 mg/5 milliliters (mL): place and dissolve 2 mg (0.1 mL) buccally (between the gum and inner lining of the cheek) every four hours for pain. morphine sulfate concentrate oral solution 100 mg/5 mL: place and dissolve 5 mg (0.25 mL) buccally every hour as needed (PRN) for breakthrough moderate to severe pain rated 4-10 out of 10 or shortness of breath. During an observation on 8/3/26 at 4:04 p.m., registered nurse (RN)-B withdrew 0.25 mL (5 mg) of morphine sulfate concentrate 100 mg/5 mL using the syringe provided with the medication. RN-B brought the medication into R43's room and administered the medication buccally. RN-B returned to the medication cart, removed the narcotic record book from the drawer, and documented the date, time, and that 0.1 mL of morphine sulfate had been administered. RN-B stated she administered 0.25 mL to R43 because the medication label identified 0.25 mL. RN-A stated she was the unit manager and R43's order had recently changed. RN-A stated 0.1 mL was the correct scheduled dose. However, RN-B explained and confirmed to RN-A that she had administered 0.25 mL. RN-A stated, That's an error, and asked whether R43 was okay. RN-A and RN-B assessed R43 following the medication error. R43's vital signs and condition remained unchanged. RN-A stated when a medication dose changed, a sticker should be applied to the medication label to alert staff to the change and ensure staff double-checked the dose. RN-A stated a medication error report would be completed and the director of nursing (DON) would be notified. R43's morphine sulfate concentrate oral solution 100 mg/5 mL medication label directed staff to place and dissolve 5 mg (0.25 mL) buccally every four hours for pain. The medication label did not reflect R43's current scheduled physician order for 2 mg (0.1 mL) every four hours for pain. No sticker or other notification identifying the change in the scheduled dose was attached to the medication. During an interview on 8/5/26 at 11:52 a.m., the DON stated RN-B followed the directions on the medication label and there was no sticker attached to the medication to alert staff that the dose had changed. The DON stated facility-wide education was provided and staff were expected to follow facility policy to ensure resident safety. During a telephone interview on 8/5/26 at 12:36 p.m., the administrator stated she expected staff to follow facility policy for medication administration to ensure resident safety. During a telephone interview on 8/5/26 at 1:11 p.m., the consultant pharmacist stated facility staff were expected to follow facility policy to ensure medications were administered safely. The facility's General Medication Pass Policy, revised 1/2025, directed staff to read medication labels three times before dispensing medications and follow the six rights of medication administration, including the right dose and right documentation. The policy did not identify a process for ensuring medication labels were updated or otherwise modified when a physician's medication order changed.		

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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 interview and document review, the facility failed to maintain a facility-wide infection surveillance system that identified, collected, analyzed, and trended signs and symptoms of possible infections and communicable diseases, including those that did not result in antimicrobial treatment. This deficient practice had the potential to affect all 41 residents who resided in the facility. In addition, the facility failed to ensure enhanced barrier precautions (EBP) were implemented for 1 of 1 resident (R5) reviewed for assistance with activities of daily living (ADLs) and wound care. Findings include: SURVEILLANCE: The facility's infection surveillance line list dated May 2026 identified resident name, location, infection date, infection type, diagnosis, medication, provider, outcome, resolution date, and bacteria. The line list identified two lower respiratory infections, two cases of cellulitis, one oral infection, one episode of diarrhea with incontinence, one pyelonephritis (kidney infection), two yeast infections, and one wound infection. All infections identified on the May 2026 line list were treated with antimicrobial medications. The line list did not identify signs or symptoms of possible infections or communicable diseases that did not result in antimicrobial treatment or viral illnesses. The facility's infection surveillance line list dated June 2026 identified resident name, location, infection date, infection type, diagnosis, medication, provider, outcome, resolution date, and bacteria. The line list identified one fungal infection, one lower respiratory infection, one wound infection, two cases of cellulitis, three urinary tract infections, and one case of anaplasmosis (a tick-borne disease caused by the bacterium <i>Anaplasma phagocytophilum</i>). The line list did not identify signs or symptoms of possible infections or communicable diseases that did not result in antimicrobial treatment or viral illnesses. The facility's infection surveillance line list dated July 2026 identified resident name, location, infection date, infection type, diagnosis, medication, provider, outcome, resolution date, and bacteria. The line list identified one case of cellulitis, five urinary tract infections, and one case of shingles. The line list did not identify signs or symptoms of possible infections or communicable diseases that did not result in antimicrobial treatment or untreated viral illnesses. The facility's infection surveillance line list for August 2026 was requested but was not received. During an interview on 8/5/26 at 11:29 a.m., the director of nursing (DON) stated she had served as the facility's infection preventionist (IP) since January 2026. The DON stated she tried to review antibiotics that had been ordered and entered into the facility's system weekly. Once each month, the DON gathered the infection information for review at the Quality Assurance and Performance Improvement (QAPI) meeting. The DON stated the facility planned to transition to a different dashboard portal in September 2026, (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	which would make the surveillance process smoother. The DON had not completed the infection surveillance tracking for August 2026 because she generally collected the information during the first week of the following month. The DON stated when an antibiotic was initiated, nursing staff were responsible for beginning antibiotic monitoring. At times, a medical provider requested infection monitoring before a medication was ordered. Nursing staff were also expected to enter a nursing progress note for signs and symptoms of infection, and those notes were reviewed during interdisciplinary team (IDT) meetings. Although the DON stated infection information was reviewed during IDT meetings, the facility was unable to provide IDT meeting documentation demonstrating the review, analysis, or trending of infection surveillance information. The DON stated she did not track signs or symptoms of possible infections when the symptoms did not result in treatment, such as common cold symptoms. The DON acknowledged that tracking those signs and symptoms and conducting infection surveillance in the moment would allow staff to identify possible infections and take measures to prevent the potential spread of infection. During a telephone interview on 8/5/26 at 12:36 p.m., the administrator stated tracking and trending infection information in the moment allowed staff to identify infections and prevent the potential spread of infection. The facility's undated Infection Surveillance Overview policy identified infection prevention began with routine and ongoing surveillance to identify possible communicable diseases or infections before they could spread to other persons in the facility or potentially cause an outbreak. The policy identified the facility had established a system, based on national standards of practice and the facility assessment, to closely monitor all residents who exhibited signs or symptoms of infection through ongoing surveillance. The surveillance system was to include a systematic method for collecting, analyzing, and interpreting data, followed by dissemination of the information to identify infections, infection risks, and outbreaks to individuals who could improve outcomes. The policy identified the intent of surveillance was to identify possible communicable diseases or infections before they could spread to other persons in the facility. Surveillance was identified as crucial to promptly identifying possible clusters, changes in prevalent organisms, or increases in infection rates. Surveillance results were to be used to plan infection control activities, determine the need for corrective action, direct in-service education, and identify individual resident problems requiring intervention. EBP: R5's significant change Minimum Data Set (MDS) dated [DATE] identified the assessment was completed due to R5's admission to hospice care. R5 had intact cognition and was dependent with most activities of daily living (ADLs), including dressing, grooming, and toileting. R5 was dependent with transfers and unable to ambulate. R5 had an indwelling Foley catheter and was always (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	incontinent of bowel. Diagnoses included right above-the-knee amputation, heart failure, chronic obstructive pulmonary disease (COPD), diabetes, anxiety, and a history of transient ischemic attack and cerebral infarction (stroke). R5's care plan, revised 7/13/26, identified R5 had an indwelling urinary catheter. Interventions directed staff to position the catheter bag and tubing below the level of the bladder, change the catheter every four weeks and as needed, and monitor and document intake and output according to facility policy. R5 had actual impairment to skin integrity. Staff were directed to elevate R5's heels while in bed, encourage good nutrition and hydration, keep R5's skin clean and dry, observe for signs of infection, and use a pressure-relieving mattress in bed and cushion in the chair. Staff were directed to assist R5 with morning and evening care. R5 required total assistance of one staff member with dressing and grooming. During an observation on 8/4/26 at 9:59 a.m., registered nurse (RN)-E and hospice aide (HA)-D assisted R5 with a bed bath. An EBP sign was posted outside R5's room and directed staff to wear gloves and a gown when assisting R5 with ADLs, including bathing, dressing, grooming, transfers, catheter care, and wound care. A personal protective equipment (PPE) cart was located in the hallway immediately next to R5's door and contained disposable gowns and gloves. A large, dark gray, round bin was located inside R5's room and contained used gowns. RN-E and HA-D wore disposable gloves but did not wear gowns while providing R5's care. RN-E applied a clean, self-adhesive dressing over an ulcer on R5's lower right buttock. A second clean, self-adhesive dressing was observed directly above the buttock wound covering R5's coccyx wound and was dated with RN-E's initials and the current date. RN-E and HA-D then assisted R5 into a pair of jeans. HA-D emptied the wash basin into the sink, removed her gloves, and washed her hands. RN-E removed her gloves, applied alcohol-based hand rub (ABHR), and began completing a nursing assessment with R5. A joint interview was conducted with HA-D and RN-E on 8/4/26 at 10:05 a.m. HA-D stated she had not worn a gown over her clothing while assisting R5 with his bed bath that morning. HA-D stated she thought a disposable gown was required only when providing catheter care. HA-D stated the facility had never instructed her to wear PPE when providing care to a resident on precautions. RN-E stated she also thought PPE was required only when providing catheter care and stated the facility had never instructed her regarding when PPE was required when caring for residents on EBP. RN-E acknowledged she should have worn a gown while assisting R5 with care and dressing changes. During a telephone interview on 8/5/26 at 11:09 a.m., the administrator stated the facility took EBP very seriously and routinely completed audits to ensure staff compliance. The administrator stated she did not think facility staff were aware the hospice staff were not following EBP guidance because clear signage was posted on residents' doors to direct staff regarding required precautions. The administrator stated the hospice staff were educated and the problem was corrected. During an interview on 8/5/26 at 12:21 p.m., the director of nursing (DON) stated residents who required EBP had signage posted on their doors that clearly instructed staff regarding the PPE (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	required when providing care. The DON stated she educated the staff involved and reviewed EBP and contact precautions with them. The facility's Enhanced Barrier Precaution policy dated April 2025, identified EBP was an infection prevention intervention requiring gown and glove use during specified high contact resident care activities to reduce multi drug resistant organisms (MDRO) spread. The policy applied to all staff, contractors, consultants, students, volunteers, residents and visitors within the facility managed communities and across all applicable licensure types. High contact activities when EBP was required included dressing, bathing, transferring, hygiene assistance, changing linens or briefs, toilet assistance, wound care and care or use of indwelling medical devices. Donning of gown and gloves would be required immediately before performing high contact resident care activities. The facility's Hospice and Nursing Facility Services Agreement, dated 6/10/25, identified the facility would institute, implement, and maintain administrative policies, procedures, and patient care protocols in accordance with recognized professional standards of care and as necessary to implement the provisions of the agreement.		