STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245425	A. Building B. Wing	01/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Thorne Crest Retirement Center	1201 Garfield Avenue Albert Lea, MN 56007

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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 - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to provide sufficient staffing to ensure residents received care and assistance in a timely manner, when 15 of 47 residents (R3, R5, R7, R13, R15, R17, R22, R24, R25, R28, R34, R36, R39, R43, R47) reviewed for sufficient staffing, experienced excessively long call light wait times, and/or missed breakfast, or experienced a delay in getting to breakfast or delay in receiving care. This deficient practice had the potential to affect all 47 residents who resided in the facility. Findings include: Refer to F676- Based on observation, interview, and document review, the facility failed to provide assistance to complete personal hygiene care for 1 of 1 resident (R3) reviewed who needed assistance with fingernail care. Refer to F677 – Based on observation, interview and document review, the facility failed to provide timely toileting for 1 of 1 resident (R36) who was dependent upon staff for assistance with activities of daily living (ADL). Refer to F684 – Based on observation, interview, and document review, the facility failed to ensure necessary care and services were provided for 1 of 1 resident (R2) reviewed for non-pressure skin concerns, when staff failed to appropriately assess, treat, and manage bilateral lower-extremity wounds. This included failure to timely notify the provider and obtain and implement wound care orders following a change in skin condition, and failure to ensure wound care was provided as needed. These failures resulted in R2 going multiple days without wound care and placed the resident at risk for worsening skin breakdown, infection, and complications related to delayed treatment. Further, the facility failed to complete and monitor daily weights, monitor blood pressures, and administer medications in accordance with provider-prescribed blood pressure parameters and treatment orders for 1 of 1 resident (R2) reviewed for edema. In addition, the facility failed to follow physician orders for obtaining daily weights and applying elastic compression bandages to legs for 1 of 1 resident (R26), reviewed for edema. MDS/Care plan: R3's quarterly Minimum Data Set (MDS) dated [DATE], indicated R3 was cognitively intact, no rejection of care, utilized a wheelchair, required substantial/maximal assistance with personal hygiene, upper body dressing, dependent on staff for toileting hygiene and transfers; diagnoses included hemiplegia or hemiparesis, depression, dependence on renal dialysis. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	R3's care plan dated 1/2/26, mobility needs assist with transfers and bed mobility due immobility related to right side hemiparesis, chronic renal disease, severe malnutrition, and mild cognitive impairment unable to ambulate. R5's quarterly MDS assessment dated [DATE], indicated moderately impaired cognition, clear speech, could understand and be understood. R5 required substantial assistance or was dependent upon staff for most activities of daily living (ADLs), including wheelchair mobility. R5 did not walk. R7's quarterly MDS dated [DATE], indicated no cognitive impairment, utilized a wheelchair, independent with eating, dependent on staff for toileting, dressing, personal hygiene, and transfers. R13's admission MDS dated [DATE], indicated intact cognition, use of wheelchair, partial/moderate assistance with personal hygiene, dependent for toileting hygiene and lower body dressing. R15 quarterly MDS dated [DATE], indicated cognitively intact, utilized a wheelchair, supervision or touching assistance with eating, dependent on staff for toileting, dressing, toilet transfer, and chair/bed-to-chair transfer. R15's care plan dated 12/10/25, at risk for injury related to history of falls, poor balance, unsteady gait d/t (due to) decline in physical function, provide 2 assist transfer at night d/t increased weakness I need assist with ambulation, transfers, and bed mobility due to weakness and cognitive impairment, able to feed myself independently, following staff setup, need cues from staff at times for eating, staff to provide setup assist with feeding, set up tray; pour liquids, cut foods, and apply condiments with each meal, eating: sit at feeder table, supervision and cuing, bring to dining room, staff to sit with resident and provide cueing and assistance as needed. R15's nutrition - amount eaten- document amount ate for all meals dated 1/26/26, failed to indicate R15 ate breakfast. R17's quarterly MDS dated [DATE], indicated severe cognitive impairment, utilized a wheelchair, required supervision or touching assistance with eating, substantial/maximal assistance with transfers. R17's care plan dated 12/29/25, nutritional status at risk for wt (weight) loss due to poor PO (oral) intake, limited to extensive assistance with feeding at all meals, staff to provide total assistance with eating and drinking food and fluids at meals toilet hygiene, toilet every 2-3 hours assist onto toilet upon rising, before/after meals and before bedtime mobility: need assist with ambulation, transfers, and bed mobility due to dementia and weakness. R17's nutrition - amount eaten- document amount ate for all meals dated 1/26/26, failed to indicate R17 ate breakfast. R22's annual MDS dated [DATE], indicated moderately impaired cognition. R24's annual MDS dated [DATE], indicated R24 was cognitively intact, no behaviors, no rejection of care, utilized a walker and wheelchair, required partial/moderate assistance with toileting hygiene, personal hygiene, dressing, toilet transfer, chair to bed transfer, independent with sit to lying and rolling. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	R24's care plan dated 1/2/26, indicated mobility: minimal assist with transfers and bed mobility due impaired mobility related to Rheumatoid Arthritis, will self-transfer a lot of times without asking for assistance. R25's quarterly MDS dated [DATE], indicated no cognitive impairment, utilized a wheelchair, independent with eating, dependent on staff for toileting, dressing, and transfers. R25's care plan dated 12/19/25, indicated mobility: assist with transfers and bed mobility due limited mobility provide assistance with bed mobility as necessary chair / bed-to-chair transfer- dependent with hoyer lift (mechanical equipment) and 2 assist, every 2-3 hours in chair and in bed. R28's quarterly MDS dated [DATE], indicated R28 had severe cognitive impairment, utilized a wheelchair and walker, independent with eating, required partial/moderate assistance with lying to sitting, sit to stand. R28's care plan dated 11/24/25, falls: at risk for injury due to weakness, poor safety awareness related to cognitive impairment and a history of falls, will self-transfer without waiting for staff assistance. falls intervention: keep w/w (wheeled walker) within reach at all times as patient will self-transfer, ambulate and toilet regardless of if w/w is in reach, evening shift to check at end of shift mobility, need assist with ambulation, transfers, and bed mobility due weakness, tend to self transfer myself without putting on call light d/t (due to) cognitive impairment, eating: independent after set-up R34's quarterly MDS dated [DATE], indicated R34 was rarely/never understood, utilized a wheelchair, required setup or clean-up assistance with eating, substantial/maximal assistance with toileting, dressing, and transfers. R34's care plan dated 12/29/25, dietary dx (diagnosis) w/Parkinson's disease, with altered mental status and dementia.currently eating adequately but am at risk for wt loss as I decline; staff to provide setup assist with feeding, provide verbal cues, set up tray; pour liquids, cut foods, and apply condiments with each meal, encourage consumption of meals and assist as needed. R36's significant change MDS dated [DATE], indicated severe cognitive impairment, clear speech, rarely/never understood, usually understands. R36 was dependent upon staff for activities of daily living (ADLs) or required substantial assistance, did not walk. R36's care plan with revised date of 10/21/25, indicated R36 was incontinent of bladder and bowel and required assistance with toileting due to Alzheimer's disease, put on the toilet at these time frames: 5:00 a.m., upon rising, before/after meals, and HS (bedtime). R36's nutrition - amount eaten- document amount ate for all meals dated 1/26/26, failed to indicate R36 ate breakfast. R39's annual MDS dated [DATE], indicated severe cognitive impairment, utilized a wheelchair, supervision or touching assistance with eating, dependent on toileting, activities of daily living, sit to stand transfers, toilet transfers, and bed to chair transfer. R39's care plan dated 10/22/25, indicated am incontinent of bowel and bladder. need assistance with toileting tasks due to impaired cognition staff assist per mobility care plan for resident to transfer to (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	the toilet, check and change every (2-3 hours)- document refusals. mobility: need assist with transfers and bed mobility due weakness, immobility, and impaired cognition, unable to ambulate anymore, too weak to wheel myself in a regular wheelchair, chair / bed-to-chair transfer: dependent assist of two staff with use of EZ stand, use total lift if tired/weak. R39's nutrition - amount eaten- document amount ate for all meals dated 1/26/26, failed to indicate R39 ate breakfast. R43's quarterly MDS dated [DATE], indicated moderately impaired cognition, utilized a wheelchair, required supervision or touching assistance with eating, dependent on transfers, and substantial/maximal assistance with personal hygiene. R47's admission MDS assessment dated [DATE], indicated moderately impaired cognition, use of wheelchair, lower extremity impairment on one side, dependent for toileting hygiene, upper and lower body dressing, and substantial/maximal assistance for personal hygiene. Resident and Family Observations and Interviews: On 1/20/26 at 12:53 p.m., with R5 and family member (FM)-F, stated R5 used his call light to get in and out of bed; he required use of a lift, and it took two staff. FM-F stated sometimes it took over an hour for staff to respond and sometimes they would come into R5's room and shut the light off saying they would be back, but don't come back. FM-F stated, Everyone in here, meaning family members, complained about how long it took for staff to answer call lights, adding they were short staffed, and it was worse around mealtimes. FM-F stated, you don't want to use the call light at shift change in the afternoon as it took an especially long time. On 1/20/26 at 1:02 p.m., R3 was observed lying in bed and stated he required two staff to transfer from his wheelchair to bed. R3 stated that after breakfast he waited approximately two hours by the dining room door to be assisted back to his room. R3 reported he asked for help and observed two or three women walk by, but staff did not return with the required two-person assistance. R3 stated this situation happens every day. R3 further stated he did not attend lunch because it takes too long to get back to my room after lunch, and indicated prolonged wait times contributed to his decision not to attend lunch. On 1/20/26 at 2:03 p.m., R7 stated he waits almost daily for 30 or more minutes for assistance to get out of bed to use the bathroom and reported delays were worse around mealtimes. R7 stated there had been no management follow through regarding his concerns and reported weekends were worse due to agency staff unfamiliar with resident routines and equipment. R7 stated he had brought concerns to social services (SS)-A but reported no follow through. On 1/20/26 at 2:23 p.m., R13 stated she had to wait a long time for help from staff and sometimes had to have a bowel movement and did not make it in time because staff took too long. R13 further stated some days she did not go down to the dining room to eat because there were not enough staff to bring her back to her room so she would have to wait over an hour to get back to her room after meals. On 1/20/26 at 2:49 p.m., R47 stated it took a long time for staff to come when he turned his call light on. R47 stated he had to have a bowel movement in his brief while in bed because they did not come in time and he did not like having accidents in his brief. R47 further stated he had got used to telling (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	the staff they better come quickly or they were going to be cleaning up a mess. On 1/20/26 at 7:49 p.m., the director of nursing (DON) was observed assisting R34 into his room via wheelchair and confirmed evening cares were delayed. The DON stated R34 typically went to bed at 7:00 p.m. On 1/26/26 at 11:03 a.m., R15 was observed seated in a wheelchair in the day room and stated she was hungry. LPN-A asked whether she wanted breakfast or preferred to wait for lunch since it was almost lunchtime. R15 stated she had not eaten breakfast and would wait for lunch. LPN-A stated R28 had just come to the day room and had not eaten breakfast and had gotten up late due to staffing shortages. Staff Interviews: During an interview on 1/20/26 at 7:28 p.m., LPN-A stated the facility had staffing issues and stated, we just don't have enough staff. LPN-A reported there were not enough nursing staff or nursing assistants (NAs) to meet resident needs including toileting, timely morning and bedtime cares, and answering call lights. LPN-A stated the facility was expected to have six NAs on the evening shift; however, only four NAs were present. LPN-A stated with only four NAs, residents were not assisted timely. LPN-A reported a resident fall earlier that day due to insufficient staff and stated falls had increased due to inadequate staffing and increased use of agency staff unfamiliar with residents' needs. LPN-A confirmed residents were not toileted timely and toileting schedules were not consistently followed unless residents requested assistance or exhibited behaviors. During an interview on 1/21/26 at 8:40 a.m., nursing assistant (NA)-H (agency) stated it was a good place to work but changes could be made. NA-H stated residents got left in bed for long periods, there should be more staff, so much going on, frequently need two NAs in a room and that makes other residents wait. HA-H stated there were a lot of call-in's – both employed staff and agency staff. NA-H stated she left work in tears the day prior because she had 11 residents by herself and six were two-person assists or mechanical lifts. NA-H stated the facility no longer provided walkie-talkies in order to communicate and had spent up to 15 minutes looking for another NA to help her. HA-H stated it was not uncommon for residents to miss breakfast because there was no one to get them up. By the time they did get up, it was almost lunchtime. On the night shift, NAs were supposed to reposition and check/change residents every two hours. NA-H stated there were only two NAs to do that and staff were lucky if they got two or three residents done, adding there were lot of residents with soaked beds in the morning. NA-H stated the evening shift NA's put residents to bed after supper and wasn't sure how often they were checked on. When the night shift came on duty and started rounds, they immediately had to change residents and soiled bedding. The day prior, NA-H asked registered nurse (RN)-A for help and her reply was, I don't understand what's going on – it's like that every day. NA-H took that to mean, what's the big deal – it's like this every day. NA-H stated employed staff were told by the director of nursing (DON) that other facilities of a similar size had the same amount of staffing, so we had nothing to complain about. NA-H stated she doubted the number of residents who were two-person assist had been included in the comparisons. During an interview on 01/21/26 at 11:28 a.m., NA-M stated the facility was expected to have six NAs on day shift but usually only had four or five due to call-ins that were not filled. NA-M stated with only four NAs, resident care was delayed, including answering call lights, toileting residents, and providing meals timely. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 1/21/26 at 12:57 p.m., registered nurse (RN)-B stated the facility was frequently short staffed and reported there were too many tasks assigned to nursing staff to provide adequate resident care. RN-B stated nursing staff were responsible for medication administration, treatments, documentation, processing and entering physician orders, admissions, and responding to incidents, in addition to providing direct resident care. RN-B stated due to the volume of assigned duties and limited staffing, nursing staff were not always able to provide care in a timely manner. RN-B stated tasks were prioritized, which resulted in delays in treatments, answering call lights, and assisting residents with toileting and other care needs. RN-B indicated the current staffing levels and workload made it difficult to meet residents' needs consistently and adequately. During an interview on 1/21/26, at 1:30 p.m., health unit coordinator (HUC)-E, who was also the nursing staff scheduler, described her role in scheduling nursing staff and the process in completing schedules, filling open shifts, managing call-ins. HUC-E stated there had been a lot of call-ins by both employed and agency NAs. HUC-E stated while the facility had been gradually hiring more nurses and NAs, agency use was still high. HUC-E stated with each call in, they attempted to fill the shift with employed or agency NAs During an interview on 1/21/26 at 3:13 p.m., RN-C stated nursing staff were responsible for medication administration, treatments, paperwork, order entry, and admissions. RN-C stated staff did not always have time to provide timely treatments due to administrative workload. RN-C stated there were increased falls due to staff not being able to answer call lights timely or round regularly. During an interview on 1/21/26 at 1:46 p.m., the assistant director of nursing (ADON) stated floor nursing staff were responsible for medication administration, treatments, entering and processing orders, admissions, and managing incidents. The ADON stated due to workload demands, delays in care and untimely processing of orders were not uncommon. The ADON stated resident cares were rushed and nursing staff did not have dedicated time to process orders. The ADON reported nursing staff had brought concerns to leadership regarding inability to complete assigned tasks; however, there had been no change. The ADON stated a previous desk nurse position that assisted with order entry had been eliminated. The ADON further stated agency staff frequently worked in the facility and were not always familiar with resident routines, contributing to delays in care. During interview on 1/21/26 at 3:13 p.m., RN-C stated nursing staff were responsible for medication administration, treatments, paperwork, order entry, and admissions. RN-C stated staff did not always have time to provide timely treatments due to administrative workload. RN-C stated there were increased falls due to staff not being able to answer call lights timely or round regularly. During further interview on 1/21/26 at 4:15 p.m., with ADON stated after hours when the facility receptionist was off duty, the caller would be prompted to make a selection. If the caller selected the health care wing, the call went to the nurse's station. If no one answered, the caller could leave a message. ADON nurses were responsible to answer the phone if able but usually did not have time. Together with ADON looked to see how many voicemail messages were on the phone at the nurse's station. There had been 61 messages. RN-A stated nurses did not have time to listen to messages and return calls, and agency nurses would not know how. ADON had been unaware of the number of messages on the phone and didn't know how far back they went. ADON admitted many of the calls were likely from family requesting an update on their family member. During interview on 1/21/26 at 4:55 p.m., LPN-A stated evening cares were delayed due to staff shortages and lack of staff familiar with resident routines. LPN-A stated there were more falls in the (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	morning due to staffing shortages and agency staff not familiar with residents, resulting in residents attempting to self-transfer due to delayed rounding. During interview on 1/26/26 at 10:46 a.m., NA-F and NA-E stated they had not gotten R36 up yet for the day nor did he have breakfast. NA-F stated an agency NA called in so they were working short. Both NA-F and NA-E explained most of their residents required two staff assist. Between them, they had 10 residents requiring two NAs to get them up, dressed and to breakfast which took could take up to an hour. Both NA-F and NA-E stated it was not uncommon for residents to be gotten up late and miss breakfast – they could only do so much. NA-F stated when they had brought up the difficulty in getting their work done timely, the DON told them she had called other nursing homes, and no one was staffed better and that they were appropriately staffed. During interview on 1/26/26 at 10:58 a.m., HUC-E, who also served as the scheduler, stated she became aware of a staff shortage at 6:30 a.m. and reported six NAs were scheduled; however, only three were present until approximately 7:30 a.m. The HUC confirmed the facility was short staffed that morning. During interview on 1/26/26 at 10:54 a.m., NA-E stated residents were not provided breakfast on time and reported some residents had not yet eaten due to short staffing. NA-E stated all residents would have been expected to have eaten breakfast by that time. During interview on 1/26/26 at 1:00 p.m., NA-F confirmed the following residents did not receive breakfast: R17, R39, R43, R15, and R36. NA-F reported delays in breakfast service and stated R24 ate at 9:30 a.m., and R28, R25, and R34 ate at 10:00 a.m. During interview on 1/26/26 at 2:35 p.m., RN-K stated they were an agency staff who worked consistently at the facility, and stated they mainly worked the overnight shift and would frequently pick up and work a double shift during the day due to the shortage of staff. RN-K stated on overnights there was only one nurse for 48 residents and stated one nurse was not enough staff especially since they were agency staff and not familiar with the routines of the facility. RN-K stated the overnight nurse was responsible for medication administration, processing orders, stocking medications in the cart and further stated the facility had frequent falls and incident reports and stated one nurse on overnights was not enough staff to provide adequate resident care. Resident Council: During resident council interview on 1/21/26 at 2:13 p.m., R25 stated she had to wait one to two hours for her light to be answered sometimes. R7 stated he had to wait up to one hour, there was so much turnover of staff and the staff did not know the resident routines, so everything took longer. R22 stated a lot of agency staff was used and there were always new faces who did not know the routine. Call Light Response Times : Call light logs were requested for residents/resident representatives who reported long call light wait times. Logs indicated many instances of call light response times ranging from 20 minutes to over an hour. R25 (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Time frame 12/22/25 through 1/20/26. Call light activated 110 times, which indicated the following: 20-30 minutes = 9 x 31-40 minutes = 15 x 41-50 minutes = 1 x R13 Time frame 12/22/25 through 1/20/26. Call light activated 87 times, which indicated the following: 20-30 minutes = 9 x 31-40 minutes = 2 x 41-50 minutes = 2 x >60 minutes = 2 x R47 Time frame 1/9/26 through 1/20/26. Call light activated 90 times, which indicated the following: 20-30 minutes = 3 x 31-40 minutes = 9 x 41-50 minutes = 1 x >60 minutes = 1 x R7 Time frame 12/22/25 through 1/20/26. Call light activated 917 times, which indicated the following: 20-30 minutes = 72 x 31-40 minutes = 28 x 41-50 = minutes = 7 x 51-60 minutes = 3 x > 60 minutes = 5 x R5 Time frame 12/22/25 through 1/20/26. Call light activated 370 times, which indicated the following: (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	20-30 minutes = 28 x 31-40 minutes = 12 x 41-50 minutes = 10 x > 60 minutes = 5 (all were over 75 minutes) R3 Time frame 1/5/26 through 1/20/26. Call light activated 416 times, which indicated the following: 20-30 minutes = 21 x 31-40 minutes = 5 x 41-50 minutes = 3 x 51-60 minutes = 2 x > 60 minutes = 2 x Facility Assessment: Facility assessment updated 7/2025, indicated: Acuity - We have multiple mechanical lifts and multiple people with behavior issues and heavy load of hospice care. The assessment indicated 37 residents were dependent upon staff for ADLs (activities of daily living), and 10 were on hospice. Staffing parameters were an estimated range used for staffing consideration; individual extenuating circumstances e.g. needing one on one and would be reviewed and determined how to add additional staff. Staffing continued to be a challenge. The facility utilized an agency to help provide care and to prevent staff burn-out. Bonuses were used to attract new staff. Local recruitment fairs were attended by staff to promote the facility to possible new hires. Facility was engaged with ProCare to help with recruitment. The facility assessment identified a section titled Orientation which included 36 topics to be covered for all nurses and NAs. During an interview on 1/22/26 at 10:40 a.m. the DON and RN-D known as regional director of clinical services were informed of findings related to sufficient staffing and long call light response times. The DON stated the facility was appropriately staffed with nurses and NAs; she had called other facilities and their staffing was comparable. The DON stated the facility staffed according to PPD (per patient day) and did not adjust for the number of two-staff assists. The DON was informed that according to NAs on duty, 50% of their residents required a two-staff assist. In addition, the DON was informed the facility assessment updated July 2025, indicated, We have multiple mechanical lifts and multiple people with behavior issues and heavy load of hospice care. The DON acknowledged that was true. The DON was informed of observations including facility layout (significant distance staff were required to cover), no hand-held devices for staff to communicate when help was needed, and the number of two-staff assists made it a challenge for staff to complete their work timely. Further, the DON was informed of the long call light response times that were identified with review of call light logs. The DON was unaware of the call light response times, and stated their goal was to answer call lights in under five minutes. The DON stated call light response times were discussed at staff (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Thorne Crest Retirement Center	1201 Garfield Avenue Albert Lea, MN 56007

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	huddles and monthly meetings; the DON stated staff were reminded that everyone was to work as a team. If long call lights were identified, the DON stated they looked at what else was going on that day – maybe there was a reason. Requested in writing of the DON on 1/27/26, at 3:55 p.m., and not received: facility staffing plan, including now the number of NAs and nurses were determined for each shift. Facility Call Lights: Accessibility and Timely Response policy with copyright date 2025, indicated all staff members who saw or heard an activated call light were responsible for responding. If the staff member could not provide what the resident desired, the appropriate personnel would be notified.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to ensure 6 of 6 agency staff (nursing assistant (NA)-B, NA-C, NA-D, NA-G and registered nurse (RN)-G, RN-I) and 4 of 4 facility staff (NA-E, NA-J, RN-B, RN-J) received appropriate orientation and training prior to starting their first shift caring for residents. This had the potential to affect all 47 residents who resided in the facility.Findings include: Refer to F760: Based on observation, interview and document review, the facility failed to ensure medications were administered in accordance with prescriber orders when an incorrect dose of losartan (blood pressure medication) was administered incorrectly for three months, constituting a significant medication error for 1 of 5 residents (R44) reviewed for medication administration. Refer to F684: Based on observation, interview and document review, the facility failed to complete and monitor daily weights, monitor blood pressures, and administer medications in accordance with provider-prescribed blood pressure parameters and treatment orders for 1 of 1 resident (R2) reviewed for edema. In addition, the facility failed to follow physician orders for obtaining daily weights and applying elastic compression bandages to legs for 1 of 1 resident (R26), reviewed for edema. Refer to F698: Based on observation, interview, and document, the facility failed to ensure dialysis communication forms were consistently reviewed, addressed, and incorporated into the resident's medical record, and failed to ensure provider orders communicated by the dialysis provider were implemented in a timely manner for 1 of 1 resident (R3) reviewed for dialysis. Orientation Documentation: During an interview on 1/21/26 at 1:30 p.m., health unit coordinator (HUC)-E, who also helped facilitate staff orientation, stated floor staff trained new employees, both hired and agency staff; there wasn't a designated educator. HUC-E stated NAs received five shifts of orientation and nurses received seven shifts. For agency staff, HUC-E stated orientation was guided by an orientation binder at the nurses' desk, and a document titled Agency Staff Orientation Checklist/CNA. Upon review of the NA checklist, the only reference to resident cares included: use of transfer belt/lifts/oxygen, call lights, door codes, walkie talkie, restorative nursing program, vital sign monitor, reporting event to nurses, POC (point of care) charting, mealtime/feeding/water. Nothing regarding how to determine the unique and individualized needs of residents. During an interview on 1/22/26 at 10:04 a.m., with HUC-E, documentation of orientation was requested for the following agency staff and none were available: NA-B, NA-C, NA-D and NA-G, RN-G or RN-I. Personnel files revealed the following employed NAs did not have documentation of orientation: NA-E (hired 6/10/25), and NA-J (hired 9/12/25). The following employed nurses did not have documentation of orientation: RN-J (hired 9/12/25), and RN-B (hired 11/13/25). Resident Interview: R7's quarterly MDS dated [DATE], indicated no cognitive impairment, utilized a wheelchair, independent with eating, dependent on staff for toileting, dressing, personal hygiene, and transfers. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 1/20/26 at 2:03 p.m., R7 stated the facility frequently had agency staff who were not familiar with the facility routines and equipment. R7 stated he had brought concerns to social services (SS)-A but reported no follow through. Staff Interview: During an interview on 1/21/26 at 12:26 p.m., NA-G (agency) stated this was his first day; he arrived 45 minutes early and was shown around by another NA. NA-G received an assignment and was informed how his residents transferred. NA-G stated if he had questions, he would ask staff or residents. NA-G stated he had not been given a document such as a checklist to guide his orientation to ensure necessary topics were covered. During an interview on 1/21/26 at 1:46 p.m., the assistant director of nursing (ADON) stated agency staff frequently worked at the facility and may not be familiar with resident care routines. The ADON stated agency staff were expected to arrive 30 minutes prior to the start of their shift. The orientation process consisted of reviewing a training binder and receiving a list of assigned tasks. The ADON confirmed there was no formal, leadership-directed orientation program or competency-based validation process for agency staff. During an interview on 1/21/26 at 3:13 p.m., registered nurse (RN)-C stated the facility utilized a significant number of agency staff and that it was common for agency personnel to be unfamiliar with resident routines. RN-C confirmed agency staff were not provided with formal training. During an interview on 1/21/26 at 3:50 p.m., when shown the agency orientation binder referenced by HUC-E, NA-D (agency) stated she had never seen the binder before, nor had she completed an orientation checklist when she started on 11/29/25. During an interview on 1/21/26 at 4:55 p.m., licensed practical nurse (LPN)-A stated the facility frequently had more agency nursing assistants than employed staff. LPN-A reported agency staff were not familiar with residents' routines and were not provided formal orientation or training to ensure adequate resident care. During an interview on 1/22/26 at 10:40 a.m. the DON and RN-D know as regional director of clinical services informed of findings related nurse and NA competency, specifically the lack of a comprehensive orientation program for agency nurses and NAs, and some employed nurses and NAs. The facility lacked documentation of orientation to ensure relevant and essential topics were addressed. The DON stated they did not have a consistent person to provide orientation and training to staff. Both the DON and RDCS recognized there was a gap in training and admitted they did not have a comprehensive training process. The DON confirmed the facility utilized a significant number of agency nurses and NAs, and stated, Agency staff were not vested and lacked follow through. The DON stated agency staff came 30 minutes prior to start of shift and staff had them review the agency bible, which the DON described as a very large book which took a lot of time to put together, and which had policies and procedures in it. The DON stated agency staff were supposed to review the binder and ask floor staff if they had questions. The DON stated NAs could review paper copies of the Kardex located in a binder at the nurses station to learn individualized needs of residents. The DON was informed the binder did not have a Kardex for R26, and R36's was from November 2025, and had not been updated with interventions after a recent fall. The DON stated NAs could use their iPad to access resident information, but admitted each NA did not had one, nor did they fit in a pocket for ready access. The DON stated the facility did not utilize paper NA task sheets in order for NAs to (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	have key information about residents at their fingertips. The DON admitted agency and employed NAs did not have tools immediately available to them know about a residents unique and individualized needs. Staff meeting agenda provided by the DON for nurses dated 10/17/25, indicated five nurses in attendance and topic titled, training agency staff indicated: book at desk and then need to be escorted to see where things are and given codes needed. We need to be nice (they are helping us). During an interview on 1/22/26 at 4:10 p.m., NA-J (employed) who had been on orientation and following an agency NA stated she had not been given nor was she utilizing a tool to identify training areas to be covered, such as a checklist. NA-J stated she was on her fourth or fifth orientation shift and was still primarily observing. During an interview on 1/26/26 at 9:03 a.m., RN-B stated they had never received formal training or a competency checklist. RN-B stated that implementation of a formal training process would be helpful to ensure adequate care was provided to residents. During an interview on 1/26/26 at 11:53 a.m., HUC-E stated a nurse on duty was assigned to orientate a nurse and a NA to orientate a NA. When asked if nurses had time to take on this additional responsibility, HUC-E stated staff nurses were relied upon because leadership wasn't in the building from 5:00 p.m. until 8:00 a.m. If nursing staff wasn't compliant in providing orientation they were coached and if it continued, the nurse would get a verbal warning. During the same interview, HUC-E stated staff knew what to go over when orienting agency staff by using the orientation checklist and orientation binder at the nurses station. Together, went to the nurses station to view binder and checklist. HUC-E provided a binder titled, Agency Staff Orientation. The pages included abuse policy, unexplained injuries policy, resident rights, abuse, neglect, mistreatment, theft/misappropriation, PCC (Point Click Care - the facility electronic medical record) documentation, infection control topics, mandated reporting, assignments, HIPAA (Health Insurance Portability and Accountability Act), confidentiality and more. There were blank orientation checklists for NAs inside the binder, but none for nurses. HUC-E provided another binder titled Nursing Helper Binder which was utilized as a quick reference for all nurses (employed and agency) and included documentation guidelines, after hours call coverage, fall reporting, suspected infections, postmortem checklist, psychotic meds, skin issue to do list, bowel and bladder three-day tracking, wandering/elopement and more. HUC-E acknowledged their orientation program could be better, and that a new human resources director started in November 2025, and had planned to improve the orientation process. HUC-E admitted if nurses and NAs were not properly trained, it could pose a safety risk to residents. During an interview on 1/27/26 at 7:45 a.m., RN-E (employed) stated if agency nurses came early, they could provide some training such as care plans, and individual needs of the residents, but they did not come earlier enough to do much training. RN-E stated residents would benefit from that training. RN-E stated there was a binder at the nurses' desk agency nurses were supposed to go through, but Honestly, they don't – there isn't time. RN-E stated she had never seen an orientation checklist for agency nurses, but she had for hired nurses. Requested in writing of the DON on 1/27/26, at 3:55 p.m., the facility policy on orientation and training of nurses and NAs, employed and agency. Not received.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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 observation, interview and document review, the facility failed to ensure complete narcotic and controlled substance reconciliation occurred for two of two medication carts, failed to provide secure storage of disposed medications, and failed to ensure consultant pharmacist involvement and awareness of medication reconciliation and disposal processes. This practice had the potential to affect all 47 residents residing in the facility. In addition, the facility failed to ensure physician-ordered medications were re-ordered timely to prevent delay in administration and reduce the risk of complications for 1 of 1 resident (R26) reviewed for medication administration. Findings include: Refer to F760: Based on observation, interview and document review, and staff interview, the facility failed to ensure medications were administered in accordance with prescriber orders when an incorrect dose of losartan (blood pressure medication) was administered incorrectly for three months, constituting a significant medication error for 1 of 5 residents (R44) reviewed for medication administration. Narcotic and Controlled Substance Reconciliation, Secured Storage of Disposed Medication, Consultant Pharmacist Involvement During interview and observation on [DATE] at 10:42 a.m., registered nurse (RN)-B unlocked a drawer on the healthcare medication cart she was working on and showed 12 tramadol tablets (narcotic pain reliever), seven lorazepam tablets (anti-anxiety medication with risk for dependence and addiction), and 34 oxycodone tablets (narcotic pain reliever) in individual plastic packages laying loose in the drawer. RN-B stated these medications were in the drawer because the resident refused them or the pharmacy had the wrong order and continued to print excess medications. RN-B stated there was always a pile up of medications in the narcotic drawer and confirmed they were not counted during narcotic reconciliation at shift change and were not documented in the narcotic log book. RN-B stated she notified the pharmacy of the excess medications so they could fix the issue but had not heard back from them. RN-B stated RN-A, also known as the assistant director of nursing, was aware of the problem. During interview and observation on [DATE] at 9:35 a.m., RN-A opened a locked drawer on the transitional care unit medication cart and showed two tramadol tablets, seven oxycodone tablets, and 11 lorazepam tablets in individual plastic packages. RN-A stated she would not expect those medications to be loose in the narcotic drawer, would expect them to be counted as part of narcotic reconciliation, and would expect to be notified of excess narcotic medications so something could be done about it. RN-A stated RN-B had made her aware of it a few weeks ago, but she was not aware it was an ongoing problem. RN-A confirmed the loose narcotics were not counted as part of narcotic reconciliation and that could cause risk for drug diversion. During observation on [DATE] at 1:32 p.m., total from the healthcare medication cart and transitional care unit medication cart narcotic drawers contained eight tramadol, nine oxycodone, one lorazepam in individual plastic packages and uncounted with narcotic reconciliation. RN-A confirmed these medications were uncounted during narcotic reconciliation and not identified in the narcotic log book. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During observation on [DATE] at 9:08 a.m., total from the healthcare medication cart and transitional care unit medication cart narcotic drawers contained two oxycodone, three lorazepam, and ten tramadol in individual plastic packages and uncounted with narcotic reconciliation. DON confirmed these medication were uncounted during narcotic reconciliation and not identified in the narcotic log book. During interview on [DATE] at 10:14 a.m., director of nursing (DON) stated she was unaware there were loose, uncounted narcotics in medication carts. She would expect to be made aware, would expect narcotics to be counted as part of narcotic reconciliation to avoid possibility of drug diversion. During continued interview on [DATE] at 9:45 a.m., DON stated the pharmacy machine was only supposed to print what was needed and if it printed extra narcotics, they should be destroyed by two nurses, put in the medication destruction box in the lobby, and then law enforcement would pick up the medications. DON stated it was important for the narcotic medications to be counted and destroyed to avoid drug diversion. During interview on [DATE] at 1:55 p.m., DON stated due to several issues with the facility pharmacy vendor and after hearing of all the medication related concerns she would be switching to a new pharmacy vendor 6/26 and would try to get the switch completed sooner. During interview and observation on [DATE] at 10:04 a.m. assistant director of nursing (ADON) opened the medication storage room. ADON observed five cardboard boxes taped shut stacked against the wall. ADON stated medications were taken from the locked disposal container labeled Healthcare Logistics located in the lobby when the disposal container was full. Boxes were stored in the medication storage room until law enforcement was contacted to pick them up. ADON stated she was not sure the last time law enforcement had been contacted. During observation and interview on [DATE] at 11:46 a.m., DON was shown that the medication disposal container in the lobby was overflowing and was able to reach hands into the disposal box and remove three medication cards and one medication bottle containing intact medications. DON stated she was unaware the disposal was full and could be accessed by anyone in the facility which could cause possibility of unknown drug diversion. Maintenance director detached the disposal box from the wall and moved to a secure area. DON stated she would have expected to have been informed the disposal box was full so it could be emptied. During interview on [DATE] at 1:00 p.m., local law enforcement officer stated he was aware of the medication destruction process at the facility, and he was the one who picked up medications at the facility. Further stated he had not been called for a medication pick up since [DATE]. During interview on [DATE] at 2:14 p.m., consultant pharmacist (CP)-M stated he would expect tramadol, oxycodone, and lorazepam to be reconciled every shift. CP-M stated he did not think it was good practice to take medications out of the medication disposal bin and store them back in the medication room. CP-M stated he told the facility to get a new medication disposal bin a long time ago. CP-M further stated he does not have anything to do with facility policy or procedure review or development, does not attend quality assurance performance improvement (QAPI) meetings, was not aware of their medication disposal process, does not have anything to do with the facility medication reconciliation process and was not as involved at the facility as he should have been. During interview on [DATE] at 4:40 p.m., medical director stated she would expect narcotic medications to be reconciled and if excess medications were being dispensed pharmacy should have (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	been notified and medications destroyed. Timely Re-Ordering of Medication R26's face sheet received on [DATE], included diagnosis of atrial fibrillation (an irregular and rapid heart rhythm). R26's admission Minimum Data Set (MDS) dated [DATE], indicated moderately impaired cognition, clear speech, could understand and be understood. R26 required supervision or partial assistance with activities of daily living (ADLs). R26 could walk 50 feet with partial staff assistance. R26's physician orders dated [DATE], indicated: Eliquis (blood thinner medication) oral tablet 5 mg (milligrams). Give 1 tablet by mouth two times a day related to atrial fibrillation. R26's care plan with revised date of [DATE], indicated R26 had atrial fibrillation and cardiac medications would be given as ordered. R26's progress note dated [DATE] at 11:55 a.m., indicated medication unavailable. During an interview on [DATE] at 1:35 p.m., RN-I stated she had entered the above progress note and identified the medication not available as Eliquis. RN-I stated R26 was supposed to receive a dose of Eliquis that morning, but the medication was not available. RN-I stated she tried to contact the pharmacy, but the phone in that room did not work. RN-I stated she tried her cell phone and had other medications to call the pharmacy for. RN-I stated it was frustrating. During an interview on [DATE] at 1:55 p.m., the DON and RN-D known as the regional director of clinical services were informed of the medication issues RN-I had been experiencing. The DON stated she would check with RN-I. The RN-D stated the corporate office had been aware of the issues with their pharmacy vendor, were switching vendors in [DATE], and after hearing of all the medication related concerns, would try to get this facility moved up on the list to switch to a different system sooner. During an interview on [DATE] at 2:08 p.m., nurse practitioner (NP)-G was informed of Eliquis being given late to R26. NP-G stated since only one dose had been given late, it would be okay. Facility staff meeting agenda [DATE], written by the DON indicated: Medications and treatments: we cannot chart medication not available - hold order to be obtained and find out why med is not here and get ordered. During an interview on [DATE], at 12:10 p.m., the DON stated she could not recall why R26's Eliquis had been given late on [DATE]. and would have to look into it again. RN-D stated they recognized there had been issues with the pharmaceutical vendor and were looking at it at a corporate level. The DON stated the reason staff meeting agenda dated [DATE], advised nurses not to document when a medication was not available was because she expected nurses to talk to pharmacy and find out why. Medication Errors- Refer to F760 On [DATE] at 7:35 a.m., the DON stated the medication errors were nothing new regarding ongoing medication issues. The DON stated the facility faxes medication orders to the pharmacy and receives (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	confirmation, yet the pharmacy later states the order was never received. The DON confirmed there is no reconciliation process in place at the time medications were dispensed from the pharmacy to ensure they match the physician's orders. The DON stated education had been provided to nursing staff regarding medication administration and ensuring the correct dose is administered. The DON was unable to articulate specific corrective actions taken to ensure accurate receipt and dispensing of medications. The DON confirmed that audits have not been conducted since December despite continued medication discrepancies, and confirmed the staff were not educated to call the pharmacy to make sure the medication orders were received when the order was faxed. The DON stated the medical director had not been involved with the known medication error problems. On [DATE] at 8:43 a.m., during a telephone interview with the contracted pharmacy technician (PT)-O stated reported facility medication orders are e-scribed or faxed to the pharmacy. Facility staff may call the pharmacy or use an online portal system to confirm receipt of orders. Medication changes update in the pharmacy system and are transmitted to the facility through two dispensing methods: an onsite oral strip from the machine or punch card delivery. PT-O stated that once the pharmacy receives an order, it was entered into the pharmacy system. If the medication was available in the onsite dispensing machine, it is electronically transmitted to the machine, and licensed nursing staff may log into the machine, select the resident, and dispense the medication. If not available onsite, medications were dispensed via punch card delivery. The pharmacy technician reported technicians load and restock the dispensing machines twice weekly and facility licensed nurses should not load medications into the machine. All medications stocked in the machine remain the property of the pharmacy until dispensed. stated PRN medications should be removed at the time of administration and controlled substances stored on the cart should be logged in the narcotic record book. PT-O further stated the pharmacy offers training and free in-service education to nursing staff regarding the dispensing system. On [DATE] at 9:22 a.m., the DON stated she had been placing calls to the pharmacy regarding medication errors and had not received a call back. The DON stated they did not remember how to log into the pharmacy portal. The DON stated that none of the facility staff had received training from the pharmacy regarding the pharmacy medication dispensing process or portal information and was unaware that portal training was an available service. The DON reported she had not received any training from the pharmacy company on the process and was not aware the contracted pharmacy provided training to the facility staff. The DON stated the pharmacy technician stocks the medications in the dispensing machine and that facility staff do not stock medications. The DON discussed attempts to establish a process for order verification, stating that the facility had attempted to fax orders, call to confirm receipt, and refax when necessary, describing the process as a real challenge. The DON stated attempts to establish pharmacy system that was reliable system but stated nothing had been successfully implemented. The DON stated the medication errors have been a known issue for months and no formalized process had been put in place to prevent the errors from recurring. The DON stated there was no report currently being utilized to track missed or late medications. The DON stated she was sure there is one in the system but was unsure how to generate the report. When asked whether a report identifying late or omitted medications would be expected given the ongoing medication-related concerns, the DON stated the issue was on the list to discuss with corporate nursing. The DON was unable to provide evidence of routine monitoring or auditing of medication administration records (MARs) for late, missed, or omitted doses. AlixaRx Pharmacy Provider Agreement dated [DATE], indicated the following: Scope of services: pharmacy will provide pharmacy products to facility and it's residents in a prompt (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	and timely manner in accordance with applicable law, collaborate with facility to coordinate pharmacy documentation process. Automated dispensing unit technology: pharmacy will work with the facility to instruct facility's personnel on the proper utilization of all pharmacy equipment. Drug distribution and related services: pharmacy shall furnish all pharmacy products requested by facility and it's residents pursuant to the order of the resident's attending physician, consulting physician, medical director, or other lawful prescriber. Pharmacy shall respond to the reasonable needs of facility regarding transmission of data between pharmacy and facility. Delivery: Pharmacy shall arrange for all new orders and routine reorders to be delivered by pharmacy within a timely fashion to meet the needs of the resident. Facility shall use reasonable efforts to aggregate, organize, and plan all new admissions orders and routine reorders with pharmacy. Facility Medication Storage policy undated, indicated the following: It is the policy of this facility to ensure all medications housed on our premises will be stored in the pharmacy or medication rooms to ensure security. Unused Medications: The pharmacy and all medication rooms are routinely inspected by the consultant pharmacist for discontinued, outdated, defective, or deteriorated medications. These medications are destroyed in accordance with our Destruction of Unused Drugs Policy. Facility Destruction of Unused Drugs undated, indicated the following: All unused, contaminated, or expired prescription drugs shall be disposed of in accordance with state laws and regulations. Drugs will be destroyed in a manner that renders the drugs unfit for human consumption and disposed of in compliance with are current applicable state and federal requirements. Our facility uses a waste disposal service or reverse distributor to destroy dangerous drugs and controlled substances. An inventory of dangerous drugs and controlled substances will be verified by the consultant pharmacist. Facility Medication Administration policy undated, indicated the following: Medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice, in a manner to prevent contamination or infection. 1. Ensure that the six rights of medication administration are followed: Right resident Right drug (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Right dosage Right route Right time Right documentation Compare medication source (bubble pack, vial, etc.) with MAR to verify resident name, medication name, form, dose, route, and time. Refer to drug reference material if unfamiliar with the medication, including its mechanism of action or common side effects. Administer within 60 minutes prior to or after scheduled time unless otherwise ordered by physician. If other than PO route, administer in accordance with facility policy for the relevant route of administration (i.e., injection, eye, ear, rectal, etc.). If medication is a controlled substance, sign narcotic book. Correct any discrepancies and report to nurse manager. Facility Medication Orders policy undated, indicated the following: This facility shall use uniform guidelines for the ordering of medication. Documentation of Medication Orders: Each medication order should be documented with the date, time, and signature of the person receiving the order. The order should be recorded on the physician order sheet, and the Medication Administration Record (MAR). Clarify the order. Enter the order on the medication order and receipt record. If using electronic medication records, input the medication order according to the electronic health record (EHR) instructions and facility policy. Call or fax the medication order to the provider pharmacy. Transcribe newly prescribed medications on the MAR or treatment record or ensure the order is in the electronic MAR. When a new order changes the dosage of a previously prescribed medication, discontinue previous entry by writing DC'd and the date, or discontinue the order as per the electronic software instructions and retype the new order. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Enter the new order on the MAR or ensure the new order is in the electronic MAR. Notify resident's sponsor/family of new medication order. The nurse should document an order by telephone or in person on the physician's order sheet or input into electronic record as per facility policy, transmit the appropriate copy to the pharmacy for dispensing, and place the signed copy on the designated page in the resident's medical records. Physician orders should be signed per state specific guidelines.

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a plan that describes the process for conducting QAPI and QAA activities. Based on interview and document review the facility failed to maintain documentation and demonstrate evidence of a comprehensive, data-driven quality assurance and performance improvement (QAPI) program. These findings had potential to affect all 47 residents who resided in the facility.Findings include:See F684: Based on observation, interview, and document review, the facility failed to ensure necessary care and services were provided for 1 of 1 resident (R2) reviewed for non-pressure skin concerns, when staff failed to appropriately assess, treat, and manage bilateral lower-extremity wounds. This included failure to timely notify the provider and obtain and implement wound care orders following a change in skin condition, and failure to ensure wound care was provided as needed. These failures resulted in R2 going multiple days without wound care and placed the resident at risk for worsening skin breakdown, infection, and complications related to delayed treatment. Further, the facility failed to complete and monitor daily weights, monitor blood pressures, and administer medications in accordance with provider-prescribed blood pressure parameters and treatment orders for 1 of 1 resident (R2) reviewed for edema. In addition, the facility failed to follow physician orders for obtaining daily weights and applying elastic compression bandages to legs for 1 of 1 resident (R26), reviewed for edema. See F755: Based on observation, interview and document review, the facility failed to ensure complete narcotic and controlled substance reconciliation occurred for two of two medication carts, failed to provide secure storage of disposed medications, and failed to ensure consultant pharmacist involvement and awareness of medication reconciliation and disposal processes. This practice had the potential to affect all 47 residents residing in the facility. In addition, the facility failed to ensure physician-ordered medications were re-ordered timely to prevent delay in administration and reduce the risk of complications for 1 of 1 resident (R26) reviewed for medication administration. During review of past complaints and facility reported incidents during survey preparation, a potential trend was noted in October 2025, where three incidences of medications or treatments not been completed as ordered by the provider. During survey, the survey team identified the same concerns. In addition, a significant number of concerns related to the contracted pharmaceutical service had been identified during survey which the facility was aware of but did not address at the QAPI level. During an interview on 1/22/26 at 10:40 a.m., the director of nursing (DON) stated the three facility reported incidents from October 2025, related to failure of nursing staff to administer medications and/or treatment per physician orders had resulted in termination of a long-term nurse. The DON stated the incidents has been brought up at QAPI meetings and, Everyone had been happy with my education and audits. Education and audits were requested and not received. As a result, QAPI minutes were requested.QAPI minutes were received from the administrator for January 2025 through January 2026. The meeting minutes did not reflect, as the DON stated they would, the identification of a trend from October 2025, where medications and/or treatments had not been administered per physician orders. There had been no data reported, no root cause analysis done, no education, no audits, and no follow up to ensure resolution. QAPI meeting minutes were in grid-format with four headings: 1) topic, 2) process owner, 3) summary, trends, root casual factors, recommendations for improvement, decision to develop action plan, 4) X if AP needed. Multiple times summaries documented one month, stayed the same for subsequent months. There had been no evidence topics were selected for QAPI based on high-risk, high volume or problem prone areas. Minutes were primarily focused on information or data sharing. During an interview on 1/27/26 at 2:31 p.m., with the administrator, DON, and registered nurse (RN)-D known as regional director of clinical services, the administrator stated corporate set the QAPI agenda topics, and whoever was the process owner filled in their summary section. The meeting did not have a designated facilitator. Standing topics included marketing, medical records, therapy, wellness, performance improvement initiative program/QIIP, grievance/missing property summary, medical director information, follow up reports/other, pastoral care, survey performance/readiness, (continued on next page)

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	consultant reports - pharmacy, approval guidelines, policies, procedures, environmental, culinary, infection prevention, employee satisfaction, recruitment and retention, resident council summary, family council summary, education hours, volunteer hours, census summary and discharge tracking, activities, customer satisfaction surveys, quality trigger measure, AWAIR (workplace accident and injury reduction)/safety, OHFC (office of health facility complaints)/abuse, 30 day re-admits, fall prevalence, incidents/accidents. The designated process owner then added summary notes. The DON admitted she had no training in QAPI, but felt they had an effective program - they just didn't document their work. The DON stated they did not review medication errors or resident events at QAPI. The DON stated they had an event last fall with a resident who fell and sustained burns. The administrator stated that event had not been brought to QAPI for discussion and input. In retrospect, the administrator stated it should have been. Both the DON and administrator acknowledged they should be addressing issues that come up, such as the significant issue of their medication delivery system with medications not being available to staff, but had not considered that. Nor had long call light wait times been considered. Topics identified in QAPI minutes, and correlating concerns identified during survey included:--2/18/25: Daily Nursing Expectations were shared with staff. This was repeated in minutes on 3/18/25, 4/28/25, 5/20/25, 6/18/25, 7/16/25. Nothing more. During interview on 1/27/26 at 2:46 p.m., the administrator and DON could not recall this nor knew what the expectations were. --4/28/25: Nurses: change of condition/assessments/when to call doctor; reviewed within huddles. Education printed for nurses on how to properly assess and document change findings. Copies in each nurse report book.During interview on 1/27/26 at 2:51 p.m., the DON acknowledged this had not been entirely resolved, adding she thought she had done audits for a while and then it had dropped off. --Minutes dated 5/20/25, 8/20/25, 9/24/25, 10/15/25, and 11/19/25, indicated: Onboarding process related to orientation and orientation process: time to onboarding and the actual orientation that is offered. During an interview on 1/27/26 at 2:52 p.m., the DON stated she had been working on orientation as they had not had a human resource director at the time. The DON stated when she started in her role in February 2025, there were so many things to focus on that orientation and training had not been on her radar. --Minutes dated 7/16/25, 10/15/25, and 11/19/25, indicated: Employee satisfaction: Strengths: feel welcomed, work is meaningful, understood goals. Improvement: More consistent staffing, more support and feedback from supervisors during the first 90 days. During interview on 1/27/26 at 2:55 p.m., the administrator stated he had started to review survey results with the new HR director who started in November 2025, adding they wanted to improve staff retention. A mock survey for survey readiness was conducted in September and October 2025, but results had not been included at QAPI for discussion and learning. The administrator, DON and RN-D also know as regional director of services, acknowledged there was a lack of training and knowledge in the QAPI process, and that the facility had not been effectively identifying concerns, analyzing and tracking performance, measuring successes and making sure improvements were sustained. The facility QAPI policy with review date of 6/27/25, indicated QAPI committee consisted of representatives from all departments including pharmacy. However, in 2025, the pharmacists last QAPI meeting attendance was March 2025. Facility Quality Assurance/Assessment and Performance Improvement Plan with review date of 6/27/25, indicated: QAPI program was to utilize an on-going, data driven, proactive approach to advance the quality of life and quality of care for all residents. QAPI principles would drive decision making to promote excellence in all resident and staff related areas. All facility staff, families and residents would be encouraged to be involved in identifying opportunities for improvement, partake in QAPI teams, imbed QAPI activities in all core processes and provide ongoing feedback. The QAPI program encompassed post-acute care, long term care and outpatient therapy. The QAPI committee consisted of representatives from all departments including nursing, food and nutrition, pharmacy, laundry, maintenance, health information technology, therapeutic recreation, therapy, business office and administration. Involvement would be varied by topic and may include committee, sub-committee or (continued on next page)

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	verbal/written input. The facility would monitor multiple data sources and performance indicators in determining areas of concern, gaps and opportunities and also to determine effectiveness of system modifications and other interventions. All data would be reviewed against state, national or organization benchmarks or thresholds as appropriate and would be reported to the Board of Directors on a quarterly basis. Data for adverse events and medical errors would be tracked, causes analyzed and preventative actions and mechanisms put into place. Potential sources of data may include survey outcomes, complaints, near misses, input from staff, residents, families, medication errors, pharmacist reports, staff retention and Five Star report.

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. Based on interview and document review, the facility failed to have evidence of a Performance Improvement Project (PIP) which focused on high risk or problem-prone areas, identified thorough data collection, analysis and evaluation of identified concerns during Quality Assurance and Performance Improvement (QAPI). This had the potential to affect all 47 residents who resided in the facility.Findings include:During an interview on 1/27/26 at 2:31 p.m., with the administrator, the director of nursing (DON) and registered nurse (RN)-B known as regional director of clinical services, the DON stated the facility PIP (performance improvement project) for 2025, had been short stay pressure ulcers, which had been selected by the previous regional nurse consultant. The DON stated there had been no concerns and nothing to improve. Despite this conclusion, the DON could not provide documentation that a performance improvement process had been utilized to arrive at this conclusion. No rationale for selection of this PIP, no data gathered, no feedback from staff, no analysis, no conclusion. Further, the DON stated she did not consider selecting a different PIP when she determined there had been nothing to improve with the short stay pressure ulcer PIP. The DON and administrator admitted a PIP had not been completed in 2025.Facility Quality Assurance/Assessment and Performance Improvement Plan with review date of 6/27/25, indicated: At least annually a project that focused on high risk or problem-prone areas would be addressed through the QAPI program including PIP development. A minimum of one PIP and a maximum of four PIPs would occur simultaneously. The facility used a systematic approach to determining the root cause of an issue and any contributing factors. The team considered the implications of any interventions or changes to systems for potential negative outcomes in other areas. The team would determine whether a pilot test or facility wide change is appropriate based on the facts gathered. Each PIP team determined the timing for conduction of periodic measurements and reviews to evaluate whether new actions/interventions are being followed/performed consistently. If any backsliding occurred, the team would continue with the PDSA (plan, do check, act) cycle with changes in processes/procedures as required.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and staff interview, the facility failed to ensure laundry was handled, transported, and processed in a manner that prevented the spread of infection. Specifically, soiled linens were transported unbagged from resident rooms and through hallways, and the facility failed to implement oversight, staff education, and monitoring of laundry infection control practice, further the facility failed to follow infection prevention and control practices related to enhanced barrier precautions (EBP), wound care, and appropriate use of personal protective equipment (PPE) for 1 of 1 resident (R2) reviewed for non-pressure skin concerns,, failed to identify residents who met criteria for EBP, post required signage, educate staff on EBP versus contact precautions, and ensure staff used appropriate PPE and infection control practices during wound care. Findings include: Laundry On 1/21/26 at 8:16 a.m., observation and interview with staff who requested anonymity, was observed in a utility room, removing laundry from carts. The staff stated laundry was gathered from the soiled utility rooms on each hallway and was routinely soiled laundry was found placed in the laundry carts without bagging the linens prior. Staff further stated laundry from residents with infections, including Clostridioides difficile (C. diff), was not bagged differently, and stated it was not uncommon to find laundry in the laundry carts urine and bowel soiled linens that were transported unbagged. Staff member stated it was an ongoing concern that had been brought up to leadership and the director of nursing. On 1/21/26 at 8:38 a.m., hospitality aide (HA)-J was observed and removed soiled linens from room [ROOM NUMBER] and carried the linens unbagged down the hallway to the dirty utility room. The linens were carried against HA-J's clothing and placed directly into the laundry area without being bagged. HA-J stated they had not been taught that soiled linens needed to be bagged prior to transport. HA-J stated she believed common sense would be to bag linens in the hallway but had not done so previously. On 1/21/26 at 1:46 p.m., interview with the assistant director of nursing (ADON), also served as the infection preventionist, stated it was a previous known issue laundry was being transported unbagged through hallways and stated she did not know the practice was ongoing. The ADON stated known issues with staff not handling laundry as expected but confirmed there were no audits, monitoring, or surveillance in place to ensure compliance with infection control practices related to laundry handling.On 1/22/26 at 7:35 a.m., the director of nursing stated staff were expected to bag laundry prior to removing the laundry from the rooms, and laundry was expected bagged prior to being placed in the soiled laundry cart. EBP and Dressing ChangeR2's quarterly Minimum Data Set (MDS) dated [DATE], indicated R2 had moderate cognitive impairment, no rejection of care, utilized a wheelchair, dependent on staff for toileting, dressing, and transfers, and partial/moderate assistance with personal hygiene, and transfers, and skin concerns identified moisture associated skin damage (MASD) diagnoses included peripheral vascular disease (caused by narrowing, blockage or spasms in a blood vessel) or peripheral arterial disease (narrowed arteries reduce blood flow to the arms or legs), diabetes mellitus, non-Alzheimer's dementia, hemiplegia (paralysis on one side of the body) or hemiparesis (partial weakness on one side), cellulitis (skin infection) of right lower limb, reduced mobility, muscle weakness, and edema (swelling).R2's care plan dated 12/29/25, I have diabetes, interventions included: check all of body for breaks in skin and treat promptly as ordered by doctor, inspect feet daily for open areas, sores, pressure areas, blisters, edema or redness, monitor/document/report to MD (medical doctor) PRN (as needed) for s/sx (signs/symptoms) of infection to any open areas: redness, pain, heat, swelling or pus formation; skin: history of venous ulcer right lower extremity, edema in my right lower extremity which sometimes weeps, MASD to groin on and off due to incontinence, potential for further impaired skin integrity due to diabetes, PVD, and impaired mobility related to right side hemiparesis, history of cellulitis to legs interventions included: maintain good skin hygiene, moisturize dry skin PRN, monitor labs and weights as ordered, observe for alteration in skin integrity and report to NP/PA/MD (nurse practitioner/physician (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	assistant/medical doctor), skin inspected by licensed staff week.R2's treatment administration record dated 1/1/26-1/31/26, indicated:Start date 1/27/26, cleansed BLE with wound cleanser, apply collagen to open wound bed, cover with ABD and Kerlix Change daily. one time a day for edema/weeping complete prior to applying compression wrapsStart date 1/26/26, compression wraps, toe to knee. On AM and OFF at HS two times a day for edema/weepingR2's progress note dated 1/15/26 at 11:12 a.m., registered nurse (RN)-B indicated an SBAR note (situation, background, assessment, recommendation) R2's left lower leg is warm and red and irritated, has had several episodes of cellulitis in the past. Most recently in December, Left lower leg warm, red, irritated. Drains off and on. Previously had some blisters that now have scabbed over. Temp 98.2, HR (heart rate) 49, RR (respiratory rate) 18, B/P (blood pressure)178/69, O2 (oxygen) 96%, BS (blood sugar)115, often refuses to have his legs wrapped. Also, refuses to elevate legs during the day. Will often sleep sitting in wheelchair during the night. Recommend: Evaluation from Provider.On 1/20/26 at 11:40 a.m., R46 had a dressing present on the top of his head. R46 stated he had daily dressing changes related to skin cancer. There was no signage or identification R24 was on EBP, no signage was posted, and PPE was not readily available.On 1/21/26 at 12:57 p.m., registered nurse (RN)-B entered R2's room to complete wound care without donning a gown or gloves. No EBP signage was posted, and no PPE was readily available. RN-B removed a bandage scissor form her shirt pocket and disinfected bandage scissors with an alcohol wipe. RN-B left the room to obtain gloves, returned, and donned gloves. During the dressing change, R2's legs were observed to be reddened with drainage. RN-B with gloved hands removed R2's dressing off R2's lower legs. RN-B was observed to place the dirty dressings directly on the floor. RN-B then went to the bathroom with the same gloves touched the bathroom surfaces including the faucet, then used a wet cloth and soap and water and washed R2's legs, and then used a new cloth and pattered R2's legs dry, RN-B then was observed to remove gloves and put on new gloves without disinfecting hands, and stated I should have changed my gloves sooner, and RN-B confirmed hand hygiene was not performed during the dressing change and did not change gloves until later in the process. RN-B was then observed to gather the clothes used during the dressing change and carry with bare hands, carried against their clothing, and placed into a soiled container unbagged in the hallway. RN-B stated if a resident is on EBP gown and glove is worn and stated R2 did not have signage or PPE at the door to indicate R2 was on EBP. RN-B stated the linens were not expected handles with bare hands and was not sure if dirty linens required to be bagged prior to placing in the dirty linen cart. On 1/21/26 at 1:46 p.m., interview with the assistant director of nursing (ADON), and also the infection prevention nurse. The ADON stated residents with chronic wounds may require EBP depending on drainage and containment, and stated, there is still a lot I don't know. The ADON stated she was not aware R2 had a wound and would expect a resident with a wound to be on EBP. The ADON further stated residents with wounds were placed on contact precautions and stated she did not know EBP and contact precautions were different. The ADON confirmed there was no consistent process to identify residents requiring EBP, post signage, or monitor staff compliance.On 1/22/26 at 7:35 a.m., interview with the director of nursing (DON) revealed she would expect gown and gloves to be worn for residents with chronic wounds under EBP. The DON confirmed dirty dressings should not be placed on the floor, gloves should be changed during wound care, and hand hygiene should be performed.On 1/26/26 at 9:46 a.m., DON entered R2's room and to complete R2's wound care. The DON donned gloves but not a gown while providing care to R2 with left lower leg weeping, saturated leg dressing and yellow drainage. The DON used the same gloves to cleanse the wound and handle supplies and later stated, I should have worn a gown and gloves. Facility Infection Prevention and Control Program Policy and Procedure dated 2/25, indicated:Clean linen shall be delivered to resident care units on covered linen carts with covers down.Linen shall be stored on all resident care units on covered carts, shelves, in bins, drawers, or linen closets.Soiled linen shall be collected at the bedside and placed in a linen bag. When the task is complete, the bag shall be closed securely and placed in the soiled utility room. Soiled linen shall not (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	be kept in the resident's room or bathroom.Environmental services staff shall not handle soiled linen unless it is properly bagged.Enhanced Barrier Precautions Policy and Procedure dated 6/10/25, indicated: Enhanced barrier precautions (EBP) refer to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and gloves use during high contact resident care activities.Policy Explanation and Compliance Guidelines: 1. Prompt recognition of need: a. All staff receive training on enhanced barrier precautions upon hire and at least annually and are expected to comply with all designated precautions. b. All staff receive training on high-risk activities and common organisms that require enhanced barrier precautions. c. The facility will have the discretion on how to communicate to staff which residents require the use of EBP, as long as staff are aware of which residents require the use of EBP prior to providing high - contact care activities. An order for enhanced barrier precautions will be obtained for residents with any of the following: i. Wounds (e.g., chronic wounds such as pressure ulcers, diabetic foot ulcers, unhealed surgical wounds, and chronic venous stasis ulcers) and/or indwelling medical devices even if the resident is not known to be infected or colonized with a MDRO. 3. Implementation of Enhanced Barrier Precautions: a. Make gowns and gloves available immediately near or outside of the resident's room. Note: face protection may also be needed if performing activity with risk of splash or spray (i.e., wound irrigation, tracheostomy care). b. PPE for enhanced barrier precautions is only necessary when performing high-contact care activities and may not need to be donned prior to entering the resident's room. c. Ensure access to alcohol-based hand rub in every resident room (ideally both inside and outside of the room). d. Position a trash can inside the resident room and near the exit for discarding PPE after removal, prior to exit of the room or before providing care for another resident in the same room.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Implement a program that monitors antibiotic use. Based on interview and document review the facility failed to implement and maintain an effective Infection Prevention and Control Program specific to antibiotic stewardship. The facility did not have a system to track antibiotic use, culture results, organisms identified, or antibiotic resistance to ensure residents received appropriate treatment, this had the ability to affect all 47 residents. Findings Include:Review of the Infection Prevention and Control (IPC) case log dated 1/22/26, showed documentation included resident name, room number, onset date, current prescription, prescriber, infection type, infection site, diagnosis, and category. However, the log lacked documentation of the date cultures were obtained, organisms identified from culture results, and whether organisms were resistant to prescribed antibiotics.On 1/22/26 at 12:10 p.m., the assistant director of nursing (ADON), identified as the infection prevention nurse, stated antibiotic use was not tracked. The ADON stated the facility completed a log to monitor resident symptoms, possible infections, and provider notification, but did not track culture results or antibiotic effectiveness. The ADON stated follow-up of cultures and ensuring residents were prescribed the correct antibiotic was not facility practice and there was no current process for antibiotic stewardship. The ADON stated providers were responsible to review and track culture results to ensure appropriate antibiotics were prescribed. The ADON confirmed the facility did not track antibiotic indications for use, dosage, duration, culture results, or whether antibiotics were discontinued timely. The ADON further stated if a resident had a urinary tract infection and a urine culture was obtained, the provider was expected to track and communicate results to the facility, and the facility did not have a process to ensure culture results were received or addressed.On 1/26/26 at 3:45 p.m., the director of nursing (DON) and registered nurse (RN)-D, known as the regional director of clinical operations, verified infection surveillance related to antibiotic use and resistance was not tracked on the IPC log and confirmed the facility did not have a formal antibiotic stewardship process.Facility Antibiotic Stewardship Program Policy and Procedure dated 6/25, indicated It is the policy of this facility to implement an Antibiotic Stewardship Program as part of the facility's overall infection prevention and control program. The purpose of the program is to optimize the treatment of infections while reducing the adverse events associated with antibiotic use.Director of Nursing - establish standards for nursing staff to assess, monitor and communicate changes in a resident's condition that could impact the need for antibiotics, use their influence as nurse leaders to help ensure antibiotics are prescribed only when appropriate, and educate front line nursing staff about the importance of antibiotic stewardship and explain policies in place to improve antibiotic use.The Antibiotic Stewardship Program leaders utilize existing resources to support antibiotic stewards' efforts by working with the following partners:Infection Preventionist - utilizes expertise and data to inform strategies to improve antibiotic use to include tracking of antibiotic starts, monitoring adherence to evidence-based published criteria during the evaluation and management of treated infections and reviewing antibiotic resistance patterns in the facility to understand which infections are caused by resistant organisms.Monitoring antibiotic use:Monitor response to antibiotics, and laboratory results when available, to determine if the antibiotic is still indicated, or adjustments should be made (e.g., antibiotic time-out).Antibiotic orders obtained upon admission, whether new admission or readmission, to the facility shall be reviewed for appropriateness.Antibiotic orders obtained from consulting, specialty, or emergency providers shall be reviewed for appropriateness.Monitor each monthly medication regimen review when the resident has been prescribed or is taking an antibiotic or any antibiotic regimen review as requested by the QAA committee.Random audits of antibiotic prescriptions shall be performed to verify completeness and appropriateness (process measure).Antibiotic use shall be measured by (monthly prevalence, antibiotic starts, and/or antibiotic days of therapy).At least one outcome measure associated with antibiotic use will be tracked monthly, as prioritized from the facility's infection control risk assessment and other infection surveillance data. Examples include tracking C. difficile infections, (continued on next page)

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	245425	A. Building B. Wing	01/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Thorne Crest Retirement Center	1201 Garfield Avenue Albert Lea, MN 56007

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	antibiotic resistance, adverse drug events related to antibiotic use, or costs related to antibiotic use.Nursing will monitor the initiation of antibiotics on residents and conduct an antibiotic timeout within 48-72 of antibiotic therapy to monitor response to the antibiotic and review laboratory results and will consult with the practitioner to determine if the antibiotic is to continue or if adjustments need to be made based on the findings.New or changed orders for antibiotics based on the antibiotic timeout recommendations will be obtained from the practitioner.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to maintain a clean and sanitary environment free from persistent odors for one of three hallways, which resulted in strong and ongoing odors of urine and bowel movements. In addition, the facility failed to ensure clean air/heating vents in common areas including two resident hallways and one day room. This had the potential to affect residents, staff or visitor who resided and/or used hallways and common areas. Findings include: Odors R24's annual Minimum Data Set (MDS) dated [DATE], indicated R24 was cognitively intact, no behaviors, no rejection of care, utilized a walker and wheelchair, required partial/moderate assistance with toileting hygiene, personal hygiene, dressing, toilet transfer, chair to bed transfer, independent with sit to lying and, rolling, no trial of toileting program, occasionally incontinent of urine, always continent of bowel, diagnoses included benign prostatic hyperplasia (BPH) (enlarged prostate), obstructive uropathy (blockage in the urinary tract that hinders normal urine flow), and rheumatoid arthritis. R24's Care Area Assessment (CAA) dated 1/2/26, indicated R24 occasionally incontinent of urine and has a diagnosis of BPH with obstruction. He declines any surgical interventions at this time. He needs assistance with his toileting tasks due to his immobility related to rheumatoid arthritis. R24's care plan dated 1/2/26, indicated bowel and bladder: incontinent of bowel and bladder, regular underwear and will take myself to the toilet without asking for assistance, more episodes of incontinence and refuse to wear pads, staff offers to assist me to the toilet but I will refuses and then toilet myself, R24 removes incontinent pad and do not ask to have a new one put on, diagnosis of BPH with obstruction and declines any surgical interventions, staff assists with changing brief and incontinence cares after each incontinent episode, complete peri cares and manipulate clothing as needed, toilet hygiene- partial assist of one staff, incontinent of bladder and wears medium-large pull up- heavy absorbency, family provides pull ups, toilet transfer: partial assist of one staff with use of gait belt and grab bars to go on and off toilet, bowel & bladder elimination- incontinent of bladder, staff to ensure resident is wearing a brief, encourage and check resident every 2-3 hours. On 1/20/26 at 3:03 p.m., family member (FM)-E stated the entire facility smelled of bowel movements and urine throughout the hallways. On 1/20/26 at 4:11 p.m., the surveyor observed a strong odor of bowel movements and urine throughout the hallway outside of R24's room. On 1/21/26 at 8:13 a.m., the surveyor observed a strong urine odor in the south hallway. On 1/21/26 at 8:31 a.m., R24's room door was open and R24 was not present in the room. A strong urine odor was observed throughout the room, and loose clothing was observed on the floor. On 1/21/26 at 8:32 a.m., R20 was observed in the hallway and stated it was common to have strong (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	and unpleasant urine odors in the hallway. On 1/21/26 at 8:33 a.m., R22 was observed in the hallway and stated there was always a urine odor throughout the hallway and stated it gets stinky. On 1/21/26 at 8:34 a.m., a registered nurse (RN) stated she smelled urine in the hallway and stated it was a very unpleasant odor. On 1/21/26 at 8:28 a.m., a staff member who requested anonymity stated housekeeping staff were aware of a urine odor in R24's room. The staff member stated housekeeping cleaned the room; however, the urine odor persisted. The staff member further stated urine-soaked clothing was often thrown on the floor, bed, and chair, and other residents had complained about the odor. On 1/21/26 at 8:38 a.m., hospitality aide (HA)-J stated urine odors originating from R24 room was common and was reported R24 frequently refused to wear briefs, resulting in urine-soaked bedding, flooring, and chair surfaces. HA-J stated they had reported the issue to nursing staff. On 1/21/26 at 8:58 a.m., another staff member who requested anonymity stated the urine odor in R24's room had been a known issue for months. The staff member stated staff were limited to the cleaning and odor-removal products leadership allowed them to use and were not permitted to use additional odor-eliminating products. The staff member stated urine-soaked clothing was frequently left on the floor and not bagged for laundry, waterproof mattress pads were not in use, and R24 was not consistently encouraged by staff to toilet. The staff member further stated agency staff were not trained on proper laundry handling and sanitation procedures and confirmed the urine odor was very strong. The staff member stated there were multiple occasions when puddles of urine were observed near the chair, and a blanket on the floor was warm and saturated with urine. On 1/21/26 at 11:02 a.m., R24 was observed seated in a recliner in his room and stated he did not wear briefs, did not have a laundry basket, and often placed urine-soaked clothing and blankets on the floor. Pants and a blanket were observed on the floor, and R24 confirmed both items were soaked with urine and had been on the floor since early that morning. A wheelchair cushion with a distinct darker area was observed to be wet, and R24 confirmed the wheelchair cushion was saturated with urine. R24 further stated he placed his urine-soaked blankets on the floor. On 1/21/26 at 11:07 a.m., Health Unit Coordinator (HUC)-E stated the urine odor from R24's room was a known issue and stated staff had counseled the resident and spoken with family; however, the issue persisted and no laundry basket was available in the room. On 1/21/26 at 11:10 a.m., the director of nursing (DON) confirmed urine-soaked blankets were present on the floor and stated she would expect protective pads to be in place on the bed, wheelchair, and recliner. The DON confirmed urine stains were present on the bed linens. On 1/21/26 at 11:25 a.m., NA-H stated she had observed urine odors outside of R24's room since November 2024. NA-H stated R24 frequently refused care and urine-soaked clothing, and blankets were often placed on the floor and required bagging and removal to the soiled utility room. On 1/21/26 at 9:43 a.m., the DON acknowledged the urine odor in R24's room was a known issue and stated the facility was actively working on ways to prevent the odor. The DON confirmed R24 was alert and oriented and was not on a toileting schedule. The DON stated disposable chux (disposable, (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	absorbent pads used to protect surfaces like mattresses and furniture from moisture and fluids, particularly in cases of incontinence). were expected to be in place on R24's bed, recliner, and wheelchair; however, the DON confirmed the chux were not present. The DON stated she did not smell urine in the hallway when R24's door was closed but was informed that staff, visitors, and residents were able to smell urine in the hallways. The DON stated others being able to smell urine in the hallway was a big deal. The DON further stated she had educated staff during huddles to immediately remove urine-soaked clothing from R24's room. The administrator stated R24 was extremely incontinent, alert, and oriented, had refused briefs for months, and had the right to refuse care. The DON stated housekeeping cleaned R24's room daily and nursing assistants were expected to immediately bag urine-soaked laundry; however, the DON acknowledged no audits were completed to ensure compliance. The DON further stated improper handling of urine-soaked laundry posed a risk for contamination and infection control concerns. The DON confirmed the wheelchair cushion was urine-soaked, loose urine-soaked clothing was present on the floor, and other residents should not have to experience urine odors throughout the hallways. Facility Routine Cleaning and Disinfection policy dated 6/10/25, indicated:It is the policy of this facility to ensure the provision of routine cleaning and disinfection in order toprovide a safe, sanitary environment and to prevent the development and transmission of infections to theextent possible.Cleaning refers to the removal of visible soil from objects and surfaces and is normally accomplished manually or mechanically using water and detergents or enzymatic products Vents During an observation on 1/20/26 at 6:45 p.m., cold air was felt coming out of a large vent on the ceiling of resident hallway near rooms three, four, and five. The vent was covered in a thick layer of gray dust and fluffy debris. During observation on 1/22/26 at 11:58 a.m., two vents in the hallway of the transitional care unit were covered with gray dust and fluffy debris. An additional vent blowing directly into the main day room near the nurses' station where multiple residents were seated was also covered in a thick layer of gray dust and fluffy debris. During interview on 1/22/26 at 2:49 p.m., housekeeper (H)-A stated she did not clean common area vents and was not sure who was responsible for that. H-A looked at the vent in the hallway near rooms three, four, and five and stated it was very dirty. H-A stated she cleaned only bathroom vents in resident rooms. During interview on 1/22/26 at 12:01 p.m., environmental director (ED)-A stated he was not aware of dirty vents but had heard about it during survey and observed the dirty vents. ED-A stated he reviewed his maintenance logs and cleaning vents was not part of a scheduled cleaning routine. ED-A stated vents needed to be cleaned to ensure less dust and allergens in the air. ED-A stated he would put vents on a monthly cleaning rotation. During interview on 1/22/26 at 2:55 p.m., administrator stated he would expect vents in common areas to be cleaned on a regular basis. Facility Routine Cleaning and Disinfection policy dated 6/10/25, indicated it was the policy of the facility to ensure the provision of routine cleaning and disinfection in order to provide a safe, sanitary environment. Cleaning refers to the removal of visible soil from objects and surfaces and is normally accomplished manually or mechanically using water and detergents.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to ensure the provider was timely notified and appropriate orders were obtained and implemented following a change in condition related to worsening skin integrity for 1 of one 1 resident (R2) reviewed for skin changes. This failure resulted in delayed treatment, lack of wound care orders, and inconsistent care, placing the resident at risk for infection and further skin breakdown. In addition, the facility failed to notify the resident representative when there had been a change in condition for 1 of 1 resident (R26), reviewed for notification of change. Findings include: Physician Notification R2's quarterly Minimum Data Set (MDS) dated [DATE], indicated R2 had moderate cognitive impairment, no rejection of care, utilized a wheelchair, dependent on staff for toileting, dressing, and transfers, and partial/moderate assistance with personal hygiene, and transfers, and skin concerns identified moisture associated skin damage (MASD) diagnoses included peripheral vascular disease (caused by narrowing, blockage or spasms in a blood vessel) or peripheral arterial disease (narrowed arteries reduce blood flow to the arms or legs), diabetes mellitus, non-Alzheimer's dementia, hemiplegia (paralysis on one side of the body) or hemiparesis (partial weakness on one side), cellulitis (skin infection) of right lower limb, reduced mobility, muscle weakness, and edema (swelling). R2's care plan dated 12/29/25, I have diabetes, interventions included: check all of body for breaks in skin and treat promptly as ordered by doctor, inspect feet daily for open areas, sores, pressure areas, blisters, edema or redness, monitor/document/report to MD (medical doctor) PRN (as needed) for s/sx (signs/symptoms) of infection to any open areas: redness, pain, heat, swelling or pus formation; skin: history of venous ulcer right lower extremity, edema in my right lower extremity which sometimes weeps, MASD to groin on and off due to incontinence, potential for further impaired skin integrity due to diabetes, PVD, and impaired mobility related to right side hemiparesis, history of cellulitis to legs interventions included: maintain good skin hygiene, moisturize dry skin PRN, monitor labs and weights as ordered, observe for alteration in skin integrity and report to NP/PA/MD (nurse practitioner/physician assistant/medical doctor), skin inspected by licensed staff week. R2's treatment administration record dated 1/1/26-1/31/26, indicated: Start date 11/11/24, compression wraps to bilateral lower legs, on am and off HS (bedtime) for edema two times a day for edema in BLE (bilateral lower extremity) related to localized edema. Start date 2/1/25, nurse to complete and document skin check in the evening every Wed, Sat Start date 8/21/25, check feet every HS for any sores, cuts, or changes. Update Wound Nurse/MD as needed at bedtime Start date 10/15/25, cleanse RLE (right lower extremity) prior to compression then apply [NAME] cream. Apply compression. every day shift for dry skin and edema BLE R2's progress note dated 1/15/26 at 11:12 a.m., registered nurse (RN)-B indicated an SBAR note (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	(situation, background, assessment, recommendation) R2's left lower leg is warm and red and irritated, has had several episodes of cellulitis in the past. Most recently in December, left lower leg warm, red, irritated. Drains off and on. Previously had some blisters that now have scabbed over. Temp 98.2, HR (heart rate) 49, RR (respiratory rate) 18, B/P (blood pressure)178/69, O2 (oxygen) 96%, BS (blood sugar)115, often refuses to have his legs wrapped. Also, refuses to elevate legs during the day. Will often sleep sitting in wheelchair during the night. Recommend: Evaluation from Provider. R2's document SBAR communication tool undated, RN-B indicated R's had a red lower left leg, irritated, warm, past history of cellulitis, not on any antibiotic, recently hospitalized for cellulitis no recent changes in condition, left lower leg red warm and irritated, wound open/scabbed areas on both legs, continues to refuse wraps, legs are weepy, sometimes sleeps in bed, likes to sit up in wheelchair. Temp 98.2, HR 49, RR 18, B/P 178/69, O2 96%, BS 115. R2's record review lacked documentation the provider had been notified of R2's left lower leg assessment. On 1/21/26 at 12:57 p.m., RN-B entered R2's room, and stated she would be completing R2 's wound care. RN-B stated R2's order must have changed when she observed an ABD (a highly absorbent dressing designed for wounds with heavy drainage) pad present on R2's left leg, and RN-B stated she did not remember R2 having an order for ABD dressing. RN-B removed R2's socks from both feet and used a scissors to cut off the Kerlix and remove the dressings. The legs were observed to be reddened with yellowish drainage on the left leg. RN-B stated she usually cleans the legs with gentle soap and water. RN-B applied [NAME] cream (moisturizer for dry skin) to R2's lower left and right legs but not to the open areas, then picked up the soiled dressings from the floor, removed her gloves, and offered to rewrap the legs; R2 declined compression wraps. RN-B stated Kerlix (dressing used to cover and protect wounds) was not available, as the facility had run out and stated she would have to use a different type of dressing to secure the ABD. RN-B applied ABD pads directly to both lower legs, securing them with Coban (non-adhesive elastic wrap). RN-B stated staff normally would not use Coban without Kerlix and that Kerlix would absorb drainage and protect the open areas. RN-B was observed to complete the dressing change and then exited the room. RN-B then stated she wrote an SBAR last week due to the change in R2's skin on his legs and were observed warm and weeping, with open areas. RN-B stated she verbally notified the director of nursing (DON), assistant director of nursing (ADON) and the, Health unit coordinator (HUC)-E that R2 had a new issue with his legs and was instructed to complete a Teladoc (virtual doctor) appointment with R2. RN-B stated she did not have time to complete Teladoc visit with R2 due to all her other duties as a nurse that include, medication pass, treatments, dressing changes, and processing orders. RN-B stated the Teladoc system is time consuming, and the floor nurse was responsible for completing the Teladoc system, and stated she completed an SBAR due to the provider being at the facility the following day. RN-B stated she completed an SBAR and gave to either the ADON or DON. RN-B stated she completed a progress note in the EMR the day she observed R2's skin changes on the legs. On 1/21/26 at 4:44 p.m., licensed practical nurse (LPN)-A stated he was not aware R2 had any dressing changes or open areas on his legs and stated if dressing changes were necessary the EMR (electronic medical record) treatment orders would indicate orders. LPN-A confirmed R2 had no dressing change order and was unaware the legs were red and weeping and did not assess them. LPN-A stated he would expect dressing change orders, including gauze and ABD pads, and that the provider should have been notified. On 1/21/26 at 2:57 p.m., the DON stated she remembered seeing an SBAR on R2, within the last week (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	or two and paraphrased the information and notified the provider regarding open areas and weeping areas, and was not sure how the provider was notified but further stated she remembers updating the provider, DON was observed to look through documentation and stated she could not find documentation the provider was notified. The DON stated she would have expected documentation of provider notification and expected the provider to assess R2. On 1/21/26 at 5:06 p.m., during a follow up interview the DON and RN-C known as regional director of clinical services reviewed documentation and were unable to find evidence the provider had been notified of the change in skin condition. The DON found an SBAR in her office undated and stated the SBAR was from 1/8/26; however, upon further review, she determined a progress note dated 1/15/26 matched the SBAR she received. The DON confirmed the provider should have been notified of the change in skin condition and stated it was her responsibility to track SBARs submitted to providers. The DON stated the nursing staff complete the SBARs and either give to her, the ADON, or HUC-E and then she reviews the SBARs for accuracy and either puts the SBARs back in a folder in HUC-E's office for providers to review or gives the SBARS to the providers herself. The DON stated the SBAR from RN-B was not followed up on as expected and she was unsure why documentation could not be located. On 1/26/26 at 4:40 p.m., during a telephone interview the medical director (MD)-F stated the provider was expected to be notified of skin changes promptly. Resident Representative Notification R26's face sheet received on 1/28/26, included diagnoses of congestive heart failure (heart not able to pump effectively), chronic obstructive pulmonary disease (lung disease that restricts airflow), respiratory failure (lungs cannot adequately supply oxygen to the blood), venous insufficiency (leg vein valves are weak preventing proper blood flow to heart), and diabetes. R26's admission MDS dated [DATE], indicated moderately impaired cognition, clear speech, could understand and be understood. R26 required supervision or partial assistance with activities of daily living (ADLs). R26 could walk 50 feet with partial staff assistance. R26's physician orders dated 1/19/26, indicated: Wound care; wash with wound cleanser, apply bacitracin, cover with gauze. One time a day. R26's care plan with revised date of 1/8/26, indicated R26 had potential for impaired skin due to weakness, diabetes and obesity. Skin would remain intact. Nursing assistants (NAs) would observe skin with morning and evening cares and report any abnormalities to the nurse. Observe for alteration in skin integrity and report to provider. Skin inspected by licensed staff weekly per schedule. R26's progress note dated 1/14/26, at 11:35 p.m., indicated a NA requested RN-C, to R26's room to assess skin condition. RN-C noted full flap loss skin tear measuring 4.3 centimeters (cm) x 3 cm to right shin area. R26 stated she did not know how it occurred. Wound was cleansed with normal saline and covered with non-adhesive pad and wrapped with kerlix. SBAR (situation, background, assessment and recommendation) left for provider. During an interview on 1/20/26 at 2:30 p.m., family member (FM)-A stated communication with the facility was poor, and I'm so frustrated. R26 stated FM-A sustained a skin tear on her right leg on 1/14/26, but she had not been notified. FM-A stated she first learned about the skin tear when she (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	arrived three or four days later and saw gauze on R26's leg. FM-A stated someone at the facility (she couldn't recall who) talked to her about this and said she would talk to the nurse involved. During an interview on 1/22/26, at 2:45 p.m., RN-C stated he notified the provider when he learned of R26's skin tear on 1/14/26, but admitted he did not notify FM-A because it was late -- about 10:00 p.m. RN-C stated he later found out FM-C wanted to be notified no matter the time. During an interview on 1/26/26, at 9:23 a.m., the DON stated she was aware of FM-A not being informed of R26's skin tear and she spoke to RN-C to remind him family was to be notified in a timely manner when changes occurred. The DON provided meeting minutes dated 10/17/25, where this topic had been discussed with nurses and in which RN-C was in attendance. During an interview on 1/27/26 at 7:40 a.m., RN-E stated she was aware of the skin tear on R26's leg. RN-E stated staff were to notify the family right away with anything unless it was care-planned not to. Facility Prevention and Treatment of Skin Breakdown/Pressure Injury Policy and Procedure dated 12/24, indicated: If a resident is admitted with impaired skin integrity or new pressure injury or a lower extremity ulcer develops, the licensed nurse implements the follow items: Documentation of the skin impairment is completed in the medical record. Staging is completed as necessary by trained licensed nursing associates Standing orders/protocol for skin impairment are initiated Notify attending provider, resident, and resident representative. Attending provider determines wound type and may provide additional orders. Notify Supervisor/designee. Evaluate current pressure reduction interventions and revise resident centered care plan. Notify dietitian for nutritional interventions as appropriate Notify therapy associates and other members of the care team as appropriate for possible additional treatment interventions. Educate resident/resident representative on skin impairment and care plan interventions. When pressure injury is present, the dressing and/or wound as appropriate are monitored daily. Weekly the licensed nurse will stage, measure, and examine the wound bed and surrounding skin. If wound bed has deteriorated; notify attending provider. Notify the attending provider, resident/resident representative and supervisor if the skin injury has not shown progress in 2 weeks and/or is deteriorating unexpectedly. Re-evaluate plan of care as appropriate. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245425	A. Building B. Wing	01/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Thorne Crest Retirement Center	1201 Garfield Avenue Albert Lea, MN 56007

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Facility Change of Condition policy dated 6/10/25, indicated the facility must inform the resident, consult with the resident's physician and /or notify the resident's family member or legal representative when there was a change requiring such notification, including accidents resulting in injury and/or the potential to require physician intervention. Circumstances that required a need to alter treatment such as a new treatment. For competent individuals, the facility must still contact the resident's physician and notify resident's representative, if known. A family that wishes to be informed would designate a member to receive calls. When a resident was mentally competent, a designated family member should be notified of significant changes in the resident health status because the resident may not be able to notify them personally, especially in the case of sudden illness or accident.

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is 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 assistance to complete personal hygiene care for 1 of 1 resident (R3) reviewed who needed assistance with fingernail care.R3's quarterly Minimum Data Set (MDS) dated [DATE], indicated R3 was cognitively intact, no rejection of care, utilized a wheelchair, required substantial/maximal assistance with personal hygiene, upper body dressing, dependent on staff for toileting hygiene and transfers; diagnoses included hemiplegia or hemiparesis, depression, dependence on renal dialysis.R3's care plan dated 1/2/26, indicated self-care: assist with dressing, personal hygiene, and bathing due to immobility related to right side hemiparesis from a history of a cva, staff assist of one to hand resident a soapy wash cloth and cue to wash face/hands/arms/torso as able during cares, staff to trim resident's finger and toe nails as needed, personal hygiene: substantial assist of one staff shower / bathe self, Tuesday and Thursday am shift, shave and trim nails after bath.R3's Documentation Survey Report dated 1/26, indicated:Personal hygiene the following dates were blank (no documentation) for day shift on 1/20/26, and blank for evenings on 1/8/26, 1/10/26, 1/11/26, 1/15/26.Shower/bathe substantial assistance with one staff, Tuesday and Thursday AM shift, shave and trim nails after bath indicated:1/8/26, 1/16/25 Not applicable (not attempted and the resident did not perform this activity prior to the current illness, exacerbation, or injury).R3's Dialysis Provider Clinic Sheet dated 12/8/25, registered nurse (RN)-G indicated concern with how R3 presented today with dirty hands, fingernails and what appears to be BM (bowel movement) on his pants, this is a procedural area and need him to be as clean as possible. On 1/21/26 at 9:25 a.m., a registered nurse (RN-G) was observed pushing R3 in a wheelchair through the hallway toward the facility's south door to await transportation for dialysis. R3 stated he was waiting for the bus to take him to dialysis. R3's hands were observed with dried red substance that covered the back of both hands. R3 stated the substance was blood that had been present for several days. R3's fingernails on both hands were observed with black and brown debris under all nails. R3 stated staff assisted him to wash his face that morning; however, staff did not assist him to wash his hands or provide a washcloth for handwashing. R3 further stated his hands were still sticky from breakfast. RN-G confirmed R3's hands and fingernails were dirty.On 1/21/26 at 9:30 a.m., the director of nursing (DON) observed R3 in the hallway. R3 stated to the DON that he needed his hands and fingernails cleaned. The DON was observed to gasp upon observing R3's hands and fingernails and stated, Oh my, and further stated, What do you got under there? The DON then washed R3's hands and cut and cleaned R3's fingernails.On 1/21/26 at 9:43 a.m., the DON stated R3's hands and fingernails were very dirty and bad and stated, It should not be like that. The DON stated staff were expected to assist R3 with handwashing every morning and whenever his hands and fingernails were visibly dirty.On 1/21/26 at 10:49 a.m., during a telephone interview, RN-H from the dialysis center stated R3 attended dialysis on Mondays, Wednesdays, and Fridays. RN-H stated R3 presenting with dirty fingernails, dirty clothing, and food residue around his mouth was an ongoing concern. RN-H stated these concerns were documented in R3's communication log that traveled with the resident between the dialysis center and the facility.On 1/21/26 at 1:00 p.m., nursing assistant (NA-F) stated she completed R3's morning cares and assisted him to wash his face; however, R3 was not assisted to wash or clean his hands or fingernails. NA-F stated R3 was expected to receive handwashing and hygiene assistance when his hands and fingernails were visibly dirty. NA-F further stated morning cares were rushed due to agency staff unfamiliar with resident care needs and staff having to assist agency staff.Facility Nail Care Policy and Procedure dated 2025, indicated: Routine cleaning and inspection of nails will be provided during ADL care on an ongoing basis. Routine nail care, to include trimming and filing, will be provided on a regular schedule. Nail care will be provided between scheduled occasions as the need arises.

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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 toileting for 1 of 1 resident (R36) who was dependent upon staff for assistance with activities of daily living (ADL). Findings include: R36's face sheet received on 1/28/26, included diagnoses of Alzheimer's disease (a type of dementia that affects memory, thinking and behavior) and Parkinson's disease (a progressive brain disorder). R36's significant change Minimum Data Set (MDS) dated [DATE], indicated severe cognitive impairment, clear speech, rarely/never understood, usually understands. R36 was dependent upon staff for activities of daily living (ADLs) or required substantial assistance. R36 did not walk. R36 was always continent of urine and always incontinent of bowel. R36's care plan with revised date of 10/21/25, indicated R36 was incontinent of bladder and bowel and required assistance with toileting due to Alzheimer's disease. Intervention with revised date of 11/4/25, indicated R36 was to be put on the toilet at these time frames: 5:00 a.m., upon rising, before/after meals, and HS (bedtime). R36's Kardex (a document used primarily by nursing assistants to quickly reference essential resident information) with print date of 1/21/26, indicated: 1) After lunch, to be toileted and lay in bed for a nap, and 2) Turn on water when sitting on the toilet to aide in toileting; 5:00 a.m., upon rising, before/after meals and at HS. During an interview on 1/21/26 at 12:41 p.m., family member (FM)-C stated R36's plan of care was to include toileting, meaning assisting R36 onto the toilet when staff got him up in the morning, and before and after meals. FM-C added, That was my understanding of how it goes. FM-C stated R36 could tell staff if he needed to, Take a leak or take a crap, but staff would need to ask him using terms like that, that he would understand. FM-C stated staff could not assume R36 would tell them when he needed to go. During the same interview, FM-C gave examples of when R36 had not been toileted per the care plan: --1/6/26, FM-D was with R36 in his room in his wheelchair after lunch. At approximately 1:30 p.m., FM-D turned on R36's call light to request staff toilet R36 and lay him in bed. After about an hour, no one came and FM-D had to leave, so she informed staff she was leaving. Staff informed FM-D, they were busy but would move R36 to the dayroom until they could get to him. At approximately 4 p.m., the hospice nurse called FM-D to give her an update and informed her that R36 had been in the dayroom; not laying down in bed. FM-C stated, so clearly, he had not been toileted or laid down after lunch, adding, he should be toileted and put to bed according to the care plan whether or not family was there. --1/13/26, FM-C stated she went to the facility to help R36 with lunch and when she sat down next to R36, immediately smelled BM (bowel movement). FM-C stated R36 had been trying to reach around to his backside to fix the problem. FM-C stated she fed him quickly then took R36 to his room. FM-C stated R36 had BM everywhere - up his back, in his chair and required a clothing change and wheelchair wiped down. FM-C stated R36 had probably been sitting in his wheelchair since breakfast and had not been toileted before lunch. FM-C stated, They did not execute the care plan. FM-C stated (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	she was not happy no one had noticed the odor, or R36's cues trying to get out of his chair and reaching behind him. ---1/20/26: FM-C stated she was with R36 in his room. R36 was in his wheelchair. At approximately 12:30 p.m., she turned on R36's call light to request R36 be toileted and laid in bed as she had to leave by 1:00 p.m. FM-C assumed R36's care plan would be executed and his call light was on, so she left. At approximately 2:30 p.m., she received a call from staff informing her R36 had fallen from his wheelchair. R36 stated, Why wasn't his care plan followed? FM-C stated she spoke to registered nurse (RN)-A who was also the assistant director of nursing (ADON) about the fall. RN-A informed FM-C she had reviewed R36's call light log and told her R36's call light had been turned on at 12:24 p.m., someone shut it off 15 minutes later, and R36 was found on the floor at 1:50 p.m. FM-C stated, I want some faith that when I'm not here he's being well cared for - I need to be able to trust them. FM-C stated most of the nursing assistants (NAs) were very good, but they were overwhelmed with work. During an interview on 1/21/26 at 4:21 p.m., (RN)-A, verified R36's care plan indicated R36 should be toileted at 5:00 a.m., upon rising, before meals and at HS. In addition, RN-A verified per the (EMR) electronic medical record, TASK tab (where NA's documented completion of tasks) that NAs were to toilet R36 upon rising, before/after meals, and HS. Looking for corresponding documentation, RN-A stated she was not able to verify it had been done at the required intervals. RN-A also verified R36's Kardex directed NA staff to toilet R36 at 5:00 a.m., upon rising, before/after meals and at HS. RN-A stated NAs would know to do this because they would have been informed at daily huddles, from NA meetings, or when hired or brought on as an agency NA. RN-A stated after R36 fell on 1/20/26, she added to the Kardex: After lunch, to be toileted and lay in bed for a nap. During an interview on 1/21/26 at 5:33 p.m., nursing assistant (NA)-B, an agency NA, stated R36 was toileted every two hours with an EZ stand (a medical transfer device). Care plan, Kardex and task list indicated R36 should be toileted at 5:00 a.m., upon rising, before/after meals and at HS. During an interview on 1/21/26 at 5:40 p.m., NA-D, an agency NA, stated R36 was toileted at beginning of her shift and after supper with the EZ stand. NA-D stated at bedtime, they changed R36's brief (incontinent pad) in his bed. While NA-E was washing R36 up, applying deodorant and dressing him, NA-E never asked R36 if he needed to use the toilet and R36 never spoke. NA-E cleaned R36's peri-area and applied a incontinent pad. Along with NA-F, assisted R36 onto the EZ stand, into the wheelchair, then to the dayroom. R36 was not toileted per care plan. During an interview and observation on 1/26/26 at 10:46 a.m., observed R36 still in bed with lights out. NA-F and NA-E stated they had not gotten R36 up yet; that he had been in bed all morning and had not had breakfast. NA-F stated due to a call-in, they were working short. NA-F entered the room to prepare R36 for the day. NA-F stated R36 would let them know if he needed to go to the bathroom, or they would ask him, or daughters would tell them. NA-F stated she would sometimes hear him say, I have to take a leak. NA-F stated when she worked, they changed his brief in the morning, and then two other times during the shift, took R36 to the bathroom to sit on the toilet. NA-F removed R36's brief which was plump and moderately heavy. Skin on R36's buttocks was normal color. NA-E entered the room to help with the EZ stand. Neither NA-E nor NA-F when asked, could verbalize the frequency of putting R36 on the toilet that was identified in R36's care plan, Kardex and Task list. During an interview on 1/27/26 at 11:08 a.m., the director of nursing (DON) was informed of findings related to R36 not being toileted per care plan, Kardex and Task list, (5:00 a.m., upon rising, (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	before/after meals and at HS), and NA staff being unaware of the required toileting plan. The DON was unaware of this. In addition, she expected staff to know the plan of care and follow it but did not monitor or audit adherence to a resident's plan of care. Facility ADL Care of Dementia Unit Residents policy dated 2025, indicated; It is the policy of this facility to provide appropriate treatment and services in relation to ADL care to residents on the dementia unit to ensure all ADL needs are met on a daily basis, while attaining or maintaining the dementia resident's highest practicable physical, mental and psychosocial well-being. The care plan interventions will be monitored on an ongoing basis for effectiveness and will be reviewed/revised as necessary. Facility Policy Activities of Daily Living (ADLs) dated 2025, indicated; Care and services will be provided for the following activities of daily living: 1. Bathing, dressing, grooming and oral care; 2. Transfer and ambulation; 3. Toileting. A resident who is unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. The facility will maintain individual objectives of the care plan and periodic review and evaluation.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to ensure necessary care and services were provided for 1 of 1 resident (R2) reviewed for non-pressure skin concerns, when staff failed to appropriately assess, treat, and manage bilateral lower-extremity wounds. This included failure to timely notify the provider and obtain and implement wound care orders following a change in skin condition, and failure to ensure wound care was provided as needed. These failures resulted in R2 going multiple days without wound care and placed the resident at risk for worsening skin breakdown, infection, and complications related to delayed treatment. Further, the facility failed to complete and monitor daily weights, monitor blood pressures, and administer medications in accordance with provider-prescribed blood pressure parameters and treatment orders for 1 of 1 resident (R2) reviewed for edema. In addition, the facility failed to follow physician orders for obtaining daily weights and applying elastic compression bandages to legs for 1 of 1 resident (R26), reviewed for edema. Findings include: SKIN ASSESSMENT and DRESSING CHANGES R2's quarterly Minimum Data Set (MDS) dated [DATE], indicated R2 had moderate cognitive impairment, no rejection of care, utilized a wheelchair, dependent on staff for toileting, dressing, and transfers, and partial/moderate assistance with personal hygiene, and transfers, and skin concerns identified moisture associated skin damage (MASD) diagnoses included peripheral vascular disease (caused by narrowing, blockage or spasms in a blood vessel) or peripheral arterial disease (narrowed arteries reduce blood flow to the arms or legs), diabetes mellitus, non-Alzheimer's dementia, hemiplegia (paralysis on one side of the body) or hemiparesis (partial weakness on one side), cellulitis (skin infection) of right lower limb, reduced mobility, muscle weakness, and edema (swelling). R2's care plan dated 12/29/25, I have diabetes, interventions included: check all of body for breaks in skin and treat promptly as ordered by doctor, inspect feet daily for open areas, sores, pressure areas, blisters, edema or redness, monitor/document/report to MD (medical doctor) PRN (as needed) for s/sx (signs/symptoms) of infection to any open areas: redness, pain, heat, swelling or pus formation; skin: history of venous ulcer right lower extremity, edema in my right lower extremity which sometimes weeps, MASD to groin on and off due to incontinence, potential for further impaired skin integrity due to diabetes, PVD, and impaired mobility related to right side hemiparesis, history of cellulitis to legs interventions included: maintain good skin hygiene, moisturize dry skin PRN, monitor labs and weights as ordered, observe for alteration in skin integrity and report to NP/PA/MD (nurse practitioner/physician assistant/medical doctor), skin inspected by licensed staff week. R2's treatment administration record dated 1/1/26-1/31/26, indicated: Start date 11/11/24, compression wraps to Bilateral lower legs, on am and off HS (bedtime) for edema two times a day for edema in BLE (bilateral lower extremity) related to localized edema. Start date 2/1/25, nurse to complete and document skin check in the evening every Wed, Sat Start date 8/21/25, check feet every HS for any sores, cuts, or changes. Update Wound Nurse/MD as needed. at bedtime (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Start date 10/15/25, end date 1/26/26, cleanse RLE (right lower extremity) prior to compression then apply [NAME] cream. Apply compression. every day shift for dry skin and edema BLE Start date 1/27/26, cleansed BLE with wound cleanser, apply collagen to open wound bed, cover with ABD and Kerlix Change daily. one time a day for edema/weeping complete prior to applying compression wraps Start date 1/26/26, compression wraps, toe to knee. On AM and OFF at HS two times a day for edema/weeping R2's progress note dated 1/15/26 at 11:12 a.m., registered nurse (RN)-B indicated an SBAR note (situation, background, assessment, recommendation) R2's left lower leg is warm and red and irritated, has had several episodes of cellulitis in the past. Most recently in December, left lower leg warm, red, irritated. Drains off and on. Previously had some blisters that now have scabbed over. Temp 98.2, HR (heart rate) 49, RR (respiratory rate) 18, B/P (blood pressure)178/69, O2 (oxygen) 96%, BS (blood sugar)115, often refuses to have his legs wrapped. Also, refuses to elevate legs during the day. Will often sleep sitting in wheelchair during the night. Recommend: Evaluation from Provider. R2's document SBAR communication tool undated, RN-B indicated R's had a red lower left leg, irritated, warm, past history of cellulitis, not on any antibiotic, recently hospitalized for cellulitis no recent changes in condition, left lower left red warm and irritated, wound open/scabbed areas on both legs, continues to refuse wraps, legs are weepy, sometimes sleeps in bed, likes to sit up in wheelchair. Temp 98.2, HR 49, RR 18, B/P 178/69, O2 96%, BS 115. R'2 progress note dated 1/24/26 10:30 p.m., indicated no new skin issues identified, skin issue has not been evaluated front right lateral lower leg redness, wound acquired in-house, unknown how long the wound has been present; front left lateral lower leg redness with dry scabs, wound acquired in-house, unknown how long the wound has been present; front right knee. scab off- red area not completely healed over wound acquired in-house. it is unknown how long the wound has been present. R2's telephone order undated, DON indicated an order from nurse practitioner (NP)-G with orders to cleanser BLE with wound cleanser, pat dry, apply collagen to wound bed, cover with ABD and kerlix, compression wrap toe to knee on in the AM and off and bedtime. R2's record review lacked documentation the provider had been notified of R2's left lower leg assessment, dressing changes, or received new wound orders until 1/22/25, however the orders were not implemented until 1/26/26 On 1/21/26 at 12:57 p.m., RN-B entered R2's room, and stated she would be completing R2 wound care. RN-B stated R2's order most have changed when she observed an ABD (a highly absorbent dressing designed for wounds with heavy drainage) pad present on R2's left leg, and RN-B stated she did not remember R2 having an order for ABD dressing. RN-B removed R2's socks from both feet and used a scissors to cut off the Kerlix and remove the dressings. The legs were observed to be reddened with yellowish drainage on the left leg. RN-B stated she usually cleans the legs with gentle soap and water. RN-B then used a washcloth with water to gently wash the legs, followed by a dry washcloth to pat the legs dry. RN-B applied [NAME] cream (moisturizer for dry skin) to R2's lower left and right legs but not to the open areas, then picked up the soiled dressings from the floor, removed her gloves, and offered to rewrap the legs; R2 declined compression wraps. RN-B stated Kerlix (dressing used to cover and protect wounds) was not available, as the facility had run out and (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stated she would have to use a different type of dressing to secure the ABD. RN-B applied ABD pads directly to both lower legs, securing them with Coban (non-adhesive elastic wrap). RN-B stated staff normally would not use Coban without Kerlix and that Kerlix would absorb drainage and protect the open areas. RN-B was observed to complete the dressing change and then exited the room. RN-B then stated she wrote an SBAR last week due to the change in R2's skin on his legs and were observed warm and weeping, with open areas. RN-B stated she verbally notified the director of nursing (DON), assistant director of nursing (ADON) and the, Health unit coordinator (HUC)-E that R2 had a new issue with his legs and was instructed to complete a Teladoc (virtual doctor) appointment with R2. RN-B stated she did not have time to complete Teladoc visit with R2 due to all her other duties as a nurse that include, medication pass, treatments, dressing changes, and processing orders. RN-B stated the Teladoc system is time consuming and complex process, and the floor nurse was responsible for completing the Teladoc system, and stated she completed an SBAR due to the provider being at the facility the following day. RN-B stated she completed an SBAR and gave to either the ADON or DON. RN-B stated she completed a progress note in the EMR the day she observed R2's skin changes on the legs. On 1/21/26 at 4:44 p.m., licensed practical nurse (LPN)-A stated he was not aware R2 had any dressing changes or open areas on his legs and stated if dressing changes were necessary the EMR (electronic medical record) treatment orders would indicate orders. LPN-A confirmed R2 had no dressing change order and was unaware the legs were red and weeping and did not assess them. LPN-A stated he would expect dressing change orders, including gauze and ABD pads, and that the provider should have been notified. On 1/21/26 at 2:57 p.m., the DON stated she remembered seeing an SBAR on R2, within the last week or two and paraphrased the information and notified the provider regarding open areas and weeping areas, and was not sure how the provider was notified but further stated she remembers updating the provider, DON was observed to look through documentation and stated she could not find documentation the provider was notified. The DON stated she would have expected documentation of provider notification and expected the provider to assess R2. On 1/21/26 at 5:06 p.m., during a follow up interview the DON and RN-D (regional director of clinical services) reviewed documentation and were unable to find evidence the provider had been notified of the change in skin condition. The DON found an SBAR in her office undated and stated the SBAR was from 1/8/26; however, upon further review, she determined a progress note dated 1/15/26 matched the SBAR she received. The DON confirmed the provider should have been notified of the change in skin condition and stated it was her responsibility to track SBARs submitted to providers. The DON stated the nursing staff complete the SBARs and either give to her, the ADON, or HUC-E and then she reviews the SBARs for accuracy and either puts the SBARs back in a folder in HUC-E's office for providers to review or gives the SBARS to the providers herself. The DON stated the SBAR from RN-B was not followed up on as expected and she was unsure why documentation could not be located. On 1/26/26 at 9:05 a.m., LPN-A stated was not aware of any dressing change orders for R2. On 1/26/26 at 9:07 a.m., the DON stated she talked to stated she spoke with Nurse Practitioner (NP-G) on 1/22/26, when she was completing rounds at the facility and received dressing change orders. The DON stated she assessed R2's legs on 1/22/26, recalling both legs were swollen, red to the knee, and weeping, with a history of cellulitis and chronic discoloration. The DON stated she wrote the order on a telephone order sheet and placed it in the HUC-E office without entering it into the EMR. The DON confirmed she did not document her assessment or enter the orders. The DON (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	confirmed R2 went the entire weekend without wound care due to no orders being implemented and stated, That's on me and I feel sick to my stomach. The DON stated documentation and orders were essential to prevent worsening skin integrity, particularly given R2's history of cellulitis. On 1/26/26 at 9:46 a.m., R2 was observed seated in his wheelchair and stated no wound care or dressing changes were completed over the weekend. The DON entered the room with dressing supplies. The right leg was open to air with flaky, dry skin. The left leg had a Kerlix wrap and ABD dressing saturated with dried yellow drainage. The DON removed the dressing and stated it likely had not been changed over the weekend due to lack of orders. The DON cleansed the wound and applied collagen dressing, ABD, and Kerlix, dating the dressing. The DON confirmed there were still no active orders in the EMR at that time. On 1/26/26 at 10:17 a.m., HUC-E stated telephone orders were placed in a folder in her office after the nurse who received the orders entered the order in the computer, HUC-E stated the telephone orders were not expected placed in her office until the order was entered into the computer. On 1/26/26 at 4:40 p.m., during a telephone interview the medical director (MD)-F stated the provider was expected to be notified of skin changes, orders were expected entered daily, and wound orders were expected completed to prevent worsening of the skin. Facility Prevention and Treatment of Skin Breakdown/Pressure Injury Policy and Procedure dated 12/24, indicated If a resident is admitted with impaired skin integrity or new pressure injury or a lower extremity ulcer develops, the licensed nurse implements the follow items: 1. Documentation of the skin impairment is completed in the medical record. Staging is completed as necessary by trained licensed nursing associates 2. Standing orders/protocol for skin impairment are initiated 3. Notify attending provider, resident, and resident representative. Attending provider determines wound type and may provide additional orders. 4. Notify Supervisor/designee. 5. Evaluate current pressure reduction interventions and revise resident centered care plan. 6. Notify dietitian for nutritional interventions as appropriate 7. Notify therapy associates and other members of the care team as appropriate for possible additional treatment interventions. 8. Educate resident/resident representative on skin impairment and care plan interventions. 9. When pressure injury is present, the dressing and/or wound as appropriate are monitored daily. 10. Weekly the licensed nurse will stage, measure, and examine the wound bed and surrounding skin. If wound bed has deteriorated; notify attending provider. 11. Notify the attending provider, resident/resident representative and supervisor if the skin injury has not shown progress in 2 weeks and/or is deteriorating unexpectedly. Re-evaluate plan of care as appropriate. Weights and Blood Pressure Monitoring R2's quarterly MDS dated [DATE], indicated R2 had moderate cognitive impairment, no rejection of care, utilized a wheelchair, dependent on staff for toileting, dressing, and transfers, and partial/moderate assistance with personal hygiene, and transfers, and diagnoses included hypertension, peripheral vascular disease (caused by narrowing, blockage or spasms in a blood vessel) or peripheral arterial disease (narrowed arteries reduce blood flow to the arms or legs), diabetes mellitus, non-Alzheimer's dementia, hemiplegia (paralysis on one side of the body) or hemiparesis (partial weakness on one side), cellulitis (skin infection) of right lower limb, reduced mobility, muscle weakness, and edema (swelling). R2's care plan dated 12/29/25, self-care: need assist with dressing, personal hygiene, and bathing (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	due to cognitive impairment, immobility related to history of CVA with right dominant side hemiplegia, will sometimes refuse assistance, interventions included obtain weights and vital signs per facility protocol, report significant weight changes to NP/PA/MD (nurse practitioner/physician assistant/medical doctor) and dietician, report abnormal vital sign readings to NP/PA/MD; hypertension with chronic kidney disease and interventions included: give anti-hypertensive medications as ordered, monitor for side effects such as orthostatic hypotension and increased heart rate (tachycardia) and effectiveness skin: history of venous ulcer right lower extremity, edema in my right lower extremity which sometimes weeps, monitor labs and weights as ordered, observe for alteration in skin integrity and report to NP/PA/MD skin inspected by licensed staff week. R2's treatment administration record and medication administration record dated 12/1/25-12/31/25, indicated: Start date 9/10/25, hydralazine oral tablet 10 mg give 1 tablet by mouth every 6 hours as needed for SBP (systolic blood pressure) > (greater than) 160 Start date 12/10/25, end date 1/9/26, torsemide oral tablet 40 MG (milligrams) give 0.5 tablet by mouth every 24 hours as needed for SOB (shortness of breath)(more than normal); weight gain of more than 3lbs (pounds) in 24hrs (hours) or 5lb in 3 days; hold BP (blood pressure)< (less than) 100/60 Start date 11/23/24, end date 1/14/26, daily weight; notify provider if weight gain is greater than 2lbs/day or 5lbs/wk (week) one time a day R2's treatment administration record and medication administration record dated 1/1/26-1/31/26, indicated: Start date 1/10/26, torsemide oral tablet 20 mg give 1 tablet by mouth one time a day related to hypertensive chronic kidney disease Start date 1/16/26, blood pressure monitoring: SBP > 160, *orders to give PRN (as needed) hydralazine (read PRN orders if given) two times a day Start date 9/10/25, hydralazine oral tablet 10 mg give 1 tablet by mouth every 6 hours as needed for SBP > 160 Start date 1/10/26, daily weight one time a day Start date 11/23/24-1/14/26, daily weight; notify provider if weight gain is greater than 2lbs/day or 5lbs/wk one time a day Provider visit dated 12/11/25, physician assistant (PA)-H indicated follow up hospital visit medication change: torsemide as needed for weight gain and pressure. Provider visit notes dated 1/8/26, PA-H indicated: daily weights, scheduled torsemide 20 mg daily, use PRN (as needed) hydralazine 10 mg every 6 hours as needed for systolic blood pressure greater than 160, and further indicated R2 was seen today for an acute visit nursing reports that his blood pressure was high at 197/81, today and his weights have been creeping up, they have noticed his legs have been more swollen and have been weeping, no shortness of breath, blood pressures have (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	generally been running high, has not been getting the torsemide not often has he gained three or more pounds in a day, will schedule torsemide 20 mg daily (should have gotten PRN torsemide a few times), has not being getting the hydralazine, and discussed this with the DON (director of nursing), there are several occasions when his blood pressure was greater than 160 and he should have been given hydralazine 10 mg, she (DON) assured me they would reinforce this. Blood Pressures on 12/1/25-1/26/26, and the MAR failed to indicate R2 received hydralazine as ordered for SBP>160 1/18/26 at 8:45 a.m., 179 / 91 1/17/26 at 9:02 a.m., 185 / 69 1/15/26 at 3:19 p.m., 171 / 61 1/15/26 at 10:02 a.m., 178 / 69 1/15/26 at 8:25 a.m., 171 / 69 1/14/26 at 8:40 a.m., 169 / 74 1/13/26 at 9:30 a.m., 198 / 80 1/12/26 at 3:43 p.m., 173 / 65 1/12/26 at 8:20 a.m., 173 / 65 1/11/26 at 8:52 a.m., 196 / 81 1/9/26 at 3:58 p.m., 180 / 67 1/9/26 at 3:57 p.m., 180 / 67 1/9/26 at 9:17 a.m., 180 / 67 1/8/26 at 8:53 a.m., 197 / 81 1/7/26 at 3:51 p.m., 183 / 73 1/7/26 at 9:17a.m., 183 / 73 1/4/26 at 3:40 p.m., 178 / 70 1/4/26 at 3:39 p.m., 178 / 70 1/4/26 at 11:25 a.m., 178 / 70 1/1/26 at 3:56 p.m., 176 / 72 (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1/1/26 at 8:39 a.m., 176 / 72 12/31/25 at 08:46 a.m., 181 / 77 12/27/25 at 8:58 a.m., 179 / 76 12/26/2025 at 9:10 a.m., 165 / 80 mmHg R2's record review indicated no weight was documented on the following dates: 1/3/26, 1/10/26, 1/19/26, and 1/24/26. R2's record review indicated the following dates*** R2 had weight gain of more than 3lbs in 24hrs or 5lb in 3 days and documentation failed to indicate torsemide 40 mg 0.5 tab was administered as ordered and failed to notify the provider of weight gain: ***1/8/26 270.0 lb 1/6/26 265.5 Lbs ***1/4/26 269.5 Lbs 12/31/25 257.5 Lbs On 1/21/26 at 12:57 p.m., RN-B entered R2's room, and stated she would be completing R2 wound care. RN-B removed R2's socks from both feet and used a scissors to cut off the Kerlix and remove the dressings. The legs were observed to be reddened with yellowish drainage on the left leg, and both legs had moderate swelling. RN-B was observed to complete the dressing change and then exited the room. RN-B further stated R2 had daily weights and that she was unaware of a new hydralazine order until the prior week, which directed administration for BP over 160. RN-B stated monitoring of BP and weights, and administration of medication were important to manage R2's fluid due to chronic swelling of the legs. On 1/21/26 at 4:44 p.m., licensed practical nurse (LPN)-A stated R2's BP the previous night was 168/79 and that he administered hydralazine but did not document the administration. He stated the PRN order had been previously being overlooked, and it was recently rewritten on the MAR for nursing to be more aware of the order and education was also provided to nursing staff. LPN-A confirmed the nursing staff received education regarding R2's blood pressure and administering medications per the BP parameters. LPN-A stated it was a known concern R2 was not receiving medications when his BP was high and when had an increase in weight. On 1/21/26 at 5:06 p.m., the director of nursing (DON) and RN-D also known as regional director of clinical services reviewed documentation The DON and RN-D stated that if medications were administered, documentation was expected; without documentation, the facility could not confirm that medications were given. The DON stated it was a known concern that daily weights were not consistently obtained and documented, and facility staff had recently received education on the importance of obtaining and documenting weights. The DON stated nursing assistants collected resident weights and reported them to the nurse, and the nurse was responsible for following up on the weights and implementing provider orders as indicated. The DON further stated facility staff received education regarding R2's ordered medications, including the requirement to administer (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1/21/26: No weight 1/22/26: No weight 1/23/26: No weight 1/24/26: No weight 1/25/26 186 lbs. During an interview on 1/26/26 at 9:39 a.m., RN-A, who was also the assistant director of nursing (ADON), stated R26 was to be weighed daily. RN-A looked in R26's EMR (electronic medical record) and verified the provider order was for daily weights. RN-A then reviewed measured weights in the EMR and stated R26 had not been weighed daily. RN-A stated this had been an on-going problem as nurses had not always communicated to nursing assistants (NAs) when a resident needed to be weighed. As a result, RN-A created a list for NA's, located at the nurses' station and also posted by the scale, for NAs to review in order to determine which residents needed weights and how often. RN-A stated the change was made about two weeks ago and the director of nursing (DON) announced it at huddle meetings and at nurse and NA meetings on 1/15/26 and 1/16/26. Together with RN-A, looked at the list posted by the scale. One sheet indicated weights on a schedule per doctors' orders must be done. R26's name was listed and indicated she was to be weighed every day. On another sheet titled Weight Tracker for January, there were no recorded weights for R26. RN-A stated if a NA (employed or agency) didn't hear the information at a huddle or attend a meeting, they likely would not know about the new lists. RN-A stated another place NAs could look was in a binder in the nurses' station which had paper copies of resident Kardex's (a document used to summarize a resident's plan of care, often used by NAs). Together with RN-A, looked in the binder and there was no Kardex sheet for R26. Reviewed NA meeting agenda dated January 2026, which included: Everyone is to be weighed in the morning before breakfast on shower days. Daily weights are not optional. Nothing on the agenda about the new forms and process implemented by RN-A. Three NAs attended the meeting. Reviewed nurse meeting agenda dated January 2026, which included: Weights. Nothing on the agenda about the new forms and process implemented by RN-A. Five nurses attended the meeting. During an interview on 1/27/26 at 11:08 a.m., the DON was informed daily weights on R26 had not been occurring per physician order, nor were Ace wraps being applied daily per physician order. The DON stated she was unaware and had not been informed by staff. The DON expected nursing staff to carry out physician orders and stated she had no idea why this was occurring. The DON stated she did not routinely monitor to ensure physician orders were being carried out by staff. During an interview on 1/27/26 at 12:57 p.m., NA-A stated she did not know which residents needed weights, adding she thought there was a sheet at the desk. NA-A was not aware R26 needed a daily weight. Facility Weight Monitoring Policy and Procedure dated 2025, Weight can be a useful indicator of nutritional status. Significant unintended changes in weight (loss or gain) or insidious weight loss (gradual unintended loss over a period of time) may indicate a (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review, the facility failed to provide timely toileting for 1 of 1 resident (R4) who required staff assistance with activities of daily living (ADL). Findings include: R4's quarterly Minimum Data Set (MDS) dated [DATE], indicated severe cognitive impairment, delusions, physical and verbal behavioral symptoms, rejection of care, utilized a wheelchair, required maximal/substantial assistance with activities of daily living and transfers, frequently incontinent of urine, occasionally incontinent of bowel, diagnoses included non-Alzheimer's dementia, depression, urinary tract infection, and history of falling.R4's care plan dated 12/1/25, indicated bowel and bladder incontinent of bowel and bladder, require assistance with toileting due to weakness and impaired , toilet hygiene- substantial assist, offer toileting upon rising, before and after meals, HS (bedtime), midnight and 4 a.m.R4's Care Conference Summary dated 11/25/25, indicated family wants staff to get R4 to the bathroom after meals. Staff will be educated on this to ask her if she has to use the restroom. Informed family it is on her care plan to do this but will educated staffR4's documentation of tasks dated 1/26/26, indicated Bowel & Bladder Elimination-Offer toileting upon rising, before and after meals, HS (bedtime) midnight and 4a.m. and R4's documentation included:1/14/26,6:02 a.m.1:30 p.m.1/15/2026,1:04 a.m.4:58 a.m.5:42 a.m.2:16 p.m.14:16 p.m.9:30 p.m.1/16/2026,12:24 a.m.2:26 a.m.05:39 a.m.10:00 a.m.14:08 p.m.10:11 p.m.1/17/2026,12:09 a.m.1:21 a.m.5:15 a.m.9:06 a.m.1:49 p.m.5:59 p.m.8:23 p.m.9:48 p.m.1/18/2026,12:00 a.m.2:00 a.m.4:00 a.m.6:00 a.m.1:22 p.m.8:55 p.m.1/19/2026,1:42 a.m.3:31 a.m.4:00 a.m.6:00 a.m.2:29 p.m.9:17 p.m.1/20/2026,1:03 a.m.4:50 a.m.5:13 a.m.6:21 p.m.8:29 p.m.1/21/2026,1:09 a.m.4:26 a.m.1:50 p.m.8:32 p.m.9:58 p.m.R4's documentation failed to indicate toileting upon rising, before and after meals, HS (bedtime) midnight and 4 a.m.On 1/20/26 at 3:03 p.m., during a telephone interview family member (FM)-E stated they had previously raised concerns with the facility regarding (R4) not being toileted or having briefs changed routinely. FM-E stated R4 frequently smelled of urine and bowel and further stated she had also noticed odors of urine and bowel throughout the facility.On 1/21/26 at 8:09 a.m., R4 was observed seated at a dining room table eating breakfast.On 1/21/26 at 10:58 a.m., R4 observed seated in a wheelchair in the day room.On 1/21/26 at 12:41 p.m., R4 was observed seated at the dining room table eating lunch and receiving cueing assistance from staff.On 1/21/26 at 1:42 p.m., nursing assistant (NA)-G stated they were assigned to R4 today. NA-G stated it was their first day at the facility as agency staff, and stated they knew how the residents transferred by what was written down. NA-G was observed and pulled out a small piece of paper and stated R4 required two people assist with transfers and toileting. NA-G stated R4 had not requested assistance and had not informed staff of the need to be toileted and confirmed R4 had not been offered to be toileted since 9:30 a.m., NA-G stated they were unfamiliar with R4's care and stated would expect R4 to notify staff when they wanted to be toileted. On 1/21/26 at 3:09 p.m., R4 continued to be seated in a wheelchair by the nursing station.On 1/21/26 at 3:13 p.m., NA-D stated they started their shift at 2:00 p.m. and had recently changed R4's brief and observed dried bowel movement on the brief that appeared to indicate R4 had not been changed for an extended period. NA-D stated the timing of R4's last brief change had not been reported during shift report. NA-D stated R4 was expected to be toileted with a brief change every two hours and R4 was not able to verbalize her needs.On 1/21/26 at 3:25 p.m., NA-C stated R4 toileting was expected every two hours.On 1/21/26 at 4:55 p.m., licensed practical nurse (LPN)-A stated staff were expected to toilet R4 every two hours, and stated the facility had staffing challenges of shortage of staff and large amount of agency staff that delayed routine care, due to staffing issues and agency staff unfamiliarity with resident care.On 1/26/26 at 5:42 p.m., the director of nursing (DON) stated staff were expected to toilet R4 per the care plan and document toileting and refusals.Facility ADL Care of Dementia Unit Residents policy dated 2025, (continued on next page)

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	245425	A. Building B. Wing	01/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Thorne Crest Retirement Center	1201 Garfield Avenue Albert Lea, MN 56007

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	indicated;It is the policy of this facility to provide appropriate treatment and services in relation to ADL care to residents on the dementia unit to ensure all ADL needs are met on a daily basis, while attaining or maintaining the dementia resident's highest practicable physical, mental and psychosocial well-being. The care plan interventions will be monitored on an ongoing basis for effectiveness and will be reviewed/revised as necessary.Facility Policy Activities of Daily Living (ADLs) dated 2025, indicated;Care and services will be provided for the following activities of daily living: 1. Bathing, dressing, grooming and oral care; 2. Transfer and ambulation; 3. Toileting.A resident who is unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.The facility will maintain individual objectives of the care plan and periodic review and evaluation.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure dialysis communication forms were consistently reviewed, addressed, and incorporated into the resident's medical record, and failed to ensure provider orders communicated by the dialysis provider were implemented in a timely manner for 1 of 1 resident (R3) of one reviewed for dialysis.Findings Include:R3's quarterly Minimum Data Set (MDS) dated [DATE], indicated R3 was cognitively intact, no rejection of care, utilized a wheelchair, required substantial/maximal assistance with personal hygiene, upper body dressing, dependent on staff for toileting hygiene and transfers; diagnoses included hemiplegia or hemiparesis, depression, dependence on renal dialysis.R3's care plan dated 1/2/26, need hemodialysis r/t (related to) renal failure and interventions included: encourage resident to go for the scheduled dialysis appointments, receives dialysis Monday, Wednesday, Friday transportation provided by facility.Review of R3's dialysis communication forms from 12/15/25 through 1/21/26, indicated forms dated 12/15/25, 12/19/25, 12/22/25, 1/16/26, and 1/21/26. The facility failed to provide any additional forms or documentation of communication from dialysis.R3's dialysis communication form dated 1/16/26, registered nurse (RN)-G indicated: please see attached order for Claritin (medication used to treat allergies and hives), this was ordered on 12/29/25, and do not see on R3's MAR (mediation administration record), will help with rash and scratching.R3's MAR dated 12/1/25-12/31/25, failed to indicate an order for Claritin.R3's MAR dated 1/1/26-1/31/26, indicated start date 1/20/26, Claritin oral tablet chewable 5 mg (milligrams) give 1 tablet by mouth one time a day for itching.On 1/20/26 at 12:57 p.m., R3 was observed lying in bed and reported ongoing itching of his arms for approximately one month and stated he was unsure whether the facility or physicians were addressing the concern. R3 was observed to have multiple scratches of varying sizes on bilateral arms.On 1/21/26 at 3:13 p.m., RN-C stated R3 had a dialysis communication folder that traveled to and from dialysis appointments; however, RN-C reported finding prior dialysis communication forms in the back pocket of R3's wheelchair that had not been reviewed or addressed. RN-C stated the facility utilized a high volume of agency nursing staff and indicated the communication process may not have been followed due to agency staff being unfamiliar with the expectation to review the dialysis communication forms.On 1/21/26 at 9:25 a.m., RN-G stated they were an agency nurse and was observed to remove dialysis communication form in the back pocket of R3's wheelchair dated 1/16/26. RN-G stated they were not educated or trained by the facility regarding the requirement to review dialysis communication forms or ensure provider communication was addressed upon the resident's return from dialysis.On 1/21/26 at 9:43 a.m., the director of nursing (DON) confirmed a dialysis communication form dated 1/16/26, was found in the back pocket of R3's wheelchair and had not been addressed. The DON stated nursing staff were expected to retrieve the dialysis communication form when R3 returned from dialysis and document any provider communication or new orders in a progress note within the electronic medical record (EMR).On 1/21/26 at 10:21 a.m., during a telephone interview, RN-H from the dialysis provider stated concerns regarding R3's skin condition had been communicated through the dialysis communication forms and stated Claritin had been ordered in December to address itching; however, the medication had not been started until the current week. RN-H stated they would have expected the order to be addressed and implemented sooner.On 1/22/26 at 7:35 a.m., the DON stated the facility was unable to locate all dialysis communication forms for R3 and confirmed forms were expected to be scanned into the EMR if not otherwise documented in a progress note. The DON confirmed the facility could not locate a dialysis communication form dated 12/29/25, related to the Claritin order and confirmed the medication was not initiated until 1/20/26. The DON further stated the Claritin should have been ordered and administered as directed by the dialysis provider on 12/29/2Facility Dialysis Agreement dated 3/10/2009, indicated Those areas of the Nursing Home's plan of care in which Clinic and Hospital (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	shall furnish direction to the Nursing Home shall include, but not be limited to: (a) procedures for handling medical and non-medical emergencies, including complications, equipment failure and a Clinic and Hospital contact in case of emergencies; (b) follow-up care, observation, and monitoring;(c) medications; (d) nutritional needs and fluid restrictions; and(e) Resident education.

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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, and staff interview, the facility failed to ensure medications were administered in accordance with prescriber orders when an incorrect dose of losartan (blood pressure medication) was administered incorrectly for three months, constituting a significant medication error for 1 of 5 residents (R44) reviewed for medication administration. Findings Include:R44's Minimum Data Set (MDS) dated [DATE], indicated R44 was cognitively intact, required partial/moderate assistance with personal hygiene, and diagnoses included hypertension. R44's care plan dated 12/19/25, indicated R44 at risk cardiovascular status r/t (related to) hypertensive heart disease and atherosclerosis of aorta.R44's provider note dated 10/8/25, physician assistant (PA)-K provider note indicated decrease losartan to 25 mg (milligrams) daily. R44's medication administration record dated 10/1/25-10/31/25, 11/1/25-11/30/25, 12/1/25-12/31/25, and 1/1/26-1/31/26, indicated R44 received losartan potassium oral tablet 25 mg daily. On 1/21/26 at 8:47 a.m., observation and interview with registered nurse (RN)-G was observed to prepare R44's medications and identified a discrepancy between the medication order and the pharmacy label for losartan. RN-G stated the losartan was ordered at 25 mg, but the pharmacy-labeled medication provided in the packet was 50 mg. RN-G verified the order using the computer and packaging, determined the dose was incorrect, and did not administer the losartan.On 1/21/26 at 9:40 a.m., interview with the director of nursing (DON) stated the pharmacy was contacted today regarding R44's losartan discrepancy. The DON stated the pharmacy was filling an older order dating back to June (2025) of losartan 50 mg versus the current 25 mg order. The DON confirmed that since 10/2025, R44 had been receiving losartan 50 mg instead of the ordered 25 mg. The DON stated she would expect nursing staff to verify medication orders against pharmacy packaging.On 1/21/26 at 2:57 p.m., the DON stated an incident report was not completed related to R44's losartan dosing error and confirmed staff were not following the prescriber's order. The DON further stated there had been a lot of medication errors occurring intermittently. The DON confirmed education had been provided to staff; however, corrective actions were not consistently effective.On 1/22/26 at 7:35 a.m., interview with the DON revealed the facility did not complete medication reconciliation at the time medications were dispensed from the pharmacy to ensure the medications matched current orders. The DON confirmed the facility did not routinely call or confirm receipt of new or changed medication orders with the pharmacy, despite ongoing issues for several months in which the pharmacy stated it had not received orders. The DON was unable to articulate what specific actions had been implemented to prevent recurrence of medication errors. The DON further confirmed medication audits had not been completed since December. The DON confirmed the pharmacy performed reconciliation and placed medications into the medication dispensing system; however, the facility failed to verify accuracy upon receipt and failed to identify and correct ongoing medication discrepancies.Facility Medication Administration Policy and Procedure dated 2025, indicated:Medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice, in a manner to prevent contamination or infection.Policy Explanation and Compliance Guidelines:Ensure that the six rights of medication administration are followed: Right resident Right drug Right dosage Right route Right time Right documentation Review MAR to identify medication to be administered.Compare medication source (bubble pack, vial, etc.) with MAR to verify resident name, medication name, form, dose, route, and time.Correct any discrepancies and report to nurse manager.

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or get specialized rehabilitative services as required for a resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and documentation review, the facility failed to seek clarification and initiate physical therapy timely for 1 of 1 resident (R43) who had had orders for physical therapy after a fracture. Findings include:R43's face sheet printed 1/22/26 at 4:33 p.m., indicated diagnoses of fracture of right foot, Alzheimer's disease, pain related to hand contracture.R43's care plan dated 11/6/25, indicated need for restorative nursing, will continue to maintain current abilities. Refer to therapy as needed.R43's quarterly Minimum Data Set (MDS) dated [DATE], indicated moderately impaired cognition, rejection of care one to three days, lower extremity impairment on one side, use of wheelchair, supervision for eating, dependent for toileting, substantial assistance for bathing and dressing.During observation and interview on 1/20/26 at 7:49 p.m., R43 was in bed with daughter (FM)-B at bedside. FM-B stated she planned to take R43 home when therapy was done. FM-B stated an order for physical therapy was written 12/23/25, but therapy had not started yet. FM-B stated she was frustrated because she thought R43 would be back home by now and she could take care of her at home if physical therapy could work with her on transfers. FM-B stated she had asked director of nursing (DON) why therapy had not started but did not get an answer.Facility form titled Clinic Sheet signed by registered nurse (RN)-C, RN-E, and health unit coordinator (HUC)-E dated 12/23/25, indicated fracture of right foot, may start to place weight on right foot to transfer with assistance. May start physical therapy at this time.Facility progress note written by RN-C dated 12/23/25, indicated R43 returned from x-ray with the following orders: May start to place weight on right foot to transfer with assistance. May start physical therapy at this time. Daughter was with R43 at appointment and aware of new orders.Review of R43's physician's orders on 1/21/26 at 1:45 p.m., indicated no order for physical therapy was entered into the facility electronic health record (EHR).During interview on 1/21/26 at 4:30 p.m., RN-C stated he did not remember anything specific about R43's therapy order, but if he signed off on the order a copy would go in a folder and be given to therapy. RN-C stated that likely did not happen if therapy had not been started for R43.During interview on 1/21/26 at 4:45 p.m., HUC-E stated her signature was on the order on 12/23/25, RN-C signed on 12/23/25, and RN-E signed on 12/25/25. HUC-E stated that meant she put orders in EHR, RN-C signed off on them, and RN-E signed off as the final check to ensure the order was processed right. HUC-E stated RN-C could have forgotten to activate the orders, and RN-E should have caught that. HUC-E further stated it did not look like the orders were ever entered into the EHR.During interview on 1/21/26 at 5:02 p.m., DON stated she was not sure what the delay was in getting the therapy order entered but had done it now. DON stated therapy had needed the order to say something different, so they waited for the facility provider to change the order. DON stated therapy had been given the new order on 1/16/26, and would have expected therapy to start sooner for R43.During interview on 1/22/26 at 12:28 p.m., physical therapy assistant (PTA)-I stated it was hit or miss at the facility whether therapy orders were received promptly. PTA-I stated she believed she got R43's order on 12/24/25, and told them on 12/29/25 the order was written incorrectly and needed to say the words eval and treat. PTA-I stated she did not hear anything more about the therapy order for R43 until 1/16/26. DON emailed the provider at 4:45 p.m., and received a response from the provider with the correct order at 4:47 p.m. PTA-I stated it took two minutes for a response and wasn't sure why this couldn't have been done right away. PTA-I stated it was important to start therapy as soon as possible to reduce the risk for further decline.Facility Provision of Physician Ordered Services policy dated 6/10/25, indicated the purpose of this policy is to provide a reliable process for the proper and consistent provision of physician ordered services according to professional standards of quality, meaning that care and all services are provided according to accepted standards of practice.