STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245439	A. Building B. Wing	12/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Catholic Eldercare on Main	817 Main Street Northeast Minneapolis, MN 55413

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on observation and interview the facility failed to maintain a comfortable temperature between 71-81 degrees Fahrenheit (F) in 1 of 2 first floor dining areas. In addition, the facility failed to maintain acceptable temperature range in 1 of 1 split resident room for 2 of 2 residents (R41 and R45). Findings include:Observation/ interview on 12/15/25 at 1:30 p.m., during initial screening R41 was seated in her wheelchair in her room wearing a knitted scarf wrapped around her neck and wearing a blue quilled coat. She had her arms crossed her body and stated it was cold in her room, but it was better than the past couple of days when it was terribly cold outside. She reported she had told staff and asked to have her room warmer, but nothing had been done. she also reported it was hard to eat her meals in the room being used for the dining room because it was so cold, and she and the other residents had complained, but were told nothing could be done about it. Observation on 12/15/25 at 2:00 p.m. of the Atrium room being used for dining noted large floor to ceiling windows facing the yard area with snow against the lower portion of the windows. The ceilings were high, and ceiling fans were circulating the air, which was uncomfortably cold. Multiple tables were positioned throughout the room, and through the doors located at the end of the large room construction area was noted.Observation on12/15/25 at 4:45 p.m., R41 was transported into the Atrium room for the supper meal wearing her scarf around her neck and her quilted coat, she had the scarf pulled up around her lower face and sat with her arms across her body. She reported it was hard to eat because it was so cold and uncomfortable. Multiple residents waiting to eat their supper meal also voiced complaints that it was so cold, and the ceiling fans were making it worse. Multiple residents were noted to ask staff to turn off the fans but were told the fans were pushing the heat down, and it would be colder if they were turned off. One unidentified resident was brought into the dining area wearing, a heavy sweater, wrapped in a blanket and wearing gloves, which she kept on while trying to eat her supper. Multiple residents were wrapped in blankets and wearing heavy sweaters or coats. All but one resident present in the dining room complained it was difficult to eat because it was so cold and reported they had complained but were told nothing could be done about it. A visiting family member (requested to remain anonymous) reported it had been very cold for all the residents, and she had to get blankets and wrap around the residents to help them stay warm. She reported she had also voiced complaints to administration about how cold it was in the dining area, but nothing had been done about it. Observation/interview on 12/15/25 at 1:30 p.m. with R45 who was seated in her wheelchair in her room shared with R41. She was wearing a heavy knit sweater and covered with a blanket. She reported her room was very cold and there was cold air felt coming from the ceiling vent. She reported she had requested her room to be warmer, but nothing had been done, and multiple unidentified staff had told her room was the coldest room on the unit. R45 also complained about how cold it was in the dining area, and it was difficult to eat because she was so cold. She stated the only time she was warm was when she was in bed with all her blankets on. At 4:45 p.m. R45 was seated at a table in the dining room wearing a heavy sweater and covered with a blanket. A ceiling fan was above her and cold air movement was noted. She and multiple residents at tables throughout the room were asking for the fans to be turned off because they were so cold. Observation/interview on 12/16/25 at 12:30 (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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	p.m. identified R41 in her wheelchair in her room wearing her scarf around her neck and her quilted coat. She reported it had been cold in the dining room again this morning and the fans were still on. She stated she was hoping it would get warmer since the outside was warmer outside.R45 was seated in her wheelchair eating her noon meal in her room and stated she was not feeling well because the cold made her ache, because she had Parkinson's disease, and the cold made it worse. She reported she had been told maintenance was going to come and see what they could do to make her room warmer, but nothing had been done yet. Interview on 12/17/25 at 9:18 a.m. with the certified dietary manager (CDM) reported it had been uncomfortably cold in the Atrium room currently being used for dining during the construction period and residents had complained about the temperature, but she was told nothing could be done about it. She also reported residents had asked to have the ceiling fans turned off during meals, but administration had told her they had to remain on to regulate the heat in the room. she reported it had been very cold on a couple of days the past week when the outdoor temperature was in the single digits, and on one day they had not served in the Atrium because it was so cold. Interview on 12/17/25 at 9:19 a.m. with the maintenance director reported he had been contacted by the director of operations regarding the temperature in the Atrium during the supper meal on 12/15/25 because residents were complaining it was uncomfortably cold. He reported he had the housekeeping director check the controls to ensure the Atrium unit was running and upon his arrival the morning of 12/16/25, he entered the Atrium and confirmed it was very cold. He estimated the temperature was @ 65 degrees F. which was below the designated temperature range of 71 - 81 degrees. He reported he had reset the unit and used a temperature gun to confirm there was heat coming from the vents in the ceiling. The room was noted to be a comfortable temperature, and he reported he had been checking the temperature since that time, and it had remained at 75-79 degrees F. At 9:24 a.m. the maintenance director was observed using a temperature gun to check the temperature of air coming from the vents in the Atrium. The ceiling is 30 feet from the floor and the air coming from the vents registered 93 degrees, temperature at the table level was 82-84 degrees and beside the window was at 73 degrees. He reported he did not know what had happened to cause the unit to not be functioning properly, but it seemed to be working at the present time, and he would continue to monitor. He did voice agreement that turning the fans off on 12/15/25 during the supper meal would have been appropriate as the circulating air would have made the room feel colder to those residents seated at the tables. Regarding R41 and R45's shared room, he reported he had checked the problem with the heat, and a vent had been closed which limited the amount of heat going to the room. He had made the adjustment, and both residents had reported it had gotten more comfortable for them. Interview on 12/17/25 at 10:30 a.m. with both R41 and R45 voiced the temperature in both their room, and the dining area was much more comfortable now, but did not understand why it could not have been corrected sooner. A policy on environment and comfortable temperatures in common spaces and resident rooms was requested but not provided by the end of the survey period.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and document review, the facility failed to ensure appropriate infection control technique was followed during 1 of 1 meal service for hand hygiene and beard net use. In addition the facility failed to follow infection control practices for cleanliness and storage of reusable steam table pans . This had the potential to affect all 146 residents residing in the facility.Findings include: Observation on 12/15/25 at 1:13 p.m. with the certified dietary manger (CDM) during the initial kitchen tour identified the following items stacked on a metal cart as ready for use: 1.) Five 1/4 steam table pans that were stacked and were still wet.2.) Two 1/8 steam table pans stacked and were still wet, and a deep steam table pan with food substance left on the surface, and wetness present on the inside.3.) Two full sheet pans stacked and still wet on the interior surface.4.) Twelve 2-inch steam table pans that had been stored while still wet and remained wet at the time of observation.Interview on 12/15/25 at 1:20 p.m. with the CDM identified the steam table pans should not have been removed from the drying rack and stacked while still wet, and the soiled items should have been caught and rewashed and dried before being placed on the storage rack for reuse. She identified her expectation that items placed on the storage rack for reuse be clean and dried appropriately for reuse. Interview on 12/15/25 at 1:23 p.m. with the registered dietitian (RD) identified her expectation for reusable cookware to be appropriately cleaned and dried before it was stacked on a rack as ready for reuse. Observation on 12/17/25 at 11:37 a.m. as the noon meal was plated and loaded onto carts for transport to the facility nursing units. DA-A was observed assisting to prepare and transport meal carts to the nursing units. DA-A had a hair net on the top of his head but had hair extending @ 1 inch on the front and sides of his head. DA-A also was noted to have long facial hair and no facial hair covering in place. When an unidentified staff person asked for shredded cheese for a meal tray, DA-A used his gloved hands to remove a large container of shredded cheese from the refrigerator, Remove the cover, and use his same gloved hand to reach into the container, remove a handful of cheese and place it into a dish and hand to a person on the tray line. With his same gloved hands, he recovered the container and returned it to the refrigerator. Then with no glove change or hand hygiene he proceeded with loading resident meal trays onto the cart. Interview on 12/17/25 at 11:45 a.m. with DA-A reported he had not thought about needing to change his gloves and perform hand hygiene prior to obtaining the requested shredded cheese, and reported he should have used a spoon or scoop to retrieve the cheese rather than his hand. He also reported he was not aware he needed to be wearing a beard cover, and he normally had not done so in the past. Interview on 12/17/25 at 11:55 a.m. with the CDM reported she was not certain about when male staff needed to utilize beard covers, and DA-A did not usually have his hair and facial hair in the appearance it was at this time and she had not noticed it, but agreed he should have both hair on his head and beard covered. Review of the 8/8/22 Dining Services policies and Procedures identified hairnets must be always worn over all of hair. Hair must be neat and clean and not interfere with good infection control technique. Sideburns, mustaches, and beards must be neatly trimmed. the policy failed to address the use of facial hair coverings. A policy on cleaning and storage of reusable cooking, steamtable pans was requested but not provided by the end of the survey period.

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. Based on interview and document review, the facility failed to obtain and document an informed consent, including with explanation of risk and benefits, for 2 of 5 residents (R2, R157) reviewed for unnecessary medications.Findings include: R2R2's significant change in status Minimum Data Set (MDS) assessment, dated 10/1/25, indicated R2 had short term and long-term memory impairment with no hallucinations or delusions, no behaviors, wandering or rejection of care.During an observation and interview on 12/17/25 on 7:52 a.m., R2 was observed in the small dining room, feeding herself breakfast. She smiles at surveyor but does not answer questions. R2 appears comfortable. R2's Order Summary Report, printed 12/18/25, included the following orders: -quetiapine (an antipsychotic medication) 25 milligram (mg) tablet; take 12.5 mg by mouth three times a day with a start date of 2/10/25-sertraline (antidepressant medication to help treat depression) 50 mg by mouth once daily with a start date of 5/16/23. R2's December Medication Administration Record (MAR/TAR), printed 12/18/25, included the following: -quetiapine 25 mg tablet: take 12.5 mg by mouth three times a day for psychotic disorder with delusions due to known physiological condition with a start date of 2/10/25. Documentation indicated administered as ordered. -sertraline 50 mg: take 50 mg by mouth once a day for depression with a start date of 5/16/23. Documentation indicated administered as ordered. A document titled Informed Consent: Anti-Anxiety Medication was provided. The document indicated the medication was quetiapine 12.5 mg. The document lacked side effect information. The document lacked indication of whether consent was given or not within the provided boxes of I approve or I do not approve. Furthermore, the document lacked a date or signature of nurse.A document titled Informed Consent: Anti-Depressant Medication was provided. The document indicated the medication was sertraline 50mg which was increased on 5/16/23. The document lacked a date the form was completed. Furthermore, the document lacked any side effect information. R157R157's quarterly MDS assessment, dated 12/5/25, indicated R157 had severely impaired cognition impairment with no hallucinations or delusions, no behaviors, wandering or rejection of care.During an observation and interview on 12/15/25 at 5:09 p.m., R157 was observed seated in her wheelchair. R157 would alternate from scooting herself around in the dining room and eating supper. R157 was concerned about someone stealing her card. R157's Order Summary Report, printed 12/18/25, included the following orders: -quetiapine 25 mg tablet; take 75 mg by mouth at bedtime with a start date of 2/20/25-sertraline (antidepressant medication to help treat depression) 50 mg by mouth once daily with a start date of 5/2/24.R157's December Medication Administration Record (MAR/TAR), printed 12/18/25, included the following: -quetiapine 25 mg tablet: take 75 mg by mouth at bedtime for psychotic disorder with delusions due to known physiological condition with a start date of 2/20/25. Documentation indicated administered as ordered. -sertraline 50 mg: take 50 mg by mouth once a day for major depressive disorder with a start date of 5/2/24. Documentation indicated administered as ordered. A document titled Informed Consent: Anti-Psychotic (Neuroleptic) Medication was provided. The document indicated the medication was quetiapine 75 mg. The document was signed on 12/17/25 by responsible party. A document titled Informed Consent: Anti-Depressant Medication was provided. The document indicated the medication was sertraline 50mg. The document lacked any side effect information. The document was signed by responsible party on 12/17/25. During an interview on 12/17/25 at 11:08 a.m., health unit coordinator (HUC)-A stated they do all the uploading for the floor. HUC-A stated they do not have any consents for medications that have not been uploaded for R2 or R157. HUC-A reviewed R2 and R157 medical records. HUC-A stated there was not a signed consent for R2 for quetiapine or sertraline. HUC-A stated there was not a signed consent for R157 for quetiapine or sertraline. HUC-A verified the facility does not use paper charts and everything was kept in the electronic medical record. During an interview on 12/17/25 at 10:43 a.m., licensed practical nurse (LPN)-B stated when a resident starts on a new psychotropic medication, nursing gets a consent for the medication. LPN-B stated it was a paper consent which gets uploaded into the (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	electronic medical record. LPN-B reviewed R2 medical record and stated they could not find a signed consent for quetiapine or sertraline. LPN-B reviewed R157 medical record and stated they couldn't find consents for sertraline or quetiapine. LPN-B stated both medications should have consents given prior to administering. During an interview on 12/17/25 at 12:26 p.m., registered nurse manager (RN)-D stated the expectation was to obtain consent for psychotropic medications prior to starting them. RN-D stated it was the floor nurse's responsibility to obtain the consents. RN-D reviewed R2 and R157 medical records and verified the consents where not in the chart. During a follow up interview on 12/18/25 at 8:28 a.m., RN-D stated he followed on the consents for R2 and R157. RN-D stated he found the consents in the drawer from previous nurse manager. Surveyor and RN-D reviewed. RN-D verified R2's Informed Consent for Anti-Anxiety Medication lacked side effect information, a date, signature of nurse and whether consent was given and stated the consent should have this information. RN-D verified R2's Informed Consent for Antidepressant Medication lacked side effect information and date which the form was completed and stated the consent should have this information. RN-D stated he found R157's consent forms for antipsychotic and antidepressant medication in the drawer also and did not have signatures. RN-D stated he followed up with the nurse on the floor who then talked to the family who signed the forms. RN-D verified the forms were not signed prior. RN-D verified the consent for sertraline did not contain any side effect information along with not indicating whether consent was given by checking the I approve or I do not approve box. During an interview on 12/18/25 at 11:12 a.m., director of nursing (DON) stated the expectation would be consents for medications be obtain. DON stated a verbal consent would be acceptable if it was document. DON stated the consent should include the following: medication, dose, reason why they are taking it, benefits, side effects and dated. DON reviewed R2's consent for sertraline and quetiapine and R157's consents for sertraline and quetiapine and verified the documents lacked required information. A facility policy titled Psychotropic Medication, reviewed 10/10/25, indicated the procedure to include obtain informed consent from resident and/or responsible party. See informed consent: psychotropic medications. If consent is given continue to follow policy, if denied contact prescriber.

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to assess resident for safety and the ability to self-administer medications (SAM) for 2 of 2 resident (R109 and R170) reviewed for self-administration of medications.Findings include: R109's comprehensive Minimum Data Set (MDS) dated [DATE] identified R109 with intact cognition, required substantial assistance with toileting, showers, and dressing. Diagnoses included diabetes, morbid obesity, and an infection of the bone. R109's physician order (PO) for Miconazole powder, twice a day as needed dated 5/13/25, failed to indicate leaving it at bedside for self-administration. R109's care plan lacked indication of R109's ability to self-administer Miconazole. During observation on 12/15/25 at 2:23 p.m., R109 was sitting in wheelchair at bedside. On his rolling nightstand was a container of Miconazole Nitrate 2% antifungal powder with prescription label dated 5/13/25. R109 stated he used it as needed for skin infection. R109 also stated facility was aware of it and had been using it since admission in May of 2025. They know all about it. The bottle has [facility] name on it. R109 stated, I have not been asked about it when I admitted or how often I use it or if I need a refill. During observations on 12/15/25 at 5:08 p.m., and 12/16/25 at 2:33 p.m., the Miconazole Nitrate 2% antifungal powder was on R109s rolling nightstand. During observation and interview with registered nurse (RN)-B on 12/17/25 at 10:19 a.m., RN-B observed the miconazole on R109's rolling nightstand. RN-B said, [R109] should not have this in his room with a self-administration order and it being on his care plan. RN-B looked up R109's PO and verified there was an order for Miconazole, but no order to leave it in his room. No assessment was done. During interview with RN-A on 12/17/25 at 10:28 a.m., RN-A looked in R109 PO and stated, [order] is not in there to be left at bedside. During interview with RN-C on 12/17/25 at 10:31 a.m., RN-C stated expectation of nurses to assess every resident on admission to facility to see if they can self-administer. Then nurses are to request a physician order. The order itself needs to say if they [residents] can self-administer or frequency and to keep at bedside. During interview with director of nursing (DON) on 12/18/25 at 9:42 a.m., DON stated facility expectation of receiving a physician order first to leave medication at bedside. Then an assessment for safety is conducted and care plan is updated. For R109, It was not done and should have been. R170 R170 was admitted to the facility on [DATE]. Admitting diagnoses included acute embolism (blood cloth) and thrombosis (blood clot blocking blood flow) of left femoral vein, urinary tract infection, essential hypertension (abnormally high blood pressure that's not the result of a medical condition), (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and unspecified diarrhea. R170's Resident Profile indicated she needed maximal assistance with dressing, needed minimal assistance with transfers, ambulation with contact guard assistance, and moderate assistance with toileting hygiene. R170's profile also indicated she had pain and received pain medications per physicians or nurse practitioner orders. R170's Clinical Physician orders dated 12/22/25 indicated R170 had an order dated 12/13/25 for Benzocaine gel 20%. Special instructions: Apply a small amount of the gel to the affected area using a cotton applicator. Every 2 hours. R170's electronic medical record (EMR) lacked an assessment for self-administration of medications. In addition, there was no documentation in the progress notes about the Anbesol gel. During observation and interview on 12/15/25 at 3:33 p.m., R170 stated she had tooth pain, and the staff gave her a gel. R170 stated, I think it is Anbesol, and I can put it on myself. They told me to put it on my finger and rub it around my teeth, but I am squirting the gel because it needs to get in all crevices to work. R170 had a small basket on her bed side containing a tube of Anbesol maximum strength 20% gel inside a small Ziploc bag. The Anbesol's label indicated, apply a small amount using a cotton applicator every 2 hours as needed. R170 stated they told me to put some on the tip of my finger and nothing else. I don't know how often I can use it. They did not give me cotton applicators. They didn't give me any directions. During interview on 12/18/25 at 9:04 a.m., R170 stated her tooth pain was better, but nobody had asked her about it. The Anbesol gel was on her bed side table. During interview on 12/18/25 at 8:40 a.m., registered nurse (RN)-E stated upon admission to our transitional care unit (TCU), all residents were asked if they wanted to self-administer their medications, but most of the residents wanted the nurses to administer their medications. RN-E stated, if a resident wanted to self-administer a medication, the admission nurse would do a self-administration of medications (SAM). RN-E said after the assessment was completed, a doctor's order for self-administration was obtained. During interview on 12/18/25 at 9:13 a.m., nurse manager/RN- F stated a SAM was needed to be done to assure residents could self-administer a medication. RN-F stated a doctor needed to give an order for self-administration of medications. RN-F verified R170 did not have a SAM or a physician order to self-administer medications. During interview on 12/18/25 at 10:53 a.m., director of nursing (DON) stated medications shouldn't be left at bed side. DON stated residents needed to be assessed to determine if they were able to self-administer their medications. DON stated the residents needed to be educated about proper use of the medication, and nurses needed to make a progress note on residents' EMR. Facility policy titled Self-administration of Drugs dated 10/10/25 indicated residents have the right to self-administer drugs if the facility's interdisciplinary team had determined that the practice was safe. Policy's procedure indicated: At the time of admission or when requested, nursing completed observation to assess for self-administration of medications. (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Obtain provider order to self-administer medication if indicated. The assessment will be documented in the resident's care plan and reviewed at least quarterly or upon significant change in the resident's condition. If deemed eligible, the resident's care plan be updated. A signed consent form will be required from the resident or their legal representative, acknowledging their responsibility in self- administering medication. Medications approved for self-administration will be stored securely at a designate place according to care plan.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** During observation, interview and record review, the facility failed to accommodate resident needs by ensuring the call light was accessible for 2 of 2 residents (R5, R101) reviewed for call lights.Findings include:R5R5's annual Minimum Data Set (MDS), dated [DATE] identified R5 with impaired cognition, required substantial assistance for personal hygiene, dressing, and rolling from side to side in bed. In addition, R5 had diagnoses of diabetes, aphasia (communication disorder affecting speech, understanding, reading and writing), dementia, schizophrenia and had an indwelling catheter (tube from bladder to outside the body into a bag).R5's Care Plan dated 5/16/22 identified: Answer call lights per protocol.During observation on 12/15/25 at 2:35 p.m., R5 was lying in bed sleeping. Their call light was resting on top of nightstand out of sight and out of reach of resident.During interview with licensed practical nurse (LPN)-A on 12/16/25 at 3:32 p.m., LPN stated, Call light should be in reach at all time [for] safety.During interview with registered nurse (RN)-A on 12/16/25 at 3:38 p.m., RN-A stated R5 was capable of using a call light and had used it in the past. RN-A stated expectation of call lights to be in reach so she can call anything she may need something.R101R101's quarterly MDS dated [DATE], identified impaired cognition, dependent on staff for bathing, toileting, dressing, personal hygiene, and rolling from side to side in the bed. In addition, R101 had diagnoses of Alzheimer's, Parkinson's, psychosis, and was on hospiceDuring observation and interview on 12/18/25 at 8:32 a.m., R101 was lying in bed, positioned on left side to face the wall. Both arms were bent towards torso with wrists were touching his face. A soft call light was placed on the bed next to his head out of reach and sight of resident. LPN-B looked at R101 and stated the call light was out of his reach.During interview with nursing assistant (NA)-B on 12/17/25 at 12:46 p.m., NA-B stated call lights should be in reach for anything to call for help. If out of reach, they [residents] might not be able to get help.During interview with NA-C on 12/17/25 at 12:55 p.m., NA-C stated expectation of call lights to be in reach of residents when they are in their rooms. If they [residents] can't reach it then it is not right. Their needs are not met.During interview with director of nursing (DON) on 12/18/25 at 9:44 a.m., DON stated expectation of all nursing staff to ensure call lights were in reach of all residents, so they [residents] can ask for help if needed.Facility policy titled Call Light, reviewed 9/17/2025 identified, The call light must be placed within reach of the resident while in their room.

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Catholic Eldercare on Main	817 Main Street Northeast Minneapolis, MN 55413

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review the facility failed to ensure the accuracy of 1 of 1 resident (R41) medical record when R41 had conflicting end of life (code status) documentation. :Findings include:R41's current, undated electronic medical record (EMR) identified R41 was marked as full code (wanting all lifesaving measures including cardiopulmonary resuscitation (CPR), R41's [DATE], Provider Orders for Life-Sustaining Treatment (POLST) identifiedA: Attempt Resuscitation/CPRB. Full TreatmentC. Documentation of Discussion-Patient has Capacity D. Signature by R41 dated [DATE] and by certified nurse practioner (CNP) dated [DATE]R41's current, electronically signed physician orders identified her code status as Do Not Resuscitate/Do Not Intubate (DNR/DNI). Interview on [DATE] at 12:14 p.m. with R41 identified she wanted full resuscitative measures performed if she was found to not be breathing or have a pulse. Interview on 12/16//25 at 12:45 p.m. with licensed practical nurse (LPN)-C reported would initially check the EMR face sheet banner, then the orders, and she also identified there was a reference book kept at the nursing station for staff to reference for code status of residents. LPN-C further identified there was supposed to be a copy of each resident's care plan posted on the inside of the room closet door to allow for quick access. LPN-C referenced R41's EMR and confirmed the current physician orders listed her code status as DNR/DNI which was not correct. She reported the error should have been caught at the time of admission on [DATE] and would need to be corrected immediately. LPN-C provided documentation of the date the order was changed on [DATE]. Interview on [DATE] at 12:50 p.m. with registered nurse (RN)-A reported in an emergency when code status needed to be confirmed she would initially go to the EMR, open the face sheet where code status was displayed on the resident banner. She reported there was also a hard copy kept in a binder at the nursing station for quick reference by staff. Upon review of R41's EMR she confirmed the current physician orders conflicted with the POLST and care plan and should have been caught and corrected at the time the orders were entered and reviewed in the record. Interview on [DATE] at 1:05 p.m. with the director of nursing (DON) identified his expectation for staff to confirm the POLST, EMR banner, physician orders and care plan were reviewed to ensure a resident's correct code status was identified and documented. He agreed R41 could have potentially not received resuscitative measures in an emergent situation. A policy related to Advance Directives and/or emergent situations regarding provision of CPR was requested but not provided by the end of the survey period.

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. Based on observation, interview, and document review, the facility failed to ensure residents were free from physical restraints for 1 of 1 resident (R101) who utilized a pillow rolled to prevent resident from attempting to self-transfer from his bed. Findings include: R101's 12/4/25 accepted Quarterly Minimum Data Set (MDS) assessment identified he had severed cognitive impairment, moderate visual impairment, was dependent on staff for ADLs including eating. His most recent fall occurred on 11/22/25 when he had fallen from his chair in the common areas. He had diagnosis of Parkinson's disease with psychotic disturbance, dementia in Alzheimer's disease, impaired mobility and ADLs, and depression, he received daily psychotropics, Parkinson's disease medication, Tylenol, and topical analgesic medication. Had been admitted to hospice services 4/24/25 with a terminal diagnosis of -Parkinson's disease with dementia. No restrictive devices were identified in the assessment.R101's current undated care plan identified he received hospice services, and the care plan was integrated with the facility care plan. The intervention identified placement of a pillow on the left side of the Broda chair for comfort due to his leaning to the left. He was to be assisted back to the nursing station following visits to allow for visual monitoring. Target behaviors were identified with monitoring and documentation to be completed. Medications were to be administered as ordered with monitoring for effectiveness and potential side effects. Safety related to falls always included incline his wheelchair except during meals to prevent falls. Position by nursing station to allow for supervision. When falls occur investigate root cause through IDT meeting protocol. The care plan did not include any type of restraint or device to restrict movement. R101's current undated care plan identified he had his most recent fall on 11/22/25 related to an attempt to self-transfer, and the most recent interventions was positioning resident close to the nursing station to allow for supervision and verbal reminders. He had severe cognitive impairment) related to [dementia, Parkinson's disease, Alzheimer's disease, Major depressive disorder, with psychotic symptoms, affecting orientation, memory, and/or decision-making. Hospice services identified a terminal diagnosis of Parkinson's Disease with Dementia with intervention to place a soft pillow on the left side of the Broda chair when he was seated for comfort as he leaned on the left side of the chair. Safety measures included to ensure that he was assisted back to the nursing station or where staff can visually monitor after visits. Ensure call light is within reach; reinforce its use. Target behaviors were identified, but there was no mention of assessment for use of any restrictive devices to reduce the risk of falls. Interview on 12/17/25 at 12:47 p.m. with licensed practical nurse (LPN)-D identified resident was currently receiving hospice services and was becoming weaker. She reported he did not indicate he had pain but was confused and would attempt to self-transfer at times which had resulted in him falling. LPN-E reported resident was dependent for activities of daily living (ADLS) including eating and when up in his chair was positioned where he could be observed because he would become restless, call out for his wife, and had fallen previously. During observation/interview on 12/17/25 at 1:11 p.m. with nursing assistant (NA)-E, R101 was lying in bed with the bed in low position, a neck pillow behind his neck, his chin on his chest, a body type pillow positioned on his left side between the grab bar and his body, (the bed was against the wall), and a square pillow folded and placed against his right side, preventing him from rolling back toward the room side of the bed. When asked about the pillows NA-E reported the pillow on R101's left side was for comfort as he was on his left side a lot and the pillow positioned on the right side was due to his attempts to throw his legs off the side of the bed and attempt to sit up to self-transfer. She reported the pillow was for safety to keep him from trying to get up and falling and even with the soft touch call light he could be on the floor before staff were able to get to him. She also identified when he was in his Broda chair he was placed close to the desk or in a common area where he was able to be observed by staff due to his risk of falls. Observation on 12/17/25 at 1:16 p.m. with LPN-D noted R101 tipped toward his left side resting against a pillow and (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	a square pillow folded and positioned against his back on the room side of the bed. She reported at times he would call out for help, and swing his feet out of the bed, and attempt to sit up, stating he was looking for his wife. She reported she didn't think the pillow was a restraint as it was used for his safety. LPN-D reported she did not think there had been an assessment completed for any restrictive devices. Observation/Interview on 12/17/25 at 1:26 p.m. with the director of nursing (DON) reported he was not aware of any type of restraint in use for R101. He accompanied this writer to R101's room and observed the pillow positioned behind resident on the room side of his bed to keep him from turning toward the edge of his bed. He confirmed if the pillow prevented the resident from putting his legs out of bed or turning it would be considered a restraint if it had not been assessed, and he was not aware it had been. He removed the pillow on the room side of the bed and reported he would need to talk with staff about the use of a pillow to keep him from turning to the room side of the bed as it would need to be assessed as a restraint. Interview on 12/17/25 at 2:48 p.m. with R101's spouse reported she had received a call from the DON a short time ago, but she did not understand what he was talking about. She reported a pillow was used for comfort on resident's left side as he was positioned on his side a lot and he was very thin. She reported the family was concerned about him falling because as he was weak and did not realize he could no longer get up by himself. She reported she was not aware of the square pillow being used, but she did know staff had told her they placed a pillow under the sheet at night so he would not attempt to put his legs off the bed, sit up and possibly fall. She reported she was aware when he was in his chair, he was kept close to the desk so that staff could watch to make sure he did not fall out of his chair again because he was restless and would attempt to get up. Interview on 12/18/2025 at 8:35 a.m. with hospice RN-E identified R101 was seated in a Broda chair and placed at the nursing station due to anxiety and agitation where he could be observed as a precaution for falls. RN-E reported R101 had restless type behaviors and received Seroquel scheduled due to anxiety and restless and at night to help him rest. He identified he was not R101's primary nurse and he was not aware of what the facility staff were doing when he was in bed for comfort and/or safety. Interview on 12/18/25 at 9:15 a.m. with registered nurse (RN)-D (hospice RN) identified she was at the facility four days/week and felt the communication was good. She also reported she spoke frequently with the medical provider on any areas of concern or need for possible medication changes. RN-D reported R101 had falls with the most recent occurring on November 22, 2025, when he had fallen from his chair in the common area. She identified interventions to keep him safe included having him within sight and voice range of the nursing station to remind him to sit back down. She identified most of his falls took place when he was still ambulatory, but he also liked to roll to the edge of bed. She reported she had had discussions with the DON and facility staff regarding the possible intervention of a perimeter mattress, and there had been discussion on the use of restraints especially with the family, but she was not aware of anything in use. She reported the perimeter mattress was the responsibility of facility under the periderm, and hospice would negotiate if hospice Medicare was to cover the cost, or the facility periderm would need to cover the cost. RN-D identified she had reached out to her supervisor r/t discussion as to who could provide the perimeter mattress but had not heard back at the current time. She stated, she felt it was a safety concern for him to have a perimeter mattress. and she had also had discussions with family members regarding possible opportunities for potential safety measures and they agreed. RN-D also reported she had not documented everything in matrix as she did not want to promise anything until she was able to speak with her supervisors to determine the plan of action. Review of the 5/2/25 policy Fall Prevention: Physical Restraint/Mobility Devices identified the facility's intent to remain restraint free. When circumstances and all other options have been exhausted, devices may be medically necessary to protect residents from physical injury or for psychological comfort. Prior to any device or restraint usage, the nurse, as part of a multi-disciplinary team, will complete the following steps:1.) Interventions to consider when a resident has falls or is a risk for falls. a. Observe for gait and balance impairments, transfer abilities-PT referral if indicated. b. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	medical observation/assessment by nurse, then NP or MD. Assess for possible infection, dehydration, hypoxia, constipation, toxic drug levels, recent trauma, etc. c. Drug review by pharmacy- review recent medication changes. d. Check for environmental hazards. e. Cognitive evaluation. f. Observe w/c positioning/bed mobility-OT referral if indicated. g. Check for sensory or perceptual impairments. h. Check for emotional factors or changes in routine-Psychology referral if indicated. i. 1:1 time. j. Diversional activities. k. Assisted exercise, transfer, and/or toileting2.) If falls or threatening behavior persist- consult with medical provider for the medical symptom3.) Consider the least restrictive intervention/restraint4.) Implement the intervention, device, or restraint5.) Reassessment for mobility devices6.) Reassessment for physical restraints-reassess need for intervention and possibilities for reduction at quarterly care conferences or with a Significant Change. Document on care conference summary sheet.

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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 ensure routine personal hygiene care (i.e., shower, and shaving) was provided for 1 of 3 residents (R171) reviewed for activities of daily living (ADL).Findings include:R171 was admitted to the facility on [DATE] with a diagnosis of jaw osteonecrosis due to drugs (condition where jawbone tissue dies and becomes exposed in the mouth), prostate cancer, depression, sleep apnea and polyneuropathy (damage to multiple peripheral nerves, causing numbness, weakness, and pain).R171's Resident Profile dated 12/18/25 indicated R171 required assistance with bathing, dressing, and toileting. Profile indicated R171 needed extensive assistance with grooming and set-up with eating. Resident Profile also indicated R171 was at risk for skin integrity loss and would require daily monitoring and wound treatment.R171's care plan indicated he needed assistance with grooming, bathing, toileting and dressing.During observation and interview on 12/15/25 at 5:51 p.m., R171 stated he wanted to shave this morning. The nursing assistant (NA) asked R171 if he had an electric razor, and he said no. NA left the room and returned with a disposable razor and asked R171 Where do you want it (the razor)? R171 stated the NA did not offer to help him. R171 stated he liked to be cleaned shaven and touched his overgrown facial hair and said I don't like this. I haven't shaved for 8 days. The overgrown facial hair was about 0.75 centimeters long. R171 also stated, he had not taken a shower while in the hospital or at the facility. R171 said a nurse told him he would shower once a week, but he had not yet received one. R171 added he had scalp dermatitis with severe dandruff. He said this morning I went to the clinic, and when I removed my sweater, it was like a snowstorm; dandruff flew all over the room. It was embarrassing.During interview on 12/16/25 at 12 p.m., R171 said he was about to leave to go to his clinic. He had not shaved and said he did not get a shower.During interview on 12/16/25 at 1:44 p.m., NA-F stated she helped R171 in the morning. NA-F stated she helped R171 to dress, comb his hair and did not offer help him to shave.During interview on 12/17/25 at 10:26 a.m., NA-H stated residents hd scheduled showers in the morning and afternoon shifts. NA-H stated in the mornings she helped residents to go to the bathroom, helped them with their briefs or to use the toilet. NA-H helped them to dress and wash their faces and teeth. Regarding shaving, NA-H stated the staff waited until the family brought their electric shaving machines. Otherwise, they used the disposable razors and offered their help to the residents. NA-H did not help R171 in the morning.During interview on 12/17/25 at 10:38 a.m., NA- G stated he helped R171 to get ready in the morning. NA-G stated he helped R171 to wash his face, brush his teeth and helped him to dress. NA-G stated he didn't notice if R171 needed to shave or not. During interview on 12/17/25 at 11:01 a.m., family member (FAM)-A said his father shaved yesterday, but not very well. FAM-A had a picture which showed several unshaved areas.During interview on 12/17/25 at 12:16 p.m., nurse manager/registered nurse (RN)-F stated R171 needed assistance with dressing, grooming, and bathing. RN-H stated R171 needed help with meal set up and shaving. RN-F stated she expected the staff to offer and help residents to shave. Regarding showers, RN-F stated R171 was scheduled for a shower on Tuesday afternoon. R171 was scheduled to receive a shower on 12/16/25, but there was no documentation it was given as scheduled. RN-F confirmed there was no documentation about resident receiving a shower since his admission. RN-H stated whether a resident received a shower, it needed to be documented.During interview on 12/18/25 at 10:09 a.m., director of nursing (DON) stated his expectation was to follow residents' care plan. DON stated the nurses and NAs get a notification on their care sheets about showers. The NAs give the shower, and the nurses complete a skin assessment. The nurses document skin concerns and would also document if a resident refused a shower or a bed bath. DON stated if the residents don't bring their own electric shaving machine, the facility provided a disposable razor. His expected the NAs to provide the necessary assistance to shave the residents. DON added, showers and shaving were a matter of good customer service.Requested a policy about ADLs but none received.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to implement a palm protector for 1 of 1 resident (R78) reviewed for range of motion (ROM).Findings include:R78's quarterly Minimum Data Set (MDS) dated [DATE] indicated R78 was cognitively intact, had no behaviors or rejected personal cares, needed touching assistance with eating, and needed maximal assistance with toileting hygiene, dressing, bed mobility and transfers. MDS indicated R78 was at risk for skin breakdown, and ROM was not assessed.R78's face sheet dated 12/18/25 indicated diagnoses of benign neoplasm of meninges (non-cancerous tumor growing in the protective membranes covering the brain and spinal cord), chronic obstructive pulmonary disease (lung disease that blocks the airflow and make it difficult to breath) , hemiplegia (paralysis of one side of the body) and hemiparesis (weakness or inability to move one side of the body) following cerebral infraction affecting right dominant side.R78's Occupational Therapy Evaluation and Plan of Treatment report dated 12/1/25, indicated R78's (ROM) of upper right extremity was within normal limits. R78's upper left extremity ROM was impaired.R78's Resident Profile and Care plan dated 12/16/25 lacked documentation about the Posey palm protector.R78's medication administration records and treatment administration records between 7/1/25 through 12/15/25 lacked documentation about the Posey palm protector.During observation and interview on 12/16/25 at 8:58 a.m., R78 stated her left hand became a clenched fist without noticing. R78 stated the therapist used to put a brace on her left hand, but Friday she had her last therapy session. R78 stated she was supposed to use the brace during the day and remove it at bedtime, but the nursing staff does not put on her brace. During interviewed R78's left hand was clenched while her palm protector was on a recliner next to her bed.During observation on 12/16/25 at 1:48 p.m., R78 was sitting in her custom-made wheelchair. She did not have the white Posey palm protector on. The palm protector was on the recliner chair.During interview on 12/16/25 at 1:50 p.m., the director of rehabilitation (DR) stated R78 had been evaluated and treated by the therapy department. DR provided a copy of an email dated 7/10/25 from an occupational therapist (OT) to nurse manager/registered nurse (RN)-F. OT informed RN-F she had provided an edema glove and a Posey palm protector for R78's left hand. The email indicated R78 could wear the palm protector during the day and the edema glove as needed. DR stated. when a resident completed their rehabilitation services, the therapist sends an email with recommendations to the appropriate nurse manager. DR stated the nurse manager was supposed to implement the recommendations. During interview on 12/17/25 at 12:24 p.m., RN-F verified there was no documentation on R78's orders, care plan, or the medication or treatment administration records. RN-F reviewed her emails and verified she had received the 12/5/25 email form the therapist. However, RN-F stated she did not read the email. Therefore, she did not implement the therapist's recommendation.During interview on 12/18/25 at 10:44 a.m., director of nursing (DON) stated the palm protector needed to be implemented as ordered and added to the care plan to prevent contractures and protect resident's skin. DON stated the facility would need to improve communication between the nursing and therapy department.Requested a facility policy about use of splints/pal protectors but none received.

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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 record review, the facility failed to ensure appropriate management of an indwelling catheter was provided for 1 of 1 residents (R5) reviewed for indwelling catheters. Findings include:R5's annual Minimum Data Set (MDS), dated [DATE] identified R5 with impaired cognition, required substantial assistance for personal hygiene, dressing, and rolling from side to side in bed. In addition, R5 had diagnoses of diabetes, aphasia (communication disorder affecting speech, understanding, reading and writing), dementia, schizophrenia and had an indwelling catheter (tube from bladder to outside the body into a bag).R5's physician orders (PO) dated 5/19/25 stated, Large drainage bag on when in bed (include daytime naps).During observation on 12/15/25 at 2:35 p.m., R5 was lying in bed sleeping. A small leg bag with urine was observed to be attached to R5's left leg, which was horizontal to level of bladder, however no large night urine drainage bag was not observed in room.During observation on 12/16/25 at 1:29 p.m., R5 was lying in bed sleeping. A s mall leg bag with urine was observed to be attached to R5's left leg which was horizontal to level of bladder. A large night urine drainage bag was not observed in room.During interview with licensed practical nurse (LPN)-A on 12/16/25 at 3:32 p.m., LPN-A stated R5 should have [large urine drainage bag] on any time if [R5] is in bed, otherwise urine can back up and risk infection.During interview with registered nurse (RN)-A on 12/16/25 at 3:38 p.m., RN-A stated R5 had a suprapubic catheter and was to have the large bed bag on when R5 is lying down in bed. RN-A stated nursing assistants were responsible for changing the small leg bag to the large one when R5 is to lay down in bed.During interview with nursing assistant (NA)-A on 12/17/25 at 10:07 a.m., NA-A stated expectation of the large drainage bag to be used when R5 lays down in bed and for the small leg bag to be used when R5 is up in a chair.During interview with RN-B on 12/17/25 at 10:13 a.m., RN-B stated expectation of nursing assistants to change the large urine drainage bag to the small leg bag when the aides assist the resident to get up out of bed. Also, RN-B stated aides are expected to switch the leg bag to the large drainage bag anytime the resident lays down to rest so the urine could always be draining below the bladder.During interview with RN-C on 12/17/25 at 10:31 a.m., RN-C stated expectation of large urine drainage bag to be attached to side of bed below the level of the bladder every time the resident is in bed. If [urine bag] is not below the bladder, the urine can get clogged [or back up] in the tube.During interview with infection control preventionist (IP) on 12/17/25 at 2:24 p.m., IP stated expectation of nursing assistants to change the catheter bags from the large drainage bag to the leg bag every morning unless it is care planned otherwise. When residents want to lay down, like after lunch, then the aides are to change the leg bag to the large drainage bag for gravity to assist with keeping urine below the bladder.During interview with director of nursing (DON) on 12/18/25 at 9:47 a.m., DON stated expectation for nursing assistants to change the leg bag to the large drainage bag when resident is in bed. Even for naps. DON stated, gravity is needed for flow of urine into the bag and not back up [into] the bladder.Facility policy titled Catheter, Indwelling with review date of 10/25/25 identified, Urinary drainage bag should be below the level of the bladder at all times.

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For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide routine and 24-hour emergency dental care for each resident. Based on observation, interview and document review, the facility failed to ensure dental needs were coordinated with a dental provider for further care to reduce the risk of complication (i.e., cavities, oral pain) for 1 of 1 residents (R14) reviewed for dental care and services.Findings include:R14's significant change Minimum Data Set (MDS) assessment, 10/9/25, indicated R14's cognition was severely impaired without hallucinations or delusions present with no behaviors, rejection of care, or wandering present. Further, the MDS identified a section titled Section L-Oral/Dental Status indicated unable to examine. Section K: Swallowing/Nutritional Status indicated R14 had complaints of difficulty or pain with swallowing.R14's face sheet, printed 12/17/25, identified relevant diagnoses included: vascular dementia with anxiety, osteoarthritis, anxiety disorder and chronic knee pain.During an interview and observation on 12/15/25 on 2:48 p.m., R14 was observed propelling herself in the hallway in her wheelchair. R14 was observed to be missing numerous teeth. R14 answered questions nonsensically.During an observation on 12/16/25 at 12:27 p.m., R14 was observed eating in the dining room. R14's plate had meat and veggies that were diced up into small pieces. R14 was observed to have an untouched egg roll on her plate.R14's care plan, printed 12/18/25, identified the following: Oral/Dental: unable to perform oral examination due to elevated anxiety level with the following approaches: - notify NP [nurse practitioner] before any dental appointments to order pRN [sic] (as needed) antianxiety medicine to help her anxiety at dental appointments - observe for signs and symptoms of infection -obtain dental consult. - monitor and record percentage of food/fluid intake. -instruct resident in proper brushing techniques. - offer family the opportunity to come in and be present during dental exam to help decrease her anxiety level.- Provide assist of 1 staff (specify amount of assistance: e.g., setup, cueing, full staff performance) for oral hygiene every morning and evening(schedule).- Nutritional status use of mechanical altered diet related to decreased chewing ability - own teeth in poor condition; to include the following approaches: monitor for chewing and swallowing problems.R14's care sheet identified R14 was assist of 1 with toileting, transfers and dressing. Furthermore, R14 did not wear dentures.R14's progress notes, dated 1/16/25 to 12/15/25, reviewed and identified the following: -4/29/25: R14 noted to have increased anxiety/restlessness in the evening or during dental appointments.-4/22/25: R14 noted to have own teeth with several missing teethProgress notes lacked any dental visits, missed dental appointments, or refusal to attend a dental appointment.A Chart Progress Note, dated 4/3/25, identified R14 had completed a scheduled dental exam. R14's diagnoses/assessment indicated inflammed gingival tissue, and clinical finding of tissues are very inflamed [sic] and 6 months recall recommended. Noted Prophy completed with toothbrush and peridex, hand scaling instruments, floss and mechanical polish with oral hygiene recommendations: Recommended brushing 2x/day, flossing 1x/day with Listerine flosser, using saltwater rinses, using proxy brush. Furthermore, recall exam recommendations were exam to be every 6 months and prophylaxis visit every 3 months.No additional chart progress notes were found in R14's medical record.R14's Nutrition Risk Data Collection and Assessment, dated 10/10/25, indicated R14 had own teeth with other box mark, with notes some missing, broken, During an interview on 12/16/25 at 2:52 p.m., trained medication aid (TMA)-A stated R14 needed staff assistance with oral care. TMA-A stated they were unsure if R14 has missing teeth or wore dentures and stated that would be a better question for the nursing assistant.During an interview on 12/16/25 at 2:56 p.m., nursing assistant (NA)-E stated they were familiar with R14. NA-E stated R14 was assist of 1 with oral care. NA-E stated R14 did not wear any dentures. NA-E stated R14 was missing numerous teeth. During an interview on 12/17/25 at 10:46 a.m., licensed practical nurse (LPN)-B stated the health unit coordinator (HUC) typically coordinated all dental appointments for residents. LPN-B stated the nurse would assess if a resident was having dental pain and work with the provider if was determined the pain may be caused from an infection. LPN-B stated the HUC scheduled the on-going dental appointments.During an interview on 12/17/25 at 11:03 a.m., HUC-A stated they coordinated dental (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245439	A. Building B. Wing	12/18/2025

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F 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	appointments. HUC-A stated they got a schedule of residents that will be seen by the in-house dental provider (dental provider that comes to the facility) to review. HUC-A stated they can and do request for residents to be see when needed. HUC-A reviewed R14's medical record and stated the last dental appointment was 4/3/25. Furthermore, HUC-A reviewed the visit note and stated R14 should have been seen in July for follow up. HUC-A verified R14 had not been seen. HUC-A verified they could not locate any notes the dental provider attempted to meet with R14 and wasn't able to for any reason. During an interview on 12/17/25 at 12:20 p.m., registered nurse manager (RN)-D stated the expectation would be if a dental provider made recommendations, then they would be followed if family agreed. RN-D stated dental health is important. During an interview on 12/18/25 at 11:09 a.m., director of nursing (DON) stated the expectation would be dental recommendations would be followed. During a follow up interview on 12/18/25 at 12:23 p.m., DON provided an email exchange, dated 12/18/25, between facility and dental provider that comes to facility which outlined the priority of how they see residents in the facility. Furthermore, the email verified R14 had not been seen in a while and had now been added to the list to be seen.A facility policy titled Long-Term Care Ancillary Services, reviewed 5/25, indicated resident will have access to dental examinations, cleanings, and necessary dental treatments.

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F 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide special eating equipment and utensils for residents who need them and appropriate assistance. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review, the facility failed to provide adaptive equipment for 1 of 1 resident (R78) reviewed for adaptive equipment and observed having difficulty eating during meal observation.Findings include:R78's quarterly Minimum Data Set (MDS) dated [DATE] indicated R78 was cognitively intact, had no behaviors or rejected personal cares, needed touching assistance with eating, and was dependent with toileting hygiene, dressing, bed mobility and transfers. MDS indicated R78 was at risk for skin breakdown, and limited range of motion (ROM) was not assessed.R78's face sheet dated 12/18/25 indicated diagnoses of benign neoplasm of meninges (non-cancerous tumor growing in the protective membranes covering the brain and spinal cord), chronic obstructive pulmonary disease, hemiplegia (paralysis of one side of the body) and hemiparesis (weakness or inability to move one side of the body) following cerebral infraction affecting right dominant side.R78's Resident Profile dated 12/16/25 indicated she needed assistance to eat and directed staff to cut her meal into small pieces. R78's profile lacked documentation regarding the use of adaptive equipment for eating. R78's care plan dated 12/16/25 lacked documentation regarding adaptive equipment for eating. R78's electronical medical record EMR) lacked documentation about the use of Dycem and/or lipped plate.During observation on 12/16/25 at 8:58 a.m., R78 was in bed eating breakfast. R78 had 2 bowls of oatmeal on her bed side table. She was loosely holding a spoon on her right hand. R78's right arm had noticeable shaking. While trying to scoop the oatmeal, she would push the bowl with the spoon around the table. At some point, the bowl fell sideways between the bed table and the resident's lap. R78 used her spoon in her right hand and her left forearm to push the bowl back on the bed side table. R78 stated this is how I eat. Fun, huh? Adding, they are too busy to help.During interview on 12/16/25 at 2:33 p.m. nursing assistant (NA)-H stated R78 didn't like to be helped, but when her arm shook a lot, she would let us help her. NA-H stated she had never seen R78 use any adaptive equipment for eating. During interview on 12/16/25 at 1:50 p.m., the director of rehabilitation (DR) stated R78 was evaluated in the month of December by an occupational therapist. DR provided a copy of an e-mail dated 12/2/25 from the occupational therapist (OT) to the nurse manager/registered nurse (RN)- F. The e-mail indicated OT had provided R78 a piece of Dycem to help stabilize the patient's lipped plates.During interview on 12/17/25 at 12:24 p.m., RN-F stated she was not informed about the recommendation to use Dycem or a lipped plate. During the interview RN-F checked her e-mail and said she received the e-mail but did not open it. RN-F stated she did not implement the therapist's recommendations.During interview on 12/18/25 at 10:44 a.m., director of nursing (DON) stated the therapist's recommendations for adaptive equipment needed to be implemented to maintain resident's quality of life. DON added the facility needed to improve communication between the nursing and therapy department.Requested a policy about the use of adaptive equipment and none was received.