STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245448	A. Building B. Wing	06/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Park River Estates Care Center	9899 Avocet Street Northwest Coon Rapids, MN 55433

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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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to honor a resident's right to make choices about aspects of care related to the method of blood glucose monitoring for 1 of 1 residents (R61) reviewed for diabetic care. Findings include: R61's quarterly Minimum Data Set (MDS) dated [DATE], identified severe cognitive impairment with a diagnoses of diabetes mellitus (DM) with neuropathy (pain, numbness, tingling, and muscle weakness, primarily in the hands and feet), aphasia (language disorder that affects the ability to speak) following cerebrovascular infarct (stroke), hemiplegia (paralysis of one side of the body) and hemiparesis (weakness on one side of the body), cancer (right breast), hypertension (high blood pressure), hyperlipidemia (high cholesterol), arthritis, depression, and cataracts. R61 required extensive assistance for most activities of daily living (ADLs) and R61 was usually understood. R61's admission MDS dated [DATE] (admission) identified resident was cognitively intact, indicating cognitive decline since admission. R61's care plan with target date 5/10/25, identified potential for fluctuating blood glucose levels, with interventions in place including monitoring for hypoglycemia (low blood sugar) and hyperglycemia (elevated blood sugar), fasting serum blood sugar as ordered by doctor, and obtain accuchecks/labs per MD order, and notify of abnormal results. R61's orders identified order for blood sugar monitoring as Accucheck two times a day every other day AND two times a day every other day with an active date of 11/7/24. R61's North Memorial Health Hospital Discharge summary dated [DATE] identified, orders for medications continued unchanged, Accu-Chek FastClix and Accu-Chek Smartview testing strips, as well as Freestyle Libre 2 Reader and Sensor kit. During interview on 6/9/25 at 2:23 p.m., family member (Family)-A with R61 in agreement, voiced concerns regarding blood sugar testing. Family-A stated R61 was previously using Continuous Glucose Monitoring (CGM) device and believed residents readings were more controlled with that monitoring method. Family-A reported, they were told the facility did not allow CGM devices so were not given the choice for which device would be used. (continued on next page)

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

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 6/12/25 at 1:33 p.m., Licensed Practical Nurse (LPN)-A stated when performing an intake for a new admission the nurse would review the transfer and discharge summary which included the medication and treatments. LPN-A visualized R61's hospital discharge summary and identified R61 had orders listed for both methods of blood sugar monitoring. LPN-A stated the nurse would have needed to check with the resident to determine which method was normally used and which they preferred to continue, and then order the appropriate supplies. LPN-A stated R61 had never voiced any concerns regarding the use of the Accu-Chek, and LPN-A had performed R61's blood sugar testing many times. LPN-A confirmed CGM's were allowed and used by other residents in the facility. Interview on 6/12/25 at 2:18 p.m., Director of Nursing (DON) visualized R61's hospital discharge orders and stated she would interpret them as those supplies would need to be ordered. DON stated the expectation of the nursing staff would be to have a conversation with the resident or their responsible party to determine which method would be used. Then the nurse would need to call the medical provider to get an order for that specific monitoring method. DON stated the documentation would be in an admission note or transcribed into the orders. DON stated this would be important to respect the residents wishes. Standing Orders for Skilled Nursing Facilities revised for 2025 indicated for diabetic management, initiate QID (four times a day) blood glucose monitoring x3 days for ALL diabetes patients unless ordered otherwise. Blood Glucose Monitoring policy dated 8/13 with revision date 3/25, did not indicate a process for CGM devices. A facility policy regarding admission process and/or order implementation was requested, but was not provided by the facility. A resident choice policy was requested, but was not provided by the facility.

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F 0577 Level of Harm - Potential for minimal harm Residents Affected - Many	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. Based on observation, interview and document review, the facility failed to ensure both recertification survey results, as well as additional complaint investigations, were available for review. This had the potential to affect all 77 residents residing in the facility, as well as family, visitors, and staff. Findings include: On 6/9/25 at 12:30 p.m., it was noted the facility survey results were posted next to the staff posting. The survey results posted included the recertification survey results from the past three years however, lacked the 2567's (reports completed by both surveyors regarding findings of investigations, and the responses by the facility) regarding complaint investigations. A review of Aspen Central Office (ACO-an online computerized federal document site which contains the surveys completed for facilities, including both recertification surveys, and complaint investigation) indicated complaint investigations were completed without citations on the following dates following the recertification survey of 3/13/24: 4/24/25, 3/14/25, 12/13/24, and 7/3/24. Additionally, complaint investigations were completed and were noted to have citations issued on the following dates: 5/23/25, 3/21/25, 4/18/25 (cleared 3/21/25). During interview on 6/11/25 at 4:39 p.m., the administrator stated she was unaware that the requirements for posting of survey results were not met by placement of the corresponding letter from all investigations and the 2567 documentation. A facility policy was requested for posting of survey results, but was not available.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review, the facility failed to ensure an electric recliner was not used in a manner to restrain resident for 1 of 1 resident (R375) reviewed for restraints. Findings include: R375's admission Minimum Data Set (MDS) dated [DATE], identified R375 had intact cognition and required assistance with all activities of daily living (ADLs). R375's diagnoses included cancer, atrial fibrillation (heart rhythm disorder), heart failure (occurs when the heart muscle can't pump enough blood to meet the body's needs), hypertension (high blood pressure), benign prostatic hyperplasia (non-cancerous enlargement of the prostate gland), pneumonia and malnutrition. MDS also indicated R375 did not use any restraints. R375's care plan reviewed 5/27/25, identified R21 had limited physical mobility and was a fall risk related to activity intolerance, confusion, fatigue and impaired balance. Staff were directed to assist R375 with an assist of one and a gait belt or all transfers. R375's care plan did failed to identify the use of electric recliner. R375's electronic health record (EHR) lacked documentation of an assessment for use of the electric recliner. During observation on 6/10/25 at 2:22 p.m., R375 was sitting in an electric recliner, that was reclined back, in the day room with foot rest extended with legs fully extended resting on foot rest. R375 was sitting forward in recliner and was fidgeting with his pants. R375 was not under direct observation of staff. On 6/10/25 at 2:28 p.m., attempted to interview R375 about usage of recliner. R375 was non-sensical and did not understand what was being asked. During an observation on 6/11/25 at 3:01 p.m., R375 was assisted into recliner in the Fireside room by staff. Nursing assistant (NA)-C elevated foot rest so legs were fully extended then placed the remote back along the right side of the recliner out of R375's reach. During an observation on 6/11/25 at 3:50 p.m., R375 was attempting to put feet of the recliner down by pushing feet again foot rest and was reaching for his wheelchair. Staff noticed this and went over to talk with resident and left leaving R375 in recliner. During interview on 6/12/25 at 1:39 p.m., trained medication aide (TMA)-B stated R375 has attempted to get out of recliner by himself but needs staff assistance with getting in and out of the recliner. During interview on 6/12/25 at 1:43 p.m., licensed practical nurse (LPN)-D stated R375 was not able to get out of the recliner by himself and he needed staff to assist him. LPN-D stated R375 would not know how to use the remote due to cognitive impairment. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 6/12/25 at 1:53 p.m., nursing assistant (NA)-E stated R375 was a fall risk and would not be able to get out of recliner by himself. NA-E stated R375 did not know how to use the remote for the electric recliner. During interview on 6/12/25 at 2:28 p.m., director of nursing (DON) stated if a resident utilized an electric recliner, a physical device assessment should be completed to ensure resident was able to operate chair safely and confirmed there was no physical restraint assessment for the electric chair completed for R375. DON stated it would be important to complete an assessment to ensure resident could operate chair and if resident was not able to operate chair correctly it would be considered a restraint. The facility Physical Device Assessment policy, dated 5/25, indicated facility had a very stringent policy regarding the use of physical and chemical devices on residents. The facilities philosophy of providing residents with the highest possible quality of care and life is reflective in the belief that it is essential for the residents to maintain their dignity and independence by being permitted to take the normal risks of everyday life. Devices used in an attempt to remove these risks of living, violate the rights of the residents; greatly reduce their quality of life and present significant physical and psychological risks. For these reasons, device use in our facility will only be considered to treat a medical symptom/condition that endangers the physical safety of the resident or other residents, and under the following conditions: 1. As a last resort measure, after less restrictive measures have been taken and proven unsuccessful. 2. With the consent of the resident or responsible party. 3. When the benefits of the device outweigh the identified risks.

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to ensure the order of as-needed (PRN) psychotropic medication was limited to 14-days or extended to a specific date with supporting rationale provided by the medical provider for 2 of 5 residents (R65 and R60) reviewed for unnecessary medication use. Findings include: R65's significant change Minimum Data Set (MDS), dated [DATE], identified R65 had intact cognition and required assistance with activities of daily living (ADL's) including dressing, grooming and bathing. R65's medical diagnoses included cancer, diabetes mellitus (a disease which impacts how the body processes sugar), arthritis (painful inflammation of joints), and malnutrition (poor nutrition impacted by either intake or by how the body utilizes the food ingested. A review of R65's medication administration record (MAR), dated 6/10/25, identified the following order: Prochlorperazine Maleate (an anti-psychotic medication frequently used to treat nausea/vomiting) Oral Tablet 10 mg (milligrams) Give one tablet by mouth every 6 (six) hours as needed for nausea and vomiting. The MAR lacked a stop date for Prochlorperazine. A review of the MAR's from March, April, May also reflected orders for Prochlorperazine, which lacked either a 14 day stop date, or rationale for an extended time period. During interview on 6/11/25, at 4:15 p.m. registered nurse (RN)-A stated the floor nurses completed the transcription of orders upon admission. RN-A stated when orders, such as Prochlorperazine were received, the floor nurse might not be aware of the need for a stop date to be specified. On 6/11/25, at 4:20 p.m., the ADON stated sometimes orders for PRN antipsychotics are not written with stop dates. ADON stated he thought this was a new requirement, and some of the nurses might recognize this, however, not all nurses were aware. ADON stated the provider should have been contacted to inquire of either an end date or alternate medication. The facility policy and procedure, Psychotherapeutic Medications, revised 4/25, identified both use of psychotherapeutic medications and antipsychotic medications. The policy identified prior to the administration of an(y) antipsychotic medication, the following must be documented: appropriate diagnosis, consent, assessment prior to implementation, goals of psychotherapeutic meds. The policy lacked any indication regarding the required end date for PRN psychotropic use if to extend beyond 14 days. The policy also lacks the requirement for the resident to have a 14-day face to face provider evaluation. In addition, the policy lacked any indication as to when the use of PRN psychotropic medications were indicated, and lacked indication of the perimeters as to when they may be used. R60 R60's quarterly Minimum Data Set (MDS) dated [DATE], indicated R60 was cognitively intact, required extensive assistance with activities of daily living (ADL's). Further, the MDS outlined R60 consumed antipsychotic, antianxiety and antidepressant medications. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R60 had diagnoses which included Alzheimer's, adult failure to thrive, dementia, hypertension, anxiety, degenerative disease of nervous system, cardiomyopathy, hypothyroidism, hyperlipidemia, and osteoarthritis. R60's order summary report printed 6/11/25, identified R60 had active orders for lorazepam (medication used to treat anxiety) 0.5 mg every four hours PRN for anxiety was ordered on 5/11/25. The order lacked a 14 day stop date. R60's medication administration report (MAR) for 5/25 and 6/25 were reviewed. R60 received PRN lorazepam once daily on 5/11/25, 5/13/25 and 5/14/25, on 5/15/25 R60 received PRN lorazepam twice, once daily on 5/16/25 and 5/19/25, twice on 5/20/25, once 5/22/25, three times on 5/23/25, once daily on 5/25/25, 5/26/25, 5/28/25, and 5/29/25, twice daily on 5/30/25, and 5/31/25. On 6/2/25 lorazepam was administered twice, once daily on 6/4/25 and 6/5/25, twice on 6/6/25, once on 6/7/25, twice on 6/8/25, once daily on 6/9/25, and 6/10/25, and twice on 6/11/25. During observations on 6/10/25 at 9:27 a.m., R60 was seated in the hallway yelling out help, please help, R60 stopped for a short time then called out again in a louder voice. At 10:14 a.m., R60 was seated in room calling out help, paused for a minute then called out, help, repeatedly. At 1:56 p.m., R60 was in bed repeatedly called out help, please help. During continuous observation on 6/11/25, started observation at 8:59 a.m., R60 repeatedly called out, help, please help. Staff members would enter the room, speak calmly with R60, address any needs R60 requested, staff members would ask R60 if they could do anything else while in the room R60 declined further needs. When staff exited the room R60 started calling out, help, please help, paused then would start calling out again. Various staff entered R60's room, visited with R60, and ensured needs were met twelve separate times until continuous observation ended at 11:00 a.m., when R60 was assisted to dining room for an activity. When interviewed on 6/12/25 at 9:56 a.m., nursing assistant (NA)-B stated R60 frequently called out, was due to a mixture of anxiety and a behavior. NA-B stated R60 liked to be busy but had a short attention span. When interviewed on 6/12/25 at 10:09 a.m., licensed practical nurse (LPN)-A stated R60 called out frequently, would get loud when doing so. LPN-A stated R60 received PRN lorazepam at least daily for anxiety. When interviewed on 6/12/25 at 3:53 p.m., director of nursing (DON) stated PRN antianxiety medications required an end dated in fourteen days unless the provider gave justification for a longer time frame. When interviewed on 6/12/25 at 4:28 p.m., consultant pharmacist (CP)-A stated R60's PRN lorazepam should have had an end date. CP-A indicated there was an order dated 5/11/25, was unable to identify an end date, stated the facility failed to enter a stop date. CP-A stated pharmacy review was completed 5/20/25, but did not see there was a change. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility policy and procedure, Psychotherapeutic Medications, revised 4/25, identified both use of psychotherapeutic medications and antipsychotic medications. The policy identified prior to the administration of an(y) antipsychotic medication, the following must be documented: appropriate diagnosis, consent, assessment prior to implementation, goals of psychotherapeutic meds. The policy lacked any indication regarding the required end date for PRN psychotropic use if to extend beyond 14 days. The policy also lacks the requirement for the resident to have a 14-day face to face provider evaluation. In addition, the policy lacked any indication as to when the use of PRN psychotropic medications were indicated, and lacked indication of the perimeters as to when they may be used.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to ensure the care plan included management and monitoring of urinary catheter for 1 of 2 residents (R375) reviewed for catheter use. Findings include: R375's admission Minimum Data Set (MDS) dated [DATE], identified R375 had intact cognition and required assistance with all activities of daily living (ADLs). R375's diagnoses included benign prostatic hyperplasia (non-cancerous enlargement of the prostate gland). R375's MDS also indicated R375 had a urinary catheter. R375's electronic health record (EHR) included an order for Foley catheter 16 F (French) with 10 mL (milliliter) bulb with a start date of 5/22/25. R375's care plan, reviewed on 6/10/25, failed to include Foley catheter use or to monitor for side effects of the treatment. During interview on 6/12/25 at 1:43 p.m., licensed practical nurse (LPN)-D stated R375 had a catheter which should be monitored for signs and symptoms of infection. During interview on 6/12/25 at 2:28 p.m., the director of nursing (DON) stated nursing assistants should monitor for any signs of infection or abnormalities and update nursing when needed. Nursing should watch for side effects of catheter and urine output. The DON stated the care plan should include when a resident had a catheter in place. DON confirmed catheter use was not on R375's prior to 6/11/25, it should have been placed on care plan upon admission to the facility. DON stated it would be important for catheter use to be on care plan so staff are aware of the catheter, so it could be assessed, as well as other tasks that were assigned with the catheter care area needed to be completed. The facility Care Plan policy, dated 2/25, indicated the care plan will ensure the resident the appropriate care required to maintain or attain the resident's highest level of practicable function possible. The care plan will serve to direct the necessary care of the resident. The comprehensive care plan will have focus statements, goal statements and interventions. The care plan is to be changed and updated as the care changes for the resident and as the resident changes. It is to be current at all times.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to revise the care plan to include non-pressure wounds for 1 of 1 residents (R27) in the sample whose care plan was reviewed. Findings include: R27's annual minimum data set (MDS) dated [DATE], indicated R27 had moderate cognitive impairment and required extensive assistance with activities of daily living (ADL's). R27's face sheet printed 6/11/25, indicated R27 had diagnoses which included chronic respiratory failure, congestive heart failure, heart disease, osteoarthritis, anemia, hypertension, and Alzheimer's disease. R27's care plan undated, indicated R27 had a potential for alteration in skin related to bedfast, immobility and incontinence. Interventions included lotion dry skin, staff were directed to assist with incontinence care, heels elevated off bed surface, R27 preferred covers off feet, and staff were directed to monitor for changes in skin integrity with bathing, cares and prn (as needed), report changes to nurse. However, care plan failed to identify R27 had non-pressure wound on right foot second toe which was identified by staff on 1/26/25. When interviewed on 6/12/25, at 1:57 p.m. director of nursing (DON) stated she expected care plans to be updated when there was a change in resident status and/or new skin concern was identified. This was important to ensure all staff had current resident information and planned interventions to provide person centered care . A facility Care Plan policy dated 2/25, indicated the care plan is to be changed and updated as the care changed for the resident changed. Care plan was to be current at all times.

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 and interview, the facility failed to provide supervision during mealtimes for 3 out of 3 residents (R21, R62 and R375) reviewed for dining. Finding includes: R21's significant change Minimum Data Set (MDS), dated [DATE], identified R21 had intact cognition required supervision or touching assistance with eating. R21's diagnoses included cerebral palsy (neurological disorder that affect movement and posture), dementia and malnutrition. MDS also identified R21 was on a mechanically altered diet with thickened liquids. R62's admission MDS dated [DATE], identified R62 had moderate cognitive impairment and required supervision or touching assistance with eating. R62's diagnoses included progressive neurological condition (condition where there is a gradual and ongoing decline in neurological function, impacting various bodily systems and functions), Alzheimer's disease, dementia, Parkinson's disease and malnutrition. R375's admission MDS dated [DATE], identified R375 had intact cognition and required set up or clean-up assistance with eating. R375's diagnoses included cancer, atrial fibrillation (heart rhythm disorder), heart failure (occurs when the heart muscle can't pump enough blood to meet the body's needs), hypertension (high blood pressure), benign prostatic hyperplasia (non-cancerous enlargement of the prostate gland), pneumonia and malnutrition. During continuous observation starting on 6/11/25 at 9:05 a.m., the following was observed: -At 9:05 a.m., R375 was seated at a table in the main dining room alone at the table. R375 was drinking from a coffee cup. There were two other residents (R21 and R62) in the dining room eating. -At 9:06 a.m., unidentified kitchen staff brought R375 his tray and left the dining room. No staff present in dining room. -At 9:08 a.m., R375 remained seated at table and was looking at his meal ticket and his plate of food. R21 and R62 continued to eat their breakfast and drink fluids. -At 9:10 a.m., R375 started to eat his breakfast. -At 9:13 a.m., unidentified staff entered dining room with dirty dishes and left. -At 9:15 a.m., R375 continued to eat his breakfast. R21 started coughing while eating but resolved. -At 9:16 a.m., dietary aide (DA)-B left dining room and returned with unidentified nursing assistant (NA) and instructed her there needed to be someone in the dining room at all times while there were residents present. -At 9:18 a.m., unidentified NA left dining room while R21, R62 and R375 continued to eat. (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-At 9:19 a.m., unidentified NA returned to dining room and sat by R21. -At 9:23 a.m., R375 finished eating his breakfast and left dining room. -At 9:28 a.m., final observation, NA remained at table with R21. R62 and R375 were no longer in the dining room. During interview on 6/11/25 at 10:26 a.m., DA-B stated there was supposed to be a nursing assistant in the dining room at all times whenever there are residents present for the residents' safety. DA-B confirmed there were no staff present in the dining room this morning while R21, R62 and R375 were eating breakfast. During interview on 6/11/25 at 11:38 a.m., NA-G stated there is always supposed to be one NA in the main dining room whenever there were residents in the dining room. NA-G stated staff are never present in the main dining room when residents were eating. During interview on 6/11/25 at 12:02 p.m., assistant director of nursing (ADON) stated he expected an NA to be present in the main dining room for feeding assistance and monitoring with a nurse is close vicinity. ADON stated it was important for a staff to be present in the event of a choking episode so the NA could alert the proper staff for treatment. During interview on 6/11/25 at 2:28 p.m., director of nursing (DON) stated there should be one staff present in the main dining room and a couple of staff in the enhanced dining room. DON stated dietary would notify staff if there were any concerns that occurred in the main dining room. DON stated she would expect residents to not be left alone for more than 5 minutes without staff present. A policy was requested but was not received.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Park River Estates Care Center	9899 Avocet Street Northwest Coon Rapids, MN 55433

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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 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 record review the facility failed to provide activities of daily living (ADLs) for 2 of 3 resident (R3 and R375) who were dependent on staff for assistance with ADL's. Findings include: R375 R375's admission MDS dated [DATE], identified R375 had intact cognition and required assistance with all ADL's. R375's diagnoses included cancer, atrial fibrillation (heart rhythm disorder), heart failure (occurs when the heart muscle can't pump enough blood to meet the body's needs), hypertension (high blood pressure), benign prostatic hyperplasia (non-cancerous enlargement of the prostate gland), pneumonia and malnutrition. R375's care plan lacked evidence of resident's shaving preferences as well as direction for staff for assistance with personal hygiene and grooming. During observation on 6/9/25 at 1:13 p.m., R375 had white facial hair on cheeks, chin and upper neck approximately ½ inch long. During observation on 6/11/25 at 8:42 a.m., R375 continued to have facial hair on cheeks, chin and upper neck. During interview on 6/12/25 at 1:43 p.m., licensed practical nurse (LPN)-D stated if a resident had requested to have facial hair shaved, staff would assist resident with shaving upon request. During interview on 6/12/25 at 1:53 p.m., NA-E stated some residents prefer to have facial hair. If resident stated they would like to be shaved, NA-E would go and find a shaver and assist resident with shaving. NA-E stated she has not asked or shaved R375. During interview and observation on 6/12/25 at 2:00 p.m., R375 continued to have facial hair on cheeks, chin and upper neck and stated he did not like to have whiskers and prefers to be clean shaven. R375 stated staff have not asked him if he would like to be shaved and he did not have a razor. During interview on 6/12/25 at 2:28 p.m., DON stated she expected staff ask the resident and family what preferences the resident has regarding shaving within the first couple days of being admitted to facility. Shaving was sometimes added to the resident's care plan. DON stated R375 would need help with shaving and due to his confusion. R375 may not be able to request shaving. DON stated facility has razors to use if family members do not provide one. DON expected staff to ask R375 if he would like to be shaved. DON stated it was important for the resident to be shaved for dignity of the resident. R3 (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R3's quarterly Minimum Data Set (MDS) dated [DATE], identified R3 had moderate cognitive impairment and required assistance with all ADLs. R3's diagnoses included progressive neurological conditions, multiple sclerosis (chronic, often debilitating disease that affects the central nervous system - brain and spinal cord), peripheral vascular disease (condition affecting blood vessels outside of the heart and brain), neurogenic bladder (bladder dysfunction caused by nerve damage that disrupts the normal communication between the bladder and the brain), arthritis, Alzheimer's disease, non-Alzheimer's Dementia, malnutrition and localized edema (swelling caused by excess fluid trapped in the body's tissues. R3's care plan indicated R3 needed staff assistance with grooming. Care plan failed to provide direction to staff regarding R3's needs for assistant with personal hygiene. During observation on 6/9/25 at 7:01 p.m., nursing assistant (NA)-F was assisting R3 with peri-care after R3 was incontinent with a bowel movement (BM). NA-F used a wet washcloth and washed R3's buttocks first cleaning off of the BM and then used the same washcloth when washing R3's groin. During interview on 6/9/25 at 7:21 p.m., NA-F stated she should have used a separate washcloth for R3's front and confirmed she had washed BM off R3's buttocks first, then used the same washcloth to wash R3's groin. NA-F stated this practice was an infection control concern. During interview on 6/12/25 at 11:13 a.m., infection preventionist (IP) stated NA-F did not perform appropriate peri-care and that NA-F should have started peri-cares in the front and move to the back. IP stated if there was BM present, staff should use a different rag to clean the BM up and another rag for the peri-cares. IP stated this would be important as it was not proper infection control, and that NA-F was not following the facilities policy and procedure. During interview on 6/12/25 at 2:28 p.m., director of nursing (DON) stated peri-care that was observed was not appropriate and was a infection control concern and education was needed as policy and procedure were not followed. The Perineal Care for Residents procedure, undated, indicated staff were to gather the following supplies: basin, warm water, soap and wash clothes. For females, staff to wash the pubic area first, moving front to back. Separate the labia and wash downward on each side of the labia. Use different coroners of the washcloth for each side. Wash downward in the middle over the urethra and vaginal openings. Always wash front to back. Help the resident turn onto their side. Wash, rinse and dry the anal area well and then move them back onto their back. The facility Activities of Daily Living Policy was requested but was not 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 observation, interview and document review, the facility failed to provide routine assistance to properly position a who was dining in bed to promote comfort and ease in eating for 1 of 1 residents (R37) reviewed for positioning. In addition, the facility failed to consistently assess and monitor a wound for 1 of 1 residents (R27) reviewed for wound care. Further, the facility failed to monitor blood pressures and pulse for 1 of 1 residents (R19) who had parameters for medication administration. Findings include: R37 R37's annual Minimum Data Set (MDS) completed on 5/2/25, identified R37 had moderate cognitive impairment. R37 exhibited no signs of delirium, such as inattention, disorganized thinking, altered level of consciousness. R37 was able to eat independently once she is set up. R37 required assist to roll from left to right. R37 was fully dependent on others to transfer to/from bed. R37 was wheelchair bound. R37's medical diagnoses included hemiplegia/hemiparesis (loss of movement on one side of the body), gastroesophageal reflux disease (GERD-a disease where stomach acid flows back up into the esophagus and causes heartburn/acid reflux), diabetes (diseases that affect how the body uses blood sugar (glucose), dementia, chronic obstructive pulmonary disease (COPD) (a lung condition related to inflammation, inside the airways that limit airflow into and out of the lungs), and dysphagia (difficulty swallowing). R37's care plan revised 5/16/25, identified R37 had a self care performance deficit related to activity intolerance, dementia, impaired balance, and a history of a stroke resulting in left hemiparesis. The care plan identified R37 used assistive device grab bars to reposition and turn in bed, and to promote independence with mobility and proper positioning. R37 was identified as being independent with eating after set-up. R37's was also identified as having a potential nutritional problem related to diabetes, GERD, dysphagia, and hemiparesis following CVA (cardiovascular accident-stroke). The care plan indicated R37 dined in the main dining room, with meal set up. The care plan lacked any direction for resident to eat meals in her bed. Staff were directed to monitor/document/ report to MD (doctor) PRN (as needed) for s/sx (signs and symptoms) of dysphagia, which included pocketing, choking, coughing, drooling, holding food in mouth, several attempts at swallowing, or refusing to eat. The care plan identified the potential for alteration in respiratory status related to COPD. Staff were directed to administer oxygen as ordered by the provider and to have the head of her bed elevated at all times to prevent orthopnea (discomfort in breathing when laying down flat). R37 was noted to have GERD and staff were directed to keep the head of the bed elevated, and avoid R37 lying down for at least one hour after eating. On 6/09/25 at 6:52 p.m., R37 was observed with head of bed (HOB) elevated to approximately 45 degrees, leaning to the right side, nearly touching the side rail on the right side. R37's supper tray was noted to be in front of her. When R37 was asked how this position worked for her to eat, R37 commented, it doesn't. When asked if staff offered/provided assistance to reposition, R37 stated they do not offer to reposition often, however, R37 stated when they do it helps. R37 stated she was done with her meal at that time. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/12/25 at 9:00 a.m., R37 was observed in her bed, with breakfast tray in front of her. R37's HOB was elevated approximately 45 degrees, leaning to the right with her head observed near the right side rail. The meal tray was observed to be greater than a foot away from her. Dietary aide (DA)-A was observed as she set up tray for R37. DA-A asked R37 if she wished to have help to sit up and R37 stated she was Ok. DA-A exited room with R37 in the position as noted above. On 6/12/25 at 9:07 a.m., DA-A stated she provided assistance to R37 to set up tray. DA-A stated although she offered to provide assistance to reposition, R37 declined. DA-A stated that if assistance was needed, or if the resident was needing to be touched at all, she sought assistance from nursing, clarifying she would not provide hands on assistance. On 6/12/25 at 9:18 a.m., observed nursing assistant (NA)-B greet R37 from the door, stating Hey, (R37), how are you doing? NA-B did not enter room, or offer assistance with repostitioning. On 6/12/25 at 9:20 a.m., surveyor requested NA-B accompany her to R37's room to observe her positioning. Once in the room, NA-B stated Oh, let me get help to pull her up. NA-B proceeded to get assistance from another staff member and at 9:22 a.m., NA-B and unidentified nursing assistant moved R37 up in bed. Although R37 was now in a more upright position, and in the center of the bed, R37 was still leaning to the right side with her head near the side rail. With additional prompts from the surveyor, R37 was subsequently brought to an upright position, with her upper body not leaning to the right. Throughout the repositioning, R37 frequently stated she was Ok, however, acknowledged things were better once a change of position was offered and she was repositioned. On 6/12/25 during follow up interview with NA-B at 9:27 a.m., NA-B stated she had not even noticed R37's position when she greeted her from the door, and stated I got distracted by (roommate). NA-B stated Sometimes R37 liked to sit in different positions. NA-B stated R37 was not positioned appropriately to eat, and stated R37 should look like she does now. NA-B stated it would be difficult to eat positioned as R37 was. On 6/12/25 at 9:36 a.m., licensed practical nurse (LPN)-C was observed as she entered the room and proceeded to assist R37 with her positioning. LPN-C was interviewed upon exiting the room. LPN-C stated she had observed R37 sitting up in her bed with her breakfast tray, however she was noted to be leaning to the right hand side. LPN-C provided side support with a pillow . LPN-C stated there were concerns with R37 leaning to the right as it posed increased risk for choking. Additionally, LPN-C identified R37 used oxygen and it was important to maintain an upright position for a clear airway. LPN-C stated it would have been difficult for R37 to eat while leaning to the right hand side. A facility policy, titled Turning and Repositioning, undated indicated only that a resident who is dependent for bed mobility is to be turned and repositioned every two hours. The policy lacks information about proper body alignment or support indicated to maintain proper position. A facility policy was requested regarding set up and positioning for resident's dining in bed, however, was not available. R27 (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R27's annual Minimum Data Set (MDS) dated [DATE], indicated R27 had moderate cognitive impairment and required extensive assistance with activities of daily living (ADLs). R27's diagnoses included chronic respiratory failure, hypokalemia (low potassium), congestive heart failure, anemia (low healthy red blood cells or hemoglobin), chronic pain syndrome, major depression, and Alzheimers disease. R27's care plan undated, indicated R27 had a potential for alteration in skin as R27 was bedfast, immobility and incontinence. Interventions included lotion dry skin, assist with incontinence care, heels elevated off bed surface, R27 preferred covers off feet, and monitor for changes in skin integrity with bathing, cares and as needed, report changes to nurse. However, care plan failed to identify R27 had non-pressure wound on right foot, second toe which was identified by staff on 1/26/25, noted in progress notes. Progress note dated 1/26/2025 at 11:23 a.m., indicated R27 had scabbing and redness to right middle toe. However, there were no measurements. A bath audit dated 2/11/25, indicated open sore continued to right second toe. However, there were to measurements or further assessment. Progress note dated 2/13/2025 at 5:37 p.m., indicated R27's dorsal (top) side of the right second toe had skin breakdown measuring 1.1 centimeter (cm) by 1.1cm and it was within a bright red area that measured 3cm by 3cm. There was some green tinged exudate (drainage) present. R27 was seen by provider on 2/13/25, provider noted a non-pressure chronic ulcer of second toe measuring 3cm by 3cm with erythema (reddening) noted and slough (dead tissue) in wound bed appeared infected. R27 was started on an antibiotic for wound infection. There was no progress notes located in R27's medical record regarding non-pressure wound documentation between 2/13/25 and 2/28/25. A wound audit dated 2/28/25, indicated there was skin loss to the right second toe measured 1cm by 1cm by 0.2cm, it was partially scabbed with exposed joint tissue that was largely dry. There was no progress note located in R27's medical record for wound assessment. There were no progress notes located in R27's medical record regarding non-pressure wound documentation between 2/28/25 and 3/14/25. A wound audit dated 3/14/25, indicated R27's right dorsal second toe ulceration was scabbed, measured 1. 2cm by 1.1cm, was elevated 0.1cm. Area was reddened with no drainage. There was no progress note located in R27's medical record for wound assessment. A wound audit dated 3/21/25, indicated right second toe area measured 1.0cm by 1.1cm elevated 0.2 cm, was scabbed and dry. Area reddened with no drainage. There was no progress note located in R27's medical record for wound assessment. There were no progress notes located in R27's medical record regarding non-pressure wound documentation between 3/21/25 and 4/14/25. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A wound audit dated 4/14/25, indicated right second toe ulceration measured about 1.2cm by 1.1cm, was elevated 0.2cm, was scabbed and reddened, no drainage, was left open to air. There was no progress note located in R27's medical record for wound assessment. A wound audit dated 4/24/25, indicated right second toe ulceration measured 1.6cm by 1.0cm, elevated 0.2 cm, toe was pink and swollen. There was no progress note located in R27's medical record for wound assessment. A wound audit dated 4/29/25, indicated right second toe ulceration measured about 1.5cm by 1.0cm, was elevated 0.2cm. No drainage or redness was noted. There was no progress note located in R27's medical record for wound assessment. There were no progress notes located in R27's medical record regarding non-pressure wound documentation between 4/29/25 and 5/15/25. A wound audit dated 5/15/25, indicated right second toe ulceration measured about 2cm by 2cm and was elevated. R27 stated area was painful when touched. There was no progress note located in R27's medical record for wound assessment. A wound audit dated 5/29/25, indicated right second toe ulceration was scabbed over and measured 0.7cm by 1.4cm, there was an indentation at the exposed joint, area was less tender. There was no progress note located in R27's medical record for wound assessment. A wound audit dated 6/4/25, indicated right second toe area had scabbed area that measured 1cm by 1.1cm, there was an indentation at the exposed joint, area left open to air. There was no progress note located in R27's medical record for wound assessment. During observation on 6/09/25 at 3:49 p.m., R27 was observed to have an open area on right second toe with white raised area in center. R27 stated someone walked in front of her, toe got bumped, caused open area with toe knuckle stuck out. When interviewed on 06/12/25 at 10:09 a.m., licensed practical nurse (LPN)-A stated R27 had the area on her toe for a while, area was looked at daily but not documented on in EMR, however, measurements were completed by the assistant director of nursing (ADON) weekly. When interviewed on 6/12/25 at 11:31a.m., ADON stated wounds were measured when identified then weekly unless there was a change that indicated measurements needed to be measured before then. Wound measurements were recorded on wound audit weekly. ADON stated identified gaps in weekly wound audits were due to the area was scabbed over. ADON stated measurements would be restarted if nurses informed him the area had reopened. ADON reviewed progress notes, stated there was no indication regarding area scabbed then reopened to explain gaps in wound measurement. ADON stated weekly wound measurements were important to ensure healing was obtained with limited complications. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	When interviewed on 6/12/25 at 1:57 p.m., director of nursing (DON) stated wounds were expected to be measured and documented on in the progress notes and wound audit when identified then weekly. ADON was responsible for weekly wound assessments until healed. DON stated the nurses may complete a risk management (a facility internal incident reporting system) when new skin concern was identified, DON checked R27's medical record, stated there was no risk management completed for R27's right second toe ulceration. Requested a policy regarding non-pressure wounds. However, facility provided a Treatment and Prevention of Pressure Ulcers policy revised 3/25, policy indicated documentation in the nurses notes was done weekly, weekly wound progress sheets were done at a minimum weekly, included wound description: size, depth, character of drainage, odor, character of tissue in wound and surrounding tissue. R19 R19's quarterly Minimum Data Set (MDS) dated [DATE], identified R19 had intact cognition. R19's diagnoses included end stage renal disease (final stage of chronic kidney disease), anemia (body doesn't have enough healthy red blood cells or hemoglobin to carry sufficient oxygen to the body's tissues), coronary artery disease (arteries supplying blood to the heart become narrowed or blocked), heart failure, hypertension, peripheral vascular disease, diabetes mellitus, anxiety disorder and depression. During review of R19's electronic health record (EHR), signed physician's order indicated an order for Metoprolol Succinate ER (extended release) 25 mg (milligram) to be given by mouth two times a day for essential hypertension and to hold for heart rate less than 60 and systolic blood pressure less than 100. Medication Administration Record (MAR) and Treatment Administration Record (TAR) reviewed from 4/1/25 to 6/12/25, lacked documentation of obtaining and monitoring blood pressure and pulse prior to administration of medication from 4/1/25 to 6/12/25. Parameters were noted on the MAR. During interview on 6/12/25 at 1:43 p.m., licensed practical nurse (LPN)-D stated R19 did not have special monitoring for medication administration. LPN-D checked signed physician's orders and confirmed R19 should have blood pressure and pulse checked prior to administration of Metoprolol. LPN-D stated she was not aware of the parameters and stated she had never taken R19's blood pressure or pulse, prior to administering metoprolol to R19. LPN-D stated it would be important to check blood pressure and pulse as medication may not be able to be administered if blood pressure and/or pulse are below parameters. During interview on 6/12/25 at 2:33 p.m., director of nursing (DON) stated she expected provider's orders to be followed, including parameters of medication administration. DON confirmed R19's blood pressure and pulse should have been obtained prior to administration of the Metoprolol. DON stated following these parameters were important as it was an order from the provider and so the resident does not have any bad outcomes of the medication if it was administered when it was not supposed to be. During interview on 6/12/25 at 4:30 p.m., consultant pharmacist (CP) stated staff should have been obtaining R19's blood pressure and pulse prior to administration of Metoprolol to ensure medication was able to be administered per physician's orders. CP reviewed R19's EHR and confirmed there was no documentation of blood pressure and pulse prior to medication administration from 4/1/25 to 6/12/25. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Medication Administration/Monitoring policy and procedure was requested but was not received.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to ensure developed pressure ulcers were comprehensively assessed and monitored to ensure healing and prevent complications for 1 of 1 residents (R3) reviewed for pressure ulcer care. Findings include: R3's quarterly Minimum Data Set (MDS) dated [DATE], identified R3 had moderate cognitive impairment and required assistance with all activities of daily living (ADLs). R3's diagnoses included progressive neurological conditions, multiple sclerosis (chronic, often debilitating disease that affects the central nervous system - brain and spinal cord), peripheral vascular disease (condition affecting blood vessels outside of the heart and brain), neurogenic bladder (bladder dysfunction caused by nerve damage that disrupts the normal communication between the bladder and the brain), arthritis, Alzheimer's disease, non-Alzheimer's Dementia, malnutrition and localized edema (swelling caused by excess fluid trapped in the body's tissues. MDS indicated a risk for pressure sores and that R3 had one stage four pressure ulcer. R3's provider orders identified: -Prevalon boot to both feet at all times except for hygiene and heels may be floated with pillows in bed alternatively for pressure area treatment/prevention. -30 cc (cubic centimeter) ProSource every day with meal by dietary to promote healing of the skin. -5/19/25 wash left heel ulcer with wound cleanser and pat dry. Apply collagen sheet to wound base and cover with bordered foam dressing every two days and as needed for reopened heel ulcer R3's care plan, print date of 6/12/25, identified a potential for alteration in skin related to diagnoses with interventions to monitor for signs and symptoms of infection, elevate heels off bed surface using pillows with heel boot to be worn as ordered, encourage adequate nutritional and fluid intake during meals, monitor for changes in skin integrity with showers, cares and as needed, treatment to pressure area on heel as ordered until resolved, and weekly skin audit by licensed staff to check skin turgor and monitor for any changes in skin integrity every bath day. R3's electronic medical record (EMR) identified the following: (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-5/13/25 Weekly Wound Audit identified R3 had a left heel pressure ulcer that measured 1.4 cm (centimeter) x 0.8 cm X 0.1 cm and was staged at a stage four (a severe, deep wound that extends through all layers of skin, exposing underlying muscle, tendon, or bone). Ulcer had a lot of white macerated (softening and breakdown of tissue due to prolonged exposure to moisture) like skin removed from around the ulceration. Current base of wound was 100% whitish pink, clean and moist and had a small amount of serous (thin, watery, and clear or yellowish fluid that oozes from a wounds, primarily composed of plasma) drainage on old dressing. Treatment plan consisted of washing left heel ulcer with wound cleanser, patting dry and applying collagen sheet to wound base and cover with bordered foam dressing every two days and as needed. R3 to wear pressure redistribution boots to her heel and had a pressure redistribution surface to bed and wheelchair. R3 continued on ProSource and diuretic medication. Nurse practitioner was updated as this was the first reference of the wound. -5/30/25 Weekly Wound Audit identified R3 continued to have a left heel pressure ulcer that measured 0.4 cm x 0.4 cm X 0.1 cm and staged at a stage four. Ulcer had superficial skin loss present with new skin around the edges. Wound base was 100% clean and pink in color with some dry skin around wound edges. Small amount of serous drainage present on old dressing. Treatment plan consisted of washing left heel ulcer with wound cleanser, patting dry and applying collagen sheet to wound base and cover with bordered foam dressing every two days and as needed. R3 to wear pressure redistribution boots to her heel and had a pressure redistribution surface to bed and wheelchair. R3 continued on ProSource and diuretic medication. Nurse practitioner was updated as this was the first reference of the wound. During interview on 6/12/25 at 11:32 a.m., assistant director of nursing (ADON) stated wounds are measured on identification of the new wound and then weekly unless there are changes to the wound. ADON stated R3 had a history of pressure ulcers to her heels bilaterally and reopened at a stage four. ADON confirmed wound assessments were not completed weekly per protocol, completed on 5/13/25 and on 5/30/25. ADON stated R3 should have an assessment completed weekly as it was important to ensure that the wound is healing and there are no complications. During interview on 6/12/25 at 2:28 p.m., director of nursing (DON) stated she expected wound assessments to be completed weekly. DON confirmed wound assessments were completed and 5/13/25 and 5/30/25 and stated there should have been an assessment completed in between these assessments to check the progress of the wound and/or evaluating the treatment to see if it needs to be changed for wound healing. The Treatment and Prevention of Pressure Ulcers policy, dated 3/25, identified its purpose was to properly identify and assess residents whose clinical conditions increase the risk for development of skin issues, and pressure ulcers, to implement preventative measures, and to provide appropriate treatment measures for pressure ulcers according to the Agency for Health Care Policy and Research guidelines. Pressure Ulcer Treatment: 1. Initiate Skin and Wound Care Protocols 2. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement Care Plan for Treatment and Prevention of Pressure Ulcers 3. Initiation of a Weekly Wound with the onset of any skin condition. 4. Monitor and observe for signs/symptoms of infection and appropriate healing. 5. Documentation in the nurses' notes is done weekly. The weekly wound progress is done at a minimum weekly, in include specific wound description: size, depth, character of drainage, odor, character of tissue in wound and surrounding tissue. The purpose of this procedure is to provide guideline for the treatment of pressure ulcers to facilitate healing.

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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 ensure catheter care was provided in a manner to prevent potential urinary tract infection (UTI) for 1 of 1 resident (R3) reviewed for catheters. Findings include: R3's quarterly Minimum Data Set (MDS) dated [DATE], identified R3 had moderate cognitive impairment and required assistance with all activities of daily living (ADLs). R3's diagnoses included progressive neurological conditions, multiple sclerosis (chronic, often debilitating disease that affects the central nervous system - brain and spinal cord), peripheral vascular disease (condition affecting blood vessels outside of the heart and brain), neurogenic bladder (bladder dysfunction caused by nerve damage that disrupts the normal communication between the bladder and the brain), arthritis, Alzheimer's disease, non-Alzheimer's Dementia, malnutrition and localized edema (swelling caused by excess fluid trapped in the body's tissues. MDS indicated R3 had an indwelling catheter. R3's care plan, print date of 6/12/25, indicated R3 had an indwelling Foley catheter related to a neurogenic bladder and had a history of reporting pain at the catheter site. During observation on 6/9/25 at 7:01 p.m., nursing assistant (NA)-F was assisting R3 with night/catheter cares. R3 had a bowel movement (BM) and while NA-F was performing catheter cares she was cleaning the catheter tubing, that had some BM on tubing, wiping up catheter tube towards opening of the urethra (tube that carries urine out of the bladder). NA-F then removed catheter collection bag, that was on right leg and changed it to a larger overnight collection bag. NA-F did not alcohol wipe to sanitize ends of the collection bag or end of catheter tubing prior to connecting. During interview on 6/9/25 at 7:21 p.m., NA-F stated she cleaned the tubing inappropriately by cleaning the catheter tubing in the wrong direction and stated she should have wiped from the urethra opening down the catheter tubing. NA-F stated she did not sanitize end of the catheter tubing or the overnight collection bag prior to connecting them. During interview on 6/12/25 at 11:13 a.m., infection preventionist (IP) stated NA-F did not perform appropriate catheter care. NA-F should have cleaned the catheter tubing from the urethral opening wiping down tubing. IP stated if there was BM present, staff should use a different rag to clean the BM and another rag for the catheter cares. IP stated this would be important as it was not proper infection control and had the potential to cause R3 to get a urinary tract infection by putting different organisms close to insertion site. During interview on 6/12/25 at 2:28 p.m., director of nursing (DON) stated catheter care that was observed was not appropriate and was a huge infection control concern and education was needed as policy and procedure were not followed. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility Indwelling Urinary Catheter and Collection Device Care policy, dated 2/25, indicated it is a standard that the following procedures are maintained during care of resident with catheters. Strict catheter care will decrease the risk for obtaining a urinary tract infection (UTI). Residents with urinary catheters are to receive partial baths every a.m. and every p.m.; after every BM, and as needed. Insertion sites (meatus) and around the catheter are to be cleansed with a soapy washcloth, removing any encrustations that may have formed. Then rinsed, as well as drying the area. Washing of the catheter tubing close to the body is to be done after cleansing the meatal area. When change over from a leg bag to a bed bag, the new bag connector and catheter end must be swabbed with alcohol prior to connection.

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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 interview and document review, the facility failed to ensure post-dialysis assessment and monitoring was completed for 1 of 1 resident (R19) reviewed for dialysis. Findings include: R19's quarterly Minimum Data Set (MDS) dated [DATE], identified R19 had intact cognition. R19s diagnoses included end stage renal disease (final stage of chronic kidney disease), anemia (condition where the body doesn't have enough healthy red blood cells or hemoglobin to carry sufficient oxygen to the body's tissues), coronary artery disease (condition where the arteries supplying blood to the heart become narrowed or blocked), heart failure (occurs when the heart muscle can't pump enough blood to meet the body's need), hypertension (high blood pressure), peripheral vascular disease (condition affecting blood vessels outside of the heart and brain), diabetes mellitus (group of metabolic diseases characterized by high blood sugar levels, resulting from either the body's inability to effectively use the insulin it produces), anxiety disorder and depression. R19 received dialysis treatment that was done outside of the facility. R19's care plan with print date of 6/11/25, indicated R19 required hemodialysis related to end-stage renal disease and had a shunt in their left arm for vascular access. R19's care plan directed staff to assess access site every day and as needed, feel for palpable thrill (palpable vibration or tremor that can be felt on the skin), listen for bruit (a whooshing or blowing sound heard through a stethoscope when listening to blood flow) and report absence of these signs to dialysis unit and medical doctor. R19's medical record lacked documentation of monitoring of shunt for bruit and thrill. R19's Medication Administration Record (MAR) and Treatment Administration Record (TAR) for reviewed dates of 4/1/25 - 6/11/25 lacked directions for staff to check for bruit and thrill. In addition, MAR and TAR lacked evidence of monitoring of shunt for bruit and thrill. During interview on 6/9/25 at 6:32 p.m., R19 stated she went to dialysis three days per week on Mondays, Wednesdays, and Fridays and that nursing does not auscultate (listen to) or palpate (feel) shunt. During interview on 6/12/25 at 1:43 p.m., licensed practical nurse (LPN)-D stated there is nothing nursing has to do with the access site for dialysis. LPN-D was not aware of what bruit or thrill was and stated she does not perform them for R19. During interview on 6/12/25 at 2:28 p.m., director of nursing (DON) stated her expectations for dialysis residents were for staff to complete fluid monitoring, vital sign monitoring before and after dialysis and observation of the site to check for bleeding. DON confirmed R19 did not have an order to access for bruit and thrill and stated no, we do not check for bruit and thrill on dialysis patients. DON stated it would be important to ensure the shunt was functioning properly by monitoring the blood flow to ensure the access site would still work and that the resident could continue to receive their dialysis treatments. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility Hemodialysis Access Care policy, dated 5/25, indicated residents with a fistula would have staff check patency of the site at regular intervals. Palpate the site to feel the thrill or use a stethoscope to hear the whoosh or bruit of blood flow through the access.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to ensure pharmacist consultant recommendations were acted upon for 1 of 5 residents (R65). In addition, the facility failed to ensure consulting pharmacist identified irregularities in the monthly drug regimen reviews for 3 of 5 residents (R65, R25 and R60) reviewed for unnecessary medications. Findings include: R65's significant change Minimum Data Set (MDS) dated [DATE], identified R65 had intact cognition and remained unchanged from baseline assessment. R65 received assistance with activities of daily living (ADLs) including dressing, grooming and bathing. R65's medical diagnoses included cancer, diabetes mellitus (a disease which impacts how the body processes sugar), arthritis (painful inflammation of joints), malnutrition (poor nutrition impacted by either intake or by how the body utilizes the food ingested), pain in shoulder, cervicalgia (neck pain), and chronic pain. R65's care plain initiated 2/17/25, identified R65 had a nutritional problem r/t (related to) having been hospitalized for shoulder pain, RA (rheumatoid arthritis-an ongoing, chronic, condition that causes pain, swelling and irritation, called inflammation, in the joints, which can also damage other parts of the body) flare up. The care plan directed staff to monitor/record/ and report to provider signs and symptoms of malnutrition, however, lacked identification intervention of medication to manage any potential symptoms of nausea with the use of Prochlorperazine Maleate Oral Tablet (Compazine) as needed for nausea and vomiting. A review of R65's medication administration record (MAR) dated 6/10/25, identified the following order: Prochlorperazine Maleate (an antipsychotic medication also used to treat nausea and vomiting) Oral Tablet 10 mg (milligrams-a unit of measurement): Give one tablet by mouth every 6 (six) hours as needed for nausea and vomiting. Upon review of the MAR's from March, April and May of 2025, there was no noted use of Prochlorperazine. Upon review of resident's medical record, it was noted that although the records identified recommendations were made by the Consultant Pharmacist (CP) on 3/15/25 and 4/11/25, the electronic medical record lacked documentation to reflect what the recommendations were. Consultant Pharmacist's (CP) Report dated 3/15/25, indicated the following PRN (as needed) Prochlorperazine requires a 14-day stop date per survey guidelines. Can this be added or switched to generic Zofran (a medication used for nausea and vomiting)? This request was signed off by CP-B. Consultant Pharmacist Report dated 4/11/25, identified PRN Prochlorperazine requires a 14-day stop date per survey guidelines. Can this be added or switched to generic Zofran? This request was signed off by CP-B. On 5/20/25, the following note was reviewed from the Consulting Pharmacist and indicated: Medication regimen reviewed. No irregularities identified. This request was signed off by CP-A. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 6/11/25 at 4:15 p.m., registered nurse (RN)-A stated the consultant pharmacy reviews were managed by the director of nursing (DON) and the assistant director of nursing (ADON). RN-A stated the information is emailed following remote review by the CP. RN-A stated the March and April reports had not been uploaded, however, were located within the emails to DON/ADON. RN-A stated she would defer any further questions regarding the CP reports to ADON as he completed the follow up on 6/10/25. RN-A stated although she was not a routinely scheduled floor nurse, she did assist on the floor. RN-A stated the floor nurses complete the transcription of orders upon admission. RN-A stated when as needed medications, such as the Prochlorperazine was ordered, the floor nurse would not be aware of the need for a stop date to be specified. On 6/11/25 at 4:20 p.m., the ADON stated sometimes orders for PRN antipsychotics (a medication which alters mood or behaviors) are not written with stop dates. ADON stated this was a new requirement, and some of the nurses may recognize this, however, some may not. ADON stated it would be expected the CP would identify this during completion of the pharmacy reviews and make the recommendations. ADON stated upon review of the CP notes from March and April, when provided on 6/10/25, he noted it had not been addressed. ADON stated he had reviewed the MAR sheets, identified it had not been used, and reached out to the provider for discontinuation of the order. ADON stated both he and the DON received the emails following the CP visit. ADON stated once the email was received, it was printed out and reviewed with the provider. ADON state he was unsure how both recommendations would have been missed. ADON stated the provider should have been contacted to inquire of either an end date or alternate medication. ADON stated the DON was the one who presented the information to the medical provider for review. ADON stated once this was reviewed with the provider, it was then uploaded into the electronic record. On 6/12/25 at 2:30 p.m., the DON stated the CP completed his work remotely, and emailed the recommendations to both DON/ADON. DON state upon receipt of recommendations, she, or the ADON if designated, printed the recommendations out for follow through on nursing recommendations, or for provider review. DON stated she was unsure how the recommendations were missed in both March and April. DON stated she lacked a tracking system to ensure completion of follow up with the provider, or implementation of nursing interventions. On 6/12/25 at 4:52 p.m., CP-A stated he recently began the review for the facility with his first review for R65 occurring on 5/20/25. CP-A stated he noted the last note of his colleague (CP-B) on 4/11/25 indicated the need for clarification on the order of Prochlorperazine. CP-A stated upon completion of his review of 5/20/25, he noted this was still pending review. CP-A stated he was waiting to hear back following communication with the physician from recent recommendations. CP-A responded the information had been reviewed. CP-A stated R65 had been seen on 5/5/25 by the provider. Upon review of the provider visit note. CP-A identified the doctor had not addressed the request for clarification. CP-A stated it was his role to continue to assure that the physician is contacted, (and) to ensure compliance with the current CMS guidelines. CP-A went on to restate In my first review of the individual, I saw the response was repeated and pending, I did not choose to repeat. I am still working with them in clarifying the follow up process. R25 (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R25's annual Minimum Data Set (MDS) dated [DATE], indicated R25 was cognitively intact and was totally dependent on staff for activities of daily living (ADLs). R25 had diagnoses of bipolar disorder, adult failure to thrive, anxiety, major depression, hyperlipidemia, spinal stenosis, bradycardia, and myocarditis. R25's Order Summary Report dated 6/10/25, identified orders for Rosuvastatin (statin medication used to lower cholesterol) with a start date 4/23/24, Aripiprazole (an antipsychotic) for paranoid delusions, Venlafaxine (an antidepressant) for bipolar disorder, and Olanzapine (an antipsychotic) for bipolar disorder. R25's medical record lacked evidence of pharmacy consultant (Pharm D) recommendations for laboratory (lab) monitoring for potential side effect of statin medications as well as lab monitoring of antipsychotic medications crucial for ensuring patient safety, monitoring for potential side effects and treatment effectiveness. When interviewed on 6/12/25 at 10:09 a.m., licensed practical nurse (LPN)-A stated R25 had an order to monitor for medication side effects every shift, LPN-A stated she had not seen any side effects for R25, part of side effect monitoring included labs to monitor safety and potential side effects of medications, the order would come from the provider when time to be completed. When interviewed on 6/12/25 at 3:53 p.m., director of nursing (DON) stated the provider should be ordering labs for monitoring medications, the facility had no standing orders or facility policy regarding labs for medication monitoring. DON stated would expect the consultant pharmacist to notice this during their review and make a recommendation regarding no lab monitoring for medications in R25's medical record to ensure there were no side effects related to his medications. When interviewed on 6/12/25 at 4:28 p.m., consultant pharmacist (CP)-A stated when monthly medication reviews (MMR's) were completed the whole chart was reviewed, CP-A looked for lab monitoring, provider notes, looked at the clinical situation for all medications, assessed for appropriate use and monitoring. CP-A stated did not look for annual lab monitoring of medications, relied on the provider to order needed labs. R60 R60's quarterly MDS dated [DATE], indicated R60 was cognitively intact and required extensive assistance from staff for activities of daily living (ADLs). R60's diagnoses included Alzheimer's disease, adult failure to thrive, anxiety, dysthymic disorder (chronic depression), chronic kidney disease, cardiomyopathy, and dementia. R60's order summary report dated 6/11/25, identified R60 had active orders for lorazepam (medication used to treat anxiety) 0.5mg every four hours PRN (as needed) for anxiety was ordered on 5/11/25. The order lacked a 14 day stop date. R60's medical record lacked evidence of Pharm D recommendations to obtain a new order from the provider at 14 days or for a rationale of continued use for the Lorazepam. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	When interviewed on 6/12/25 at 10:09 a.m., LPN-A stated R60 called out frequently, would get loud when doing so. LPN-A stated R60 received PRN lorazepam at least daily for anxiety. When interviewed on 6/12/25 at 3:53 p.m., director of nursing (DON) stated PRN antianxiety medications required an end dated in 14 days unless the provider gave justification for a longer time frame. DON was not aware of where the PRN lorazepam dated 5/11/25 had come from. When interviewed on 6/12/25 at 4:28 p.m., CP-A stated PRN lorazepam should have had an end date. CP-A verified there was an order dated 5/11/25, was unable to identify an end dated, stated the facility failed to enter a stop date. CP-A stated pharmacy review was completed 5/20/25, but did not see there was a change. The facility's Consultant Pharmacist Agreement, undated, and not signed, identified under Consultant Responsibilities, it identified the Consultant Pharmacist was responsible to review the drug regimen of each resident monthly and prepare appropriate reports and recommendations including at least a review of all drugs currently ordered; information concerning the patients condition as it relates to drug therapy; and medication administration records, physician progress notes, nurses' notes, and laboratory test results. The Agreement additionally outlined the CP was report, in writing, irregularities in the storage, dispensing and administration of drugs and other matters related to the review of the drug regimen, to the administrator, and other appropriate health professionals as may be determined by the administrator and consulting pharmacist. The facility policy and procedure, Psychotherapeutic Medications, revised 4/25, identified both use of psychotherapeutic medications and antipsychotic medications. The policy identified prior to the administration of an(y) antipsychotic medication, the following must be documented: appropriate diagnosis, consent, assessment prior to implementation, goals of psychotherapeutic meds. Also identified, the physician and interdisciplinary team would determine whether the benefit of medications justified the potential risks or adverse consequence associated with the selected medications and for any resident on a psychotherapeutic medication, ongoing monitoring for side effects of all psychotherapeutic medications administered would be performed. However, the policy failed to address lab monitoring or PRN psychotherapeutic medications. The policy lacked any indication regarding the required end date for PRN psychotropic use if to extend beyond 14 days. The policy also lacks the requirement for the resident to have a 14-day face to face provider evaluation. In addition, the policy lacked any indication as to when the use of PRN psychotropic medications were indicated, and lacked indication of the perimeters as to when they may be used.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to ensure antipsychotic medications were appropriately monitored in accordance with the standard-of-care laboratory testing to help reduce the risk of medication side effects for 1 of 5 residents (R25) reviewed for unnecessary medication use. R25's annual minimum data set (MDS) dated [DATE], indicated R25 was cognitively intact and was totally dependent on staff for activities of daily living (ADLs). R25 had diagnoses of bipolar disorder, adult failure to thrive, anxiety, major depression, hyperlipidemia, spinal stenosis, bradycardia, and myocarditis. R25's Order Summary Report dated 6/10/25, identified orders for Rosuvastatin (statin medication used to lower cholesterol) with a start date 4/23/24, Aripiprazole (an antipsychotic) for paranoid delusions, Venlafaxine (an antidepressant) for bipolar disorder, and Olanzapine (an antipsychotic) for bipolar disorder. R25's medical record lacked evidence of laboratory (lab) monitoring of potential side effects and treatment effectiveness of statin, antidepressant or antipsychotic medications since R25 admitted to facility in April 2024. R25's medical record lacked evidence of pharmacy consultant (Pharm D) recommendations for lab monitoring for potential side effect of statin medications. R25's medical record lacked evidence of Pharm D recommendations for lab monitoring of antipsychotic medications crucial for ensuring patient safety, monitoring for potential side effects, and treatment effectiveness. When interviewed on 6/12/25 at 10:09 a.m., licensed practical nurse (LPN)-A stated had not seen any side effects for R25, part of side effect monitoring included labs to monitor safety and potential side effects of medications. When interviewed on 6/12/25 at 3:53 p.m., director of nursing (DON) stated the provider should be ordering labs for monitoring medications, the facility had no standing orders or facility policy regarding labs for medication monitoring. DON stated would expect the consultant pharmacist to catch and make a recommendation regarding no lab monitoring for medications in R25's medical record to ensure there were no side effects related to his medications. When interviewed on 6/12/25 at 4:28 p.m., consultant pharmacist (CP)-A stated when monthly medication reviews (MMR's) were completed the whole chart was reviewed, CP-A looked for lab monitoring, provider notes, looked at the clinical situation for all medications, assessed for appropriate use and monitoring. CP-A stated did not look for annual lab monitoring of medications, relied on the provider to order needed labs. A facility Psychotherapeutic Medications policy reviewed 4/25, indicated any resident on a psychotherapeutic medication, ongoing monitoring for side effects of all psychotherapeutic medications administered would be performed. However, the policy failed to address lab monitoring of antipsychotic medications.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Park River Estates Care Center	9899 Avocet Street Northwest Coon Rapids, MN 55433

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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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to maintain safe storage of medications when medication carts were left unlocked and unattended for 1 of 1 medication cart located on the west unit. Findings include: R51's quarterly Minimum Data Set (MDS) dated [DATE], identified R51 had severe cognitive impairment and required assistance with activities of daily living (ADL)'s. During observation on 6/11/25 at 8:52 a.m., R51 was sitting at the medication cart on west unit, fidgeting with drawers and things on top of medication cart. Staff approached R51 and asked him to not touch things and that staff were watching him. During observation on 6/11/25 at 9:00 a.m., medication cart was sitting in the hallway in the fireside room and was unlocked. R51 was wandering around the area touching and fidgeting with items. During observation and interview on 6/11/25 at 9:03 a.m., licensed practical nurse (LPN)-E returned to medication cart and locked cart. LPN-E confirmed medication cart was unlocked and stated, it was only unlocked for a couple of minutes. LPN-E confirmed R51 was around the medication cart unattended and had a history of fidgeting with different items. LPN-E confirmed she did not have the medication cart in direct eyesight during that time. During observation on 6/11/25 at 3:09 p.m., R51 was standing up at the medication cart reaching for a supplement drink that was placed on top of medication cart. Director of nursing (DON) went to medication cart and assisted R51 with sitting back down in his wheelchair. During observation on 6/11/25 at 3:10 p.m., R51 went to a different medication cart, reached for a supplement drink that was on top of medication cart and started drinking it quickly. During observation on 6/11/25 at 3:15 p.m. R51 grabbed thermometer out of the vitals cart and place on his forehead to take his temperature. During observation on 6/11/25 at 3:20 p.m., R51 was sitting in his wheelchair with his eyes partly closed. As soon as the nurse left the medication cart, R51 went to the medication cart, stood up and grabbed two supplements off the top of the medication cart and hid them in his wheelchair along the side of him and wheeled himself quickly down the hallway. During interview on 6/12/25 at 11:58 a.m., assistant director of nursing (ADON) stated he expected the medication cart to be locked whenever the nurse was away from the cart. Important for the medication cart to be locked was so no one took anything from the medication cart and confirmed R51 often wandered around in his wheelchair and will grab and pick up different items frequently. During interview on 6/12/25 at 1:43 p.m., LPN-D stated the medication cart was always locked whenever she was not standing at it with no exceptions. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During interview on 6/12/25 at 2:28 p.m., DON stated she expected medication carts to be locked any time the nurse was away and out of eyesight of them for any amount of time. DON stated this was important to make sure no one had access to items in the cart they should not have access to. This was especially important as there were vulnerable residents with cognitive decline residing in facility. During interview on 6/12/25 at 4:30 p.m., consultant pharmacist (CP) stated medication carts should be locked when the nurses were not actively using or in control of the medication cart. A policy was requested but was not received.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility staff failed to consistently implement hand hygiene following glove use for 1 of 1 residents (R36) observed for personal cares. In addition, facility failed to ensure proper personal protective equipment (PPE) was used when providing cares for 1 of 1 resident (R3) reviewed for enhanced barrier precautions (EBP). Findings include: R36 R36's quarterly Minimum Data Set (MDS) dated [DATE], identified R36 had impaired cognition never/rarely made decisions. R36 was dependent on staff for toileting, dressing, and bathing. R36's medical diagnoses included non-traumatic brain dysfunction (occurs due to internal factors affecting the brain, such as strokes, lack of oxygen, or infections), unspecified dementia (a decline in cognitive function severe enough to interfere with daily life), hemiplegia (one sided weakness), aphasia (difficulty with speaking), and speech and language deficits following cerebral infarction (stroke). R36's care plan initiated 10/12/21, identified R36 had self care deficits and limited mobility related to hemiplegia of left side, total incontinence, and dementia. The care plan also identified R36 had alteration in elimination as evidenced by R36 being incontinent of bowel and bladder related to dementia, and hemiplegia. The care plan directed staff to provide assist to check and change every two to three hours and as needed. The care plan identified R36 used the pad/brief system. During observation and interview on 6/11/25 at 3:05 p.m., nursing assistants (NA)-C and NA-D were observed as they performed personal cares for R36. Hand hygiene was performed with alcohol based hand sanitizer prior to applying gloves prior to providing cares. Both NA's were noted to wear gloves throughout the provision of cares. Following cares, incontinence brief was bagged, and gloves were removed. NA-D performed hand hygiene with alcohol based hand sanitizer. NA-C removed gloves following provision of cares, and proceeded to exit the room, walked to a room across the hall, knocked on the door, and touched the handle to go. NA-C had not performed hand hygiene and hand sanitizer or washed hands. NA-C was stopped prior to entering the other room. NA-C verified that she had not washed her hands, or performed hand hygiene prior to leaving the room, crossing the hall, knocking on the door and touching the door handle to enter the room. NA-C stated it was important to either wash hands or use hand sanitizer if appropriate so that you did not cross germs, and were not sharing germs. A facility policy, titled Antispetic Hand Cleansing Gel, last revised 5/25. identified hand gel is not to replace handwashing. Handwashing is still necessary prior to and after the care of a resident. A facility policy, titled Employee Handwashing Procedure, last revised 12/25, identified The greatest defense that an employee of Park River Estates Care Center has against the spread of infectious organisms to and from others is; handwashing. The policy directed staff to implement hand washing before and after any direct care of residents. R3 (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R3's quarterly Minimum Data Set (MDS) dated [DATE], identified R3 had moderate cognitive impairment and required assistance with all activities of daily living (ADLs). R3's diagnoses included progressive neurological conditions, multiple sclerosis (chronic, often debilitating disease that affects the central nervous system - brain and spinal cord), peripheral vascular disease (condition affecting blood vessels outside of the heart and brain), neurogenic bladder (bladder dysfunction caused by nerve damage that disrupts the normal communication between the bladder and the brain), arthritis, Alzheimer's disease, non-Alzheimer's Dementia, malnutrition and localized edema (swelling caused by excess fluid trapped in the body's tissues). MDS indicated R3 had an indwelling catheter and a stage four (severe stage of a pressure ulcer, characterized by extensive tissue damage extending to muscle, tendon, and sometimes even bone) pressure ulcer. R3's care plan print date of 6/12/25, indicated R3 had an indwelling Foley catheter related to a neurogenic bladder and a decubitus (pressure) ulcer on left heel that was a stage four. Additionally, R3's care plan lacked documentation related to EBP precautions being used with cares. During observation on 6/9/25 at 6:48 p.m., EBP precaution sign was posted on the wall, outside of R3's room, directing what precautions staff needed to wear when assisting R3. Isolation cart that contained gloves and gown was placed in the hallway to the left of R3's door. During observation on 6/9/25 at 7:01 p.m., nursing assistant (NA)-F was observed providing peri-care and catheter care to R3 in her bed. NA-F was wearing gloves, but not a gown. NA-F came into contact with bedsheets, pillow and the resident during cares multiple times while not wearing personal protective equipment (PPE). During interview on 6/9/25 at 7:21 p.m., NA-F confirmed R3 was on EBP and stated she should have worn a gown when doing catheter cares and confirmed she did not. During interview on 6/11/25 at 11:38 a.m., NA-G stated gowns are almost never used for residents who are on EBP precautions. NA-G stated gown and gloves were supposed to be worn when assisting residents on EBP precautions. During interview on 6/12/25 at 11:13 a.m., infection preventionist (IP) stated she expected staff to follow the precaution signs posted for what PPE was needed to be worn when caring for the resident. IP stated staff are really bad at following precautions guidance and stated staff never wear gowns, she had reeducated staff numerous times. IP stated she expected staff to wear a gown and gloves when doing cares for R3 as she was on EBP precautions related to indwelling catheter. During interview on 6/12/25 at 1:39 p.m., trained medication assistant (TMA)-B stated gown and gloves should be used for all residents that were on EBP precautions when coming in close contact with them such as personal cares or catheter cares. During interview on 6/12/25 at 1:43 p.m., licensed practical nurse (LPN)-D stated gloves and gowns should always be worn with cares for residents on EBP precautions. LPN-D stated some aides don't wear gowns very often. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 6/12/25 at 2:28 p.m., director of nursing (DON) stated she expected staff to follow the policy and procedure and what they had been educated on. DON stated staff should wear gloves and gown whenever they are providing cares for a resident on EBP precautions or when they may come in contact with an area/concern that causes a resident to be on EBP precautions. DON stated EBP precautions are important, so infections did not get spread to the resident or other residents leading to spread of infections. The Enhanced Barrier Precautions policy, dated 2/25, indicated it was the policy of the facility that Enhanced Barrier Precautions be implemented during high-contact resident care activities when caring for residents that have an increased risk for acquiring a multidrug-resistant organism (MDRO) such as a resident with wounds, indwelling medical devices or resident with infection or colonization with an MDRO. The purpose of Enhanced Barrier Precautions is to prevent opportunities for transfer of MDROs to employee's hands and clothing during cares, beyond situations in which staff anticipate exposure to blood or body fluids. High-Contact resident care activities include: Dressing Bathing/showering Transferring Providing hygiene Changing linens Changing briefs or assisting with toileting Device care or use: central line, urinary catheter, feeding tube, tracheostomy/ventilator Wound care: skin opening requiring a dressing and/or treatment.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. Based on observation, interview, and document review, the facility failed to consistently place the call light within reach for 1 of 1 residents (R10), who was reviewed for call light use. Findings include: R10's significant change Minimum Data Set (MDS) assessment completed 2/7/25, indicated R10 had significant cognitive impairment. R10 was noted to lack indicators of delirium, including inattention, disorganized thinking, or altered level of consciousness. The assessment lacked answers for the question Made decisions regarding tasks of daily life. The MDS identified R10 was to be interviewed regard daily and activity preferences. R10's medical diagnoses included non-traumatic brain dysfunction (occurs due to internal factors affecting the brain, such as strokes, lack of oxygen, or infections), vascular dementia, hemiplegia/hemiparesis (weakness on one side of the body), seizure disorder/epilepsy, anxiety disorder, depression, systemic lupus (a chronic autoimmune disease where the immune system attacks healthy tissues, leading to inflammation and damage across various body systems), personality change due to known physiological condition, drug induced subacute dyskinesia, fibromyalgia (a chronic disorder characterized by widespread musculoskeletal pain, fatigue, and issues with sleep, memory, and mood), and multiple sclerosis (chronic autoimmune disorder that affects the central nervous system, leading to a range of neurological symptoms and varying degrees of disability). R10's care plan dated 2/12/25, identified the following under cognition: Resident is alert and oriented to person and place with periods of confusion .Able to make some needs known, often does not use call light. The care plan identified the following diagnoses impacted his cognition, vascular dementia and cerebral infarction. Struggles to express self and needs due to speech disturbances diagnosis. The care plan directed staff to allow resident extra time to express self and needs; anticipate and meet resident's needs; and to monitor for any changes in cognition and report to NP (nurse practitioner) as needed. The care plan lacked direction to staff under cognition and communication, in addition to the diagnoses listed, R10 also had weakness on the right side of the body. The care plan lacked direction to staff to provide R10 a call light to allow resident a means to communicate his needs, and also failed to direct staff to place the call light on the left side of his body, which was not impacted by weakness. Although R10 was identified as having a self care deficit in activities of daily living (ADLs) related to hemiplegia (one sided weakness) of his right side, the care plan lacked direction to staff to provide items R10 may potentially need (call light, personal items) to the left side of R10's body to allow access to items. On 6/09/25 at 7:25 p.m., R10 was observed to be resting on his bed with his right hand resting on the bed on the right side of his body. R10's right hand was noted to have all fingers and thumb curled inward, under his hand. R10's pressure touch call light was observed to be lying next to R10's right hand. When asked if able to use the call light with his right hand, R10 stated No. When asked if he was able to reach the call light with his left hand, R10 stated No! On 6/11/25 at 4:08 p.m., R10 was observed on his back. R10's right hand was resting on the bed on the right side of the bed, no movement of R10's right hand was observed. R10's call light was observed resting under the bedding on his right side, near his right hand. R10 loudly stated, No! when asked if he was able to reach his call light with his left hand. R10 was noted to answer appopriately to Yes/No questions when asked. (continued on next page)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During observation and interview on 6/12/25 at 11:35 a.m., R10 was observed resting on the bed, R10's right hand was observed laying without movement on his right side. R10's pressure call light was observed resting next to right hand. At this time, nursing assistant (NA)-A was present in room with R10 and surveyor. NA-A stated R10 would not be able to reach/use call light with his left hand due to placement of the call light on his right side. NA-A stated R10 was unable to reach the call light, and it would need to be moved to allow R10 to reach it. NA-A proceeded to move the cord to the left side of the bed, and draped the cord over the rail. R10 indicated to NA-A, with multiple yes/no questions, he would like the call light placed on the bedside table. After the call light was placed on the bedside table on the left side of R10, R10 confirmed he was able to reach the call light. During a follow up interview and observation of R10 on 6/12/25 at 12:00 p.m., the assistant director of nursing (ADON) accompanied surveyor to R10's room, where R10 was laying in his bed. At this time, it was noted R10's pressure call light was placed on the bedside table on R10's left side, as had been previously requested by R10. The previous scenario was reviewed with ADON whether or not R10 could effectively reach call light to use if it were placed on the right side of his body. ADON proceeded to ask R10 if he could reach the call light if placed on the right side. R10 firmly responded No! ADON again encouraged R10 to try to reach the call light when placed on the right side. R10 did attempt to reach, however, was unsuccessful. ADON stated preferably the call light would be on the left side, so R10 could reach it. ADON went on to state, Obviously if he needs assistance with anything, he could (have) call(ed) out, but the preferred method would be to have (had) the call light within reach. A facility policy was requested for call light use, however, no policy was available for review.