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	04/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Park River Healthcare and Rehabilitation Center LL	9899 Avocet Street Northwest Coon Rapids, MN 55433

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F 0698 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to ensure residents receiving dialysis services were provided appropriate care and services, including failure to establish and implement an effective communication system with the dialysis center, failure to monitor and assess vascular access sites, failure to implement Enhanced Barrier Precautions (EBP), failure to monitor fluid restrictions, assess vital signs per physician orders, and failure to ensure sterile technique and follow physician direction for central venous catheter (CVC) care, for 2 of 2 residents (R16, R12) reviewed for dialysis services. These failures resulted in Immediate Jeopardy (IJ) for R16, as the facility's practices placed the resident at likelihood for serious harm, including infection, sepsis, and complications related to uncontrolled bleeding.The Immediate Jeopardy began on 4/11/26 when the facility failed to immediately contact dialysis and instead removed and changed the CVC dressing without adequate training and sterile technique as required, and was identified on 4/24/26 at 4:10 p.m. The IJ was removed on 4/27/26 at 12:08 p.m., when the facility implemented corrective actions, including initiation of monitoring protocols for dialysis access sites, implementation of Enhanced Barrier Precautions (EBP), staff education on dialysis care and sterile technique, and establishment of a communication process with the dialysis center. Findings include: R16's admission Minimum Data Set (MDS) dated [DATE] identified R16 had intact cognition and was independent with activities of daily living (ADL)'s. Relevant diagnoses included end stage renal disease (ESRD; advanced kidney failure requiring dialysis), dependence on renal dialysis (requires dialysis treatments to perform kidney function), heart failure (a condition where the heart cannot pump blood effectively), atrial fibrillation (an irregular heart rhythm), hypertension (high blood pressure), anemia (a condition with a decreased number of red blood cells causing fatigue and weakness), hyperparathyroidism (overactivity of the parathyroid glands causing abnormal calcium and phosphorus levels), and long-term anticoagulant use (ongoing use of blood thinning medication to prevent blood clots). R16's care plan, dated 4/8/26, identified R16 required offsite hemodialysis on Tuesdays, Thursdays, and Saturdays related to ESRD and included interventions related to the AV fistula for staff to assess the site every day and as needed for signs of infection, tenderness, drainage, bruit and thrill. However, there was no monitoring in place on the Medication Administration Record (MAR) or Treatment Administration Record (TAR) and no physician order for this monitoring. The care plan dated 4/8/26 identified a fluid restriction of 1500 milliliters (ml) 1200 ml for dietary and 300 ml for nursing to provide. The care plan directed daily weights. Staff were directed by the care plan to review communication from dialysis for medications given, labs performed, et, after each session. R16's care plan failed to include R16's CVC site, lacked interventions for monitoring and care of the (continued on next page)

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

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F 0698 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	CVC, and failed to include implementation of Enhanced Barrier Precautions (EBP) related to the resident's dialysis access devices. R16's uploaded dialysis documents identified records titled Dialysis (April Treatment Sheets) that contained only three of thirteen dialysis treatment run sheets received from the dialysis center and lacked evidence of communication or clinical information provided by the facility to the dialysis center. R16's electronic medical record (EMR) from 3/20/26 through 4/23/26 failed to identify evidence of a consistent communication system between the facility and the dialysis center, including lack of documentation of dialysis treatment summaries, changes in condition, weights, vital signs, or post-treatment concerns. During interview on 4/20/26 at 4:07 p.m., R16 stated he did not recall any documents being sent with him to dialysis or returning with any documentation. During interview on 4/23/26 at 10:32 a.m., the dialysis facility administrator (FA) stated the facility should send communication with residents to dialysis, including changes in condition, vital signs, access concerns, weights, and other relevant clinical information for each run. The FA stated the facility did not consistently send documentation with R16 and the dialysis center was unaware of one of R16's emergency room (ER) visits and hospitalization until R16 failed to arrive for dialysis. During interview on 4/23/26 at 4:01 p.m., director of nursing (DON) stated the facility sent only a general appointment referral consisting of the resident's face sheet and medication list and confirmed the facility was working to improve communication with the dialysis center. R16's physician orders for April 2026, identified an order for Metoprolol Tartrate 50 MG (milligram), give 50 mg by mouth two times a day for ESRD, with parameters to hold the medication for systolic blood pressure (SBP) less than 90 or pulse less than 50, initiated on 3/20/26. Review of R16's medication administration records (MAR) from 3/20/26 through 4/22/26 identified Metoprolol Tartrate was administered as ordered; however, there was no documentation blood pressure or pulse were obtained prior to administration, as required by the physician's order. During interview on 4/22/26 at 2:09 p.m., trained medication aide (TMA)-A confirmed blood pressure and pulse were not obtained prior to administration despite the medication hold parameters. During interview on 4/23/26 at 10:08 a.m., licensed practical nurse (LPN)-C stated, to her knowledge, there were no residents with medication parameters requiring vital signs prior to administration and confirmed she had not obtained vital signs that morning related to medication administration. During interview on 4/23/26 at 3:35 p.m., assistant director of nursing (ADON) confirmed vital sign monitoring was not in place and was not completed prior to medication administration for R16. During interview on 4/27/26 at 1:17 p.m., LPN-G confirmed blood pressure and pulse should be obtained prior to administering medications with hold parameters and acknowledged this was not initiated for R16 until 4/23/26. During interview on 4/27/26 at 1:48 p.m., DON and consultant nurse (C-RN) confirmed staff were (continued on next page)

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F 0698 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	implemented. During interview on 4/23/26 at 4:01 p.m., DON stated residents with external access devices should be on EBP precautions; however, R16 was not on EBP precautions. The facility's Enhanced Barrier Precautions policy, undated, required implementation of EBP for residents with indwelling medical devices, including central lines and hemodialysis access. The policy required gown and glove use during high-contact care activities and required PPE to be readily available outside the resident's room. R16's progress notes identified repeated bleeding events related to the dialysis access site. Further review identified R16 was prescribed Coumadin (warfarin; a blood thinning medication), which increased the risk for significant bleeding complications. Progress note (pre-operative history and physical) dated 4/1/26 indicated R16 was scheduled for a left AV fistula revision with aneurysmorrhaphy (surgical repair and reconstruction of a weakened or enlarged area of the dialysis fistula) on 4/6/26. Progress note dated 4/11/26 at 12:37 a.m. indicated R16 called for assistance and was found bleeding from the port area. Documentation indicated the abdominal (ABD) pad had heavy blood saturation and bleeding was described as moderate. Area was re-dressed by the evening nurse and pressure was applied with gauze to reduce bleeding. The port area appeared bruised, and the left jugular area was distended and painful to touch. Emergency medical services (911) were contacted, and R16 was transferred to the ER for evaluation. Progress note dated 4/13/26 at 3:54 a.m. indicated R16 continued to experience bleeding from the port site, nurse performed a dressing change and notified provider of bleeding. The provider attributed the bleeding to warfarin use and instructed staff to apply pressure for 10 minutes and apply ice. Progress note (physician acute visit) dated 4/13/26 indicated the shunt on R16's left anterior chest continued leaking despite a dressing change. Documentation further indicated that R16 was bleeding from the wound site on the left anterior chest and required further hospital evaluation. The physician documented concern for ongoing bleeding, possible anemia, and possible infection related to the dialysis access site. R16's physician orders on 4/23/26 failed to identify physician orders for facility staff to perform CVC dressing changes or monitor the AV fistula site, including bruit and thrill assessments. R16's EMR on 4/23/26 failed to identify evidence of monitoring or documentation of the AV fistula site, including bruit and thrill assessments. Further review failed to identify evidence sterile supplies or aseptic technique were utilized during CVC dressing changes completed by facility staff. During interview on 4/23/26 at 10:03 a.m., LPN-A stated dialysis residents should be monitored for bruit and thrill, access site complications, fluid restrictions, diet and confirmed R16 had both a fistula and recently placed CVC. During interview on 4/23/26 at 10:08 a.m., LPN-C confirmed both R16 and R12 received dialysis and stated staff should monitor access sites for complications or signs of infection and document findings on the treatment record. (continued on next page)

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F 0698 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During interview on 4/23/26 at 2:55 p.m., RN-A stated dialysis monitoring could include vital signs and access site monitoring. RN-A stated if a dialysis access site was bleeding, staff would control the bleeding and contact the on-call provider. RN-A confirmed neither dialysis resident was on precautions. During interview on 4/23/26 at 2:59 p.m., LPN-I stated staff obtained vital signs and assessed dialysis access sites upon residents' return from dialysis and documented findings in progress notes. LPN-I stated if a site was bleeding, staff would change the dressing, apply pressure, and contact the provider if bleeding did not stop. During interview on 4/23/26 at 3:35 p.m., ADON stated staff should assess dialysis access sites, monitor for signs of infection or bleeding, and notify the provider of concerns. ADON reviewed R16's EMR and confirmed there was no physician order for monitoring of the CVC or AV fistula. During interview on 4/23/26 at 4:01 p.m., DON stated staff should assess dialysis access sites, monitor for bleeding or infection, check for bruit and thrill, and ensure there was no bleeding upon return from dialysis. DON stated that dressing changes required a physician order and confirmed there was no physician order to monitor R16's access site. DON further confirmed orders for bruit and thrill monitoring were not initiated until 4/23/2026. During a telephone interview on 4/23/26 at 12:50 p.m., the FA stated R16's revised AV fistula should be monitored at least daily for bruit and thrill, and the temporary CVC should be monitored for bleeding, redness, dislodgement, and infection. FA stated nursing facility staff should never remove or replace the sterile CVC dressing and should only reinforce the dressing and apply pressure if bleeding occurred. FA stated removing and replacing the sterile dressing by nursing facility staff placed residents at risk for systemic infection. According to information provided by R16's dialysis company, a central venous catheter is only used temporarily while the AV fistula is ready to be used. R16's AV fistula was healing after surgery. Hemodialysis catheters have a higher risk of clotting and infection and provide for a slower rate. A CVC requires special handling and a registered nurse (RN) must be educated and trained in CVC care. A biopatch – a chlorhexidine (CHG) impregnated sponge which continually releases CHG is used which inhibits bacterial growth for up to 7 days. Staff outside of the dialysis unit should only reinforce the dressing, never change it with the exception of the emergency room. If there is bleeding from the site, a surgeon must be notified. A RN who changes the dressing must use sterile gloves, sterile draping and a face mask. CVC's are high risk for infection. If there are any concerns with R16's CVC or any dialysis concerns, the dialysis unit must be notified. They have emergency after hours numbers. During multiple nursing staff interviews on 4/23/26 between 3:00 p.m. and 3:30 p.m., LPN-D, LPN-E, LPN-F, and TMA-B stated residents were sent to dialysis with medication records, vital signs, and possibly weights in an envelope prepared by medical records staff. LPN-D, LPN-E, and LPN-F stated dialysis access monitoring should include assessment of CVC sites for redness, bleeding, loose dressings, and signs of infection and AV fistulas for redness, bleeding, pain, and bruit/thrill. LPN-D and LPN-E stated if a resident's CVC site was bleeding, staff would obtain supplies from the supply cart, replace the dressing, and contact the facility provider for direction. LPN-E stated staff obtained direction for dialysis care from the facility provider and did not identify contacting the dialysis center or nephrologist directly regarding dialysis access complications. R12 (continued on next page)

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F 0698 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	R12's quarterly MDS dated [DATE] identified R12 received dialysis services and had diagnoses including renal failure (decreased kidney function requiring medical management or dialysis), hypertension (high blood pressure), peripheral vascular disease (poor circulation caused by narrowed blood vessels, usually in the legs), diabetes mellitus (a condition affecting blood sugar regulation), and dementia (decline in memory and thinking abilities affecting daily functioning). R12's care plan, with a print date of 4/22/26, identified R12 required hemodialysis related to ESRD and included interventions related to monitoring the fistula access site, bleeding, infection, fluid restriction, weights, and communication with the dialysis center. Review of R12's uploaded dialysis documents identified records titled Dialysis (March Treatment Sheets), Dialysis (February Treatment Sheets), and Dialysis (November Treatment Sheets). The documents contained only laboratory results received from the dialysis center and lacked evidence of communication or clinical information provided by the facility to the dialysis center. R12's EMR on 4/23/26 failed to identify evidence of a consistent communication system between the facility and the dialysis center, including lack of documentation of dialysis treatment summaries, changes in condition, weights, vital signs, or post-treatment concerns. During interview on 4/20/26 at 2:20 p.m., R12 stated the facility only sent a medication list to dialysis and she did not return with paperwork except for laboratory results. R12's physician orders printed 4/23/26 identified an active order for a 1500 ml daily fluid restriction related to dialysis and chronic kidney disease. During observation and interview on 4/20/26 at 2:12 p.m., R12 had a water pitcher and cup in the room and stated staff would provide them upon request despite the fluid restriction. During interview on 4/22/26 at 2:23 p.m., NA-A stated they were not aware which residents were on fluid restrictions. During interview on 4/23/26 at 10:08 a.m., LPN-C confirmed R12 was on fluid restrictions and should not have a water pitcher in the room. The facility's Dialysis policy, revised 7/25, required ongoing assessment and monitoring of dialysis residents, evaluation of access sites for complications, communication with the dialysis center regarding weights, medications, fluid restrictions, and changes in condition, and coordination of care related to dialysis services. The facility's removal plan was verified as implemented on 4/27/26 between 9:00 a.m. and 12:00 p.m. by interview of RN's, LPN's, and nursing assistants who all could clearly identify how to manage a dialysis patient and had received training. In addition, training of each staff member before they worked was verified through document review. Each resident on dialysis was reviewed to ensure communication to dialysis unit was in place, assessments were added to MAR/TAR and care plans. The IJ was removed at 12:08 p.m.

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review, the facility failed to establish and maintain an infection control program, failed to have a system for preventing, identifying, reporting, investigating, and controlling infections that occurred in the facility. The facility failed to identify a potential respiratory illness outbreak with 5 residents (R38, R24, R43, R78, and R28) showing signs of illness between 4/15/26 and 4/24/26, the facility failed to assess, monitor, and document their symptoms, conduct any outbreak testing, or place on transmission-based precautions (TBP) to prevent the spread to others. In addition, the facility failed to identify the need for and implement enhanced barrier precautions (EBP) for 2 of 2 residents (R16 and R29) reviewed who required EBP. The facility's system failure had the potential affect all 85 residents who currently resided in the facility.The immediate jeopardy began on 4/15/26 when R38 developed respiratory illness symptoms and was not placed on TBP and was identified on 4/24/26 after 4 other residents (R24, R43, R78, and R28) also developed respiratory symptoms, were not placed on TBP, were not assessed, monitored and were not tested for potential infectious agent in addition to the total lack of an ongoing and effective surveillance system. The administrator and director of nursing (DON) were notified of the IJ on 4/24/26 at 4:10 p.m. The IJ was removed on 4/27/26 at 12:08 p.m. when the facility implemented an acceptable removal plan, but noncompliance remained at a lower scope and severity with potential for more than minimal harm that is not immediate jeopardy (Level F).Findings include: When interviewed on 4/22/26 at 10:00 a.m., the director of nursing (DON) stated she had been the infection preventionist since October 2025. The DON described the infection surveillance program as receiving a list of antibiotics at the end of the month and then entering them into a tracking log. Infections were not entered onto the log or tracked as they occurred in the facility, nor where they occurred in the building. No information about residents who had signs of illness such as cough or diarrhea were entered into the tracking form unless an antibiotic was initiated. She had not been able to implement a program where infection symptoms were tracked timely in order to identify if an outbreak was potentially occurring in the facility. However, staff did inform her when residents were showing signs of illness such as cough, diarrhea or other symptoms. When interviewed on 4/22/26 at 3:19 p.m., the DON stated the facility did not have a system for antibiotic time out where anyone who was started on an antibiotic would be evaluated for appropriateness of the antibiotic, any lab cultures would be reviewed to determine if current antibiotic was appropriate and resident condition would be evaluated to determine if condition was improving. The DON had access to any labs sent in but did not access them herself for evaluation. R38's annual Minimum Data Set (MDS) dated [DATE] identified moderate cognitive impairment, required assistance with most activities of daily living (ADL's) and diagnoses included vascular dementia, hypertension, asthma and dysphagia (difficulty swallowing). R38's provider note dated 4/15/26, identified she was seen for low back pain and a wet cough for 5 days as well as difficulty urinating and urinary frequency. The provider ordered a chest x-ray and urine sample. R38's physician orders dated 4/16/26 included R38 was to start an antibiotic, Doxycycline 100 mg (milligrams) twice a day for 7 days with a new diagnosis of pneumonia. A provider note identified R38 was using a nebulizer 3 times a day and was waiting on the urine specimen results. The chest x-ray results were abnormal. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	R38's progress note dated 4/16/26 identified a urine specimen was obtained at 7:00 a.m. and sent to the lab. R38's progress note dated 4/18/26 identified R38 was not feeling well, was refusing to eat and was nauseated, vital signs and oxygen saturations were within normal limits for R38 except had a rapid pulse at 104 (normal 60-100). It was noted the antibiotic ordered on 4/16/26 had not been started yet and would be initiated. R38's provider note dated 4/22/26 identified, patient was seen today for a follow-up after being diagnosed with pneumonia and staff report she is not improving that much. Patient is lying in bed she does appear to be ill. Will add Augmentin (antibiotic) for dual therapy for her pneumonia and see if it helps patient. The urine analysis and culture (UA/UC) results were requested. R38's medical record failed to include any illness monitoring. R38's vital signs were documented for 4/8/26, 4/15/26 and 4/22/26 as routine weekly vital signs. Even though R38's symptoms of a wet cough started approximately 4/8/26, there were no lung sounds, oxygen saturations, or routine vital signs and condition monitoring in the medical record except for once on 4/18/26. During observation on 4/24/26 at 10:05 a.m., R38 was in bed in her room. There was no signage outside of room or supplies located to indicate transmission-based precautions had been initiated for respiratory symptoms. When interviewed on 4/24/26 at 9:53 a.m., licensed practical nurse (LPN)-A stated when a resident shows signs of illness, the nurses will assess the resident including vital signs and lung sounds every shift and monitor for about 3 days and keep an eye on the resident. LPN-A did not know why monitoring had not been started for R38 despite her cough and start of antibiotics. When interviewed on 4/24/26 at 10:01 a.m., R38 stated she has had a cough for some time but is improving now. When interviewed on 4/24/26 at 11:30 a.m., the DON was unable to find any UA/UC results for R38 in the medical record. The DON stated residents who are showing signs of illness should have frequent vital signs, lung sounds and oxygen saturations and if stable for 3 days could go down to every shift. There was no system in place to ensure residents who exhibited signs of illness such as R38 illnesses were monitored in this way. She had hoped the nurses would implement and document this. The DON stated she would have expected a resident condition note to be put in the medical record every shift especially if staying in bed and not feeling well. Despite a wet cough for many days, R38 had not been placed on transmission-based precautions (TBP) and no testing had been ordered by the provider for influenza, RSV or COVID-19. R24's quarterly MDS dated [DATE] identified severe cognitive impairment, required assistance with most ADL's and diagnosis included dementia. R24's progress note dated 4/17/26 at 9:52 p.m. identified vital signs were stable and had received an albuterol nebulizer (used for respiratory symptoms) related to an audible wheeze and cough. Oxygen saturations were at 91% (normal 95-100%). The on-call provider was notified and orders were obtained for a chest x-ray and to administer the Albuterol nebulizer twice a day and every 4 hours as needed for cough. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	R24's progress note dated 4/18/26 at 1:14 p.m. identified a nebulizer treatment was effective for wheezing and cough. At 9:39 p.m. the chest x-ray results returned and were normal. R24's medical record between 4/18/26 and 4/24/26 failed to include illness monitoring every shift or any assessment of how she was progressing. The record included routine weekly vital signs on 4/21/26. No further lung sounds or oxygen saturations were documented. R24 had not been placed on TBP for cough. No testing for potential contagious illness had been ordered or obtained. When interviewed on 4/24/26 at 11:17 a.m. the DON stated R24 was noted to have a cough on 4/17/26. The DON reviewed R24's medical record and identified there was no illness monitoring in place related to the cough. She would have expected to see documentation of lung sounds, cough, assessment and vital signs routinely. R24 had not been placed on TBP and no testing had been ordered or conducted for potential respiratory illness outbreak. R43's quarterly MDS dated [DATE] identified moderate cognitive impairment and was independent with personal cares except bathing, diagnoses included dementia, and congestive heart failure. R43's care plan dated 3/5/26 identified shortness of breath related to emphysema and chronic obstructive pulmonary disease (COPD). R43's progress note dated 4/22/26 at 11:37 a.m. identified resident had a congested non productive cough, was afebrile and was given cough syrup. R43's progress notes dated 4/22/26 at 11:57 a.m. identified the provider was updated R43 was requesting cough syrup and new orders were obtained for Guiafed every 4 hours as needed for 3 days. R43's progress note dated 4/23/26 at 2:21 a.m. included, Resident continues to have a congested cough. Cough syrup given. Has been up and about and told writer he was feeling better. R43's progress note dated 4/24/26 at 3:10 a.m. included, Respiratory evaluation done on resident. The resident stated that he had some mucus with some blood earlier in the day and that this had occurred in the past. He reports congestion present for approximately the last 2 weeks. No shortness of breath but occasional cough present. VS were stable and had a history of mucus with smoking history and nurse practitioner saw him earlier in the week. During observation on 4/24/26 at 10:01 a.m., R43 was in his room on bed. R43 stated he had a bad cold, and had been coughing and sneezing up blood off and on. R43 was coughing during interview. R43 was not on TBP for cough. When interviewed on 4/24/26 at 11:17 a.m., the DON stated R43 was noted to start coughing on 4/22/26. The DON reviewed the medical record and identified no follow up documentation had occurred about the cough; no illness monitoring had been documented. R43 had not been placed on TBP and no testing for potential respiratory outbreak had been ordered or conducted. R43 was placed on acute change charting for 72 hours due to congestion and occasional cough today after being questioned by surveyor. R78's quarterly MDS dated [DATE] identified moderate cognitive impairment, required assistance with ADL's and diagnosis included Alzheimer's disease. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	R78's progress note dated 4/10/26 at 10:28 p.m. identified, resident complained of cold symptoms, occasional cough and hoarse voice. R78 was provided with cough syrup. There was no monitoring placed to assess R78 for continued respiratory symptoms. However, R78's temperature was taken 3 times on 4/11/26 and 4/12/26 and was afebrile. No oxygen saturations were taken in this time frame. There were no further progress notes identifying cold symptoms until seen by provider on 4/23/26, Patient was seen today by the request of staff and family as they were concerned about patient having a cough over the last couple days. Patient was seen in her room she was sitting up at edge of her bed she reports that her cough has improved significantly and she does not feel she needs any intervention at this time. There were no new orders. R78 had not been placed on TBP even though she had a cough for several days and had not been tested for potential contagious respiratory illness. On 4/23/26 at 9:51 a.m., licensed practical nurse (LPN)-D identified R78 had been coughing randomly, and staff were monitoring her status. When interviewed on 4/24/26 at 11:17 a.m., the DON stated R78 had been coughing this week and had seen provider with no new orders on 4/22/26. The DON stated staff should be monitoring for symptoms but noted no documentation had been initiated. R78 had not been placed on TBP and had not been tested for potential respiratory outbreak. R28's annual MDS dated [DATE] identified significant cognitive impairment, required assistance with most ADL's and diagnoses included Alzheimer's disease and congestive heart failure. During observation on 4/24/26 at 10:08 a.m. R28 was heard coughing. When interviewed R28 stated he had been coughing for quite a while, I cough up some stuff. The cough was noted to be loose and productive and used tissue to capture the mucous brought up with the cough. R28's progress note dated 4/24/26 at 3:41 p.m., identified R28 had stated he had been coughing for 2 days with light mucus. R28 had not shortness of breath, lung sounds were clear and vital signs stable. R28 had not been placed on TBP and no testing for potential contagious illness had been ordered or completed. When interviewed on 4/24/26 at 11:17 a.m., the DON stated R28 has a frequent cough with medical diagnosis of such and unsure if would be anything contagious. R28 had not been placed on TBP and no respiratory illness testing had been completed. R28 had been placed on acute illness charting for 72 hours. During observation on 4/24/26 at 10:01 a.m. it was noted the 5 residents were observed with a cough (R24, R28, R38, R43, and R78), three of the five residents resided in the same hall, with two being next to one another, and the third being a few doors down on the opposite side of the hall. The DON provided infection surveillance logs on 4/23/26 at 5:22 p.m. The DON identified the logs are created off of an antibiotics prescribed list, residents and infections were not added to logs as the illnesses occurred, but rather at the end of each month. The logs also did not account for residents who may show signs of infection such as diarrhea or cough that did not require an antibiotic. When reviewed the logs failed to identify start date of symptoms, any testing performed, or dates of resolution of symptoms. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The facility policy, Infection Prevention and Control Policy (IPCP) and Procedure, dated 2019, last reviewed 1/25, identified the IPCP to include the system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility. The intent of the IPCP was to establish facility wide systems for the prevention, identification, investigation, and control of infections with an ongoing system of surveillance to identify possible communicable diseases or infections before they can spread to other people. The role of surveillance was to include process and outcome surveillance, to include monitoring, data analysis, documentation, and reporting as required. Activities were to be conducted to identify practice, infection trends, and early identification of new infections and potential outbreak situations. The policy also identified standard and transmission-based policies were to be developed and precautions were to be followed to prevent the spread of infections, to include the selection of the precaution indicated, as well as to include the level of personal protective equipment (PPE) to be used. The policy further identified the type and duration of the isolation would be determined dependent on the infectious agent or organism involved. Although the policy identified transmission-based precautions, and isolation, the policy lacked identification, or definition of enhanced barrier precautions. The policy also identified an antibiotic stewardship program, which included protocols and a system to monitor antibiotic use, was to be included within the IPCP and procedure. The policy also identified the process was to include documentation of incidents identified under the facility's IPCP and the corrective action taken by the facility. R16's admission MDS dated [DATE] identified cognitively intact, was independent with ADL's, and diagnoses including on dialysis for end stage kidney disease and hyperparathyroidism (overactive parathyroid glands causing abnormal calcium and phosphorus levels) and long term anticoagulation use. R16's care plan dated 4/8/26 identified R16 required offsite hemodialysis on Tuesdays, Thursdays, and Saturdays related to ESRD and included interventions related to the AV fistula for staff to assess the site every day and as needed for signs of infection, tenderness, drainage, bruit and thrill. R16's medical record identified they also had a central venous catheter (CVC) which is a large bore tube placed into a large vein int he chest for urgent dialysis access. Typically, this is used only for a short period of time when the AV fistula is not accessible. This type of catheter/vascular access is at a very high risk of catheter related blood stream infections. 16's care plan did not identify this access site and did not direct any special infection control techniques. Guidance from the Centers for Disease Control and Prevention (CDC) identified residents with dialysis access devices were at increased risk for transmission of multidrug-resistant organisms (MDROs) and required Enhanced Barrier Precautions (EBP). During observation on 4/21/26 at 11:28 a.m. R16's room lacked any personal protective equipment (PPE) that would be used for EBP. When interviewed on 4/22/26, nursing assistant (NA)-A stated R16 was not on EBP. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	When interviewed on 4/23/26 at 10:08 a.m., licensed practical nurse (LPN)-C stated if residents are on EBP they put a sign on their door and place PPE outside the room. R16 was not on EBP. When interviewed on 4/23/6 at 2:55 p.m., registered nurse (RN)-A stated R16 was not on EBP. When interviewed on 4/23/26 at 3:35 p.m. the assistant director of nursing (ADON) stated residents with indwelling catheters required EBP and confirmed R16 was not on EBP, but should have been. When interviewed on 4/23/26 at 4:01 p.m. the DON stated residents with vascular access devices should be on EBP and verified R16 was not and should have been. R29's admission MDS dated [DATE] included severe cognitive impairment, was dependent upon staff for ADL's and had diagnoses including Alzheimer's disease and a sacral pressure ulcer stage 4 (down to bone). During observations on 4/20/26, 4/21/26, 4/22/26, 4/23/26 and 4/24/26, there was no signage outside of room, nor was there any PPE available for staff outside or inside R29's room. When interviewed on 4/22/26 at 8:39 a.m., LPN-A stated she had performed pressure ulcer care for R29 at 7:00 a.m. LPN-A stated R29 is not on any type of precautions. During observation on 4/23/26 at 9:17 a.m., the ADON entered R29's room for a dressing change. The ADON did not put on a gown, they washed their hands, put on gloves, removed the dressing over the pressure ulcer, doffed gloves and used hand sanitizer. The ADON replaced gloves and finished the dressing change. When interviewed on 4/23/26 at 9:36 a.m., the ADON stated R29 did not need to be on any type of precautions and just glove use during dressing change was adequate. Since the resident had been in the facility less than 90 days, the wound was not considered a chronic wound. Facility policy entitled: Enhanced Barrier Precautions (copyright 2025 The Compliance Store, LLC.) Initiation of Enhanced Barrier Precautions: a. Enhanced barrier precautions will be implemented for residents requiring EBP per CMS regulatory guidelines, including but not limited to residents with wounds, such as pressure ulcers, diabetic foot ulcers, unhealed surgical wounds, and venous stasis ulcers, and/or indwelling medical devices (e.g., central live, urinary catheters, feeding tubes, tracheostomy/ventilator tubes, hemodialysis catheters. PICC lines, midline catheters) and access ports. 4. Enhanced barrier precautions should be used for the duration of the affected residents' stay in the facility or until resolution of the wound or discontinuation of the indwelling medical device that placed them at higher risk. The Center for Disease Control's (CDC) Viral Respiratory Pathogens Toolkit for Nursing Homes dated 3/30/26, indicated when an infection is due to a respiratory virus, it is important to take rapid action to prevent the spread to others in the facility. Appropriate transmission-based precautions should be initiated for symptomatic residents based upon the suspected cause of infection. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The CDC's Transmission Based Precautions dated 4/3/24, indicated droplet precautions should be used for patients known or suspected of being infected with pathogens transmitted by respiratory droplets that are generated by a patient who is coughing, sneezing, or talking. Droplet precautions include hand hygiene, face mask covering the nose and mouth, and eye protection. Additionally, the Frequently Asked Questions (FAQ's) about EBP, dated 6/28/24, identified EBP as an infection control measure designed to decrease transmission of multi-drug-resistant organisms (MDROs) in nursing homes. EBP involved gown and glove use during high-contact resident care activities for residents known to be colonized, or infected, with a MDRO, as well as those who were at increased risk of MDRO acquisition (e.g. residents with wounds or indwelling medical devices). On 4/27/26 at 11:00 a.m. it was verified via observation, interview and document review the facility had implemented their removal plan by 11:00 on 4/27/26. It was verified all residents had been screened for respiratory illness, all affected residents were assessed for illness symptoms and no other residents showed any respiratory symptoms. The facility had audited all residents for the need for EBP and implemented EBP where needed. A policy and procedure was implemented to ensure EBP was implemented as needed, symptom surveillance to be completed in real time with appropriate TBP as needed, a system was set up for follow up on lab results and antibiotic timeouts. A tracker was started for all labs, and antibiotic stewardship. A new daily clinical tool for monitoring residents with signs of illness and on antibiotics was started and a system to implement monitoring on the MAR/TAR was started. Staff were all trained on the new policies and procedures. These were verified through interviews of multiple RN's, LPN's, nurse aides and document review on 4/27/26 between 9:00 a.m. and 11:00 a.m.

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many Note: The nursing home is disputing this citation.	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. Based on interview and document review the facility failed to ensure the director of nursing (DON) worked in the facility on a full-time basis. This deficient practice had the potential to affect all 85 current residents who resided in the facility.During an interview on 4/27/26 at 2:42 p.m., staffing coordinator (SC)-A stated day shift on Monday through Friday the director of nursing (DON) was the charge nurse, although typically one of the nurses on the transitional care unit (TCU) also served as the charge nurse. During an interview on 4/27/26 at 3:05 p.m., DON stated she worked 40 hours per week and at least four of those hours each week was spent on covering the role of the infection preventionist for the facility. A review of nursing staff schedules dated 4/20/26 through 4/27/26, failed to indicate the scheduled hours for the DON. A review of the facility assessment with a review date of 6/9/25, indicated staffing pattern included one DON full-time day shift. Facility Nursing Services- Registered Nurse (RN) policy dated 2025, indicated the facility would designate an RN to serve as DON on a full-time basis, the policy further defined full-time as worked 40 or more hours a week.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Implement a program that monitors antibiotic use. Based on interview and document review, the facility failed to implement an ongoing antibiotic stewardship program for the facility which had the potential to affect all 85 residents the facility, as well as the potential to impact staff and visitors. Findings include:On 4/23/26, at10:27 a.m. the director of nursing (DON)/infection preventionist (IP) stated monthly, a report called antibiotic stewardship is pulled off the electronic medical record (EMR) which included includes all antibiotics ordered in the past month. IP stated the data compiled from that report was then placed into the surveillance log. IP stated she was not completing any investigation at that time. IP stated the results of testing is not consistently reviewed in real time. IP stated a time out should have been completed on every antibiotic was effective/working, however, stated she had not implemented an antibiotic time out program yet. IP stated she was good at consistently following up on cultures performed at the hospital, either in the emergency room (ER) or upon discharge/transfer from the hospital to the facility. IP stated she had access to the hospital EMR, however, did not do so to follow up on urine cultures. IP stated stated this was important in the event the resident had a resistant organism and they were on the wrong antibiotic, adding it was Important to treat the right bug with the right med.The facility policy, Infection Prevention and Control Policy and Procedure, reviewed 1/25, indicated an Infection Preventionist (IP) was to be designated for management of the program. The policy identified the IP was responsible for reviewing microbiology culture and sensitive reports on a regular basis to identify types, antibiotic resistant organisms, and transmission of organisms between residents. Additionally, the IP was to monitor antibiotic use to help determine if use was appropriate and assure that the appropriate personal protective equipment (PPE) was used when indicated.The facility policy identified the facility IPCP was to have an antibiotic stewardship program which included antibiotic use protocols and a system to monitor antibiotic use.An additional facility policy, titled Antibiotic Stewardship Program (ASP), revised 2/25, identified it was the policy of the facility to maintain an ASP with the mission of promoting the appropriate use of antibiotics to treat infections and reduce possible adverse reactions associated with antibiotic use.

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F 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home. Based on interview and document review, the facility failed to ensure the criteria for Infection Preventionist was met with current certification and ongoing education, which had the potential to affect all 85 residents, visitors and staff. Findings include:On 4/23/26, at 10:20 a.m. (DON) identified she had completed the Infection Preventionist (IP) Specialized Training via an online training site, with a certificate issued 4/21/21 (date of expiration identified as 4/21/24). The online training site identified for renewal; the individual had to either test out at a score of 80% correct for a pass rate or have completed the course again to obtain recertification. DON stated she had a done a lot of learning, however, had not tracked it separately. A request was made for infection control training completed following the date of expiration of the certification, and this was provided.Upon review of the information for subsequent training in infection control, it was noted the sponsored online training provided included two hours in 2024, two hours in 2025, and one hour in 2026. A review of facility online training modules completed after 4/21/24, included 2.35 of training hours.During an interview on 4/27/26, at 3:05 p.m. DON stated although she worked 40 hours per week at least four of those hours each week was spent on covering the role of the infection preventionist (IP) role for the facility. The facility policy, Infection Prevention and Control Policy and Procedure, reviewed 1/25, indicated an Infection Preventionist (IP) was to be designated for management of the program. The IP requirements were as follows; primary professional training in nursing, medical terminology, microbiology, epidemiology, or another related field; was qualified by education, training, experience, or certification; and worked part-time at the facility; had completed specialized training in an infection prevention and control; and be a member of the quality assessment and assurance committee and report to the committee on a regular basis. Additionally, the policy outlined that the IP was responsible for maintaining current knowledge in the field of infectious disease and epidemiology. The policy outlined the following ways in which the knowledge would be maintained: attend education programs provided by infection control organizations; collaboration with other infection control professionals; be well-informed on current practices, including infection control and epidemiology; had actively seek out learning opportunities to promote professional growth; accessed best practices for infection prevention and control; and maintained ongoing access to current federal, state, and local regulations on infection control requirements. The policy outlined the IP was responsible for having identified and communicated information about residents with potentially transmissible infectious agents and instructed staff on how they were to care for residents on contact precautions. Additionally, the policy identified the IP was responsible for reviewing microbiology culture and sensitive reports on a regular basis to identify types, antibiotic resistant organisms, and transmission of organisms between residents. Additionally, the IP was to monitor antibiotic use to help determine if use was appropriate and assure that the appropriate personal protective equipment (PPE) was used when indicated.

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F 0572 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Give residents a notice of rights, rules, services and charges. Based on observation and interview, the facility failed to ensure the most up to date Nursing Home Resident [NAME] of Rights (RBOR) was provided to each resident residing in the facility and displayed for residents, visitors and staff to review. This had the potential to affect 63 of 85 residents currently residing in the facility as well as all staff and visitors.Findings include:On 4/20/26 at 5:08 p.m., displayed by the transitional care unit (TCU) entrance was the RBOR, revised 2016. Displayed outside of dining room in long term care was RBOR, revised 2016. During observation on 4/21/26 at 11:27 a.m., on wall by long term care entrance was a hanging bin with folder that contained paper copies of the RBOR dated February 2016. On 4/21/26 at 1:48 p.m., reviewed facility admission packet, packet contained new RBOR dated 1/1/26. When interviewed on 4/21/26 at 4:59 p.m., social services (SS)-A stated they hadn't ordered a new RBOR poster in a long time. SS-A stated new pamphlets for the admission packets were ordered in January and March. Anyone who had admitted after then would have gotten the new RBOR in the packet. However, residents that were admitted prior to the purchase in January had not been informed there was an update to the RBOR. When interviewed on 4/21/26 at 5:26 p.m., administrator stated they were not aware there were changes to the RBOR. Administrator located an email received in January from Care Providers (non-profit association representing health care facilities) that identified there was an update to the RBOR. Administrator stated the update may have been missed due to transition to new ownership. Facility Resident [NAME] of Rights policy dated 10/22, indicated the facility would provide the residents with prompt notice of any changes in any State of Federal laws related to resident rights or facility rules during the residents stay in the facility.

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 record review and interview, the facility failed to ensure residents were free from unnecessary psychotropic medications, including failure to ensure PRN psychotropic medications had appropriate stop dates, failure to attempt and document gradual dose reductions (GDRs), failure to obtain and monitor laboratory testing as indicated, and failure to monitor for adverse consequences, for 4 of 8 residents (R11, R23, R27, and R29) reviewed for unnecessary medications.Findings include: R27R27's significant change MDS dated [DATE], identified R27 had intact cognition and required assistance with ADL's. R27's diagnoses included depression (persistent sadness or loss of interest) and schizophrenia (a chronic mental disorder affecting thinking, perception, and behavior). The MDS also identified R27 was prescribed psychotropic medications. R27's physician's order summary, with a print date of 2/23/26, indicated R27 had an order for lorazepam (used to treat anxiety disorders) 0.5 mg, to be administered by mouth every 6 hours as needed (PRN) for anxiety, initiated on 02/23/2026. Further review of the EMR lacked evidence the PRN lorazepam order included a 14-day stop date or that the order was discontinued, renewed, or clinically re-evaluated after 14 days. R27's Psychoactive Medication Review assessment, completed on 3/22/26, indicated R27 was currently receiving a psychoactive medication. The assessment question, Has a gradual dose reduction (GDR) been attempted in the past quarter? was marked N/A. The assessment indicated a medication reduction was contraindicated, noting the resident was on an optimal dose and clinically stable, with a referenced medical provider note dated 2/23/26. Further review of the electronic medical record (EMR) lacked evidence of documentation to support a GDR discussion or clinical rationale on 2/23/26. During interview on 4/23/2026 at 10:08 a.m., licensed practical nurse (LPN)-C stated R27 frequently requested lorazepam for shortness of breath (SOB) and confirmed the medication did not have an end date. The LPN further stated orthostatic blood pressures were only obtained if they appeared on the Treatment Administration Record (TAR) and confirmed there was no order for orthostatic blood pressure monitoring for R9. During interview on 4/27/26 at 1:17 p.m., LPN-G confirmed R27's PRN lorazepam order did not include an end date. During interview on 4/27/26 at 12:53 p.m., consultant pharmacist (CP) stated PRN psychotropic medications should have a 14-day duration with a provider order, including documentation to support continued use beyond that timeframe. The CP stated gradual dose reductions (GDRs) should be completed in accordance with regulations, including attempts twice in the first year and annually thereafter, unless clinically contraindicated and documented by the provider. The CP further stated orthostatic blood pressures should be obtained to monitor for potential adverse effects of medications, particularly psychotropic medications. During interview on 4/27/26 at 1:48 p.m., the director of nursing (DON) and consultant nurse (C-RN) stated residents receiving psychotropic medications should be monitored for behaviors, side effects, (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	effectiveness, and adverse effects. The DON and C-RN stated orthostatic blood pressures should be obtained for residents receiving antipsychotic medications to monitor for potential adverse effects. The DON and C-RN further stated gradual dose reductions (GDRs) should be completed and reviewed to ensure psychotropic medications are not unnecessary. They acknowledged there was no documented evidence GDRs had been completed for R27. The DON and C-RN also stated PRN psychotropic medications should have a 14-day stop date unless there is documented clinical justification for extended use, including ongoing provider monitoring and documentation supporting continued need. The DON and C-RN confirmed R27's PRN lorazepam order did not include a stop date. The facility's Psychotropic Medications policy (revised 4/24, 7/25) indicated psychotropic medications should only be used when necessary to treat a specific condition and must be supported by an appropriate diagnosis. The policy required identification and ongoing monitoring of target behaviors, including documentation of behaviors, non-pharmacological interventions, side effects, and effectiveness of the medication. Psychotropic medication use was to be reflected in the care plan and routinely reviewed to ensure the lowest effective dose. Additional monitoring included assessments for movement disorders and monthly orthostatic blood pressures, when applicable. The policy further required PRN psychotropic medications to have a 14-day stop date unless renewed by the provider with documented clinical rationale for continued use. All psychotropic medication use required provider orders specifying indications and documented informed consent. In review of R29's electronic medical admission Record print date 4/24/26 ,were the following diagnoses: Alzheimer's disease with late onset, general anxiety disorder, dementia in other disease classified elsewhere, moderate without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety, personal history of malignant neoplasm of the breast (a disease where cells in the breast grow out of control, forming a tumor that can invade surrounding tissues or spread (metastasize) to other body parts), and encounter with palliative care. R29's admission comprehensive Minimum Data Set (MDS) dated [DATE], documented R29 was dependent on staff for all activities of daily living, was able to feed self after set up and was severely cognitively impaired. A review of R29's physician's orders (print date of 4/24/26) documented the following psychotropic medications: Haloperidol Oral Tablet 0.5 milligrams (mg) - give 0.5 mg by mouth three times a day for agitation / delirium / nausea related to dementia in other diseases classified elsewhere, moderate, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety. Haloperidol Oral Tablet 0.5 mg - give 0.5 mg by mouth every 1 hour as needed for agitation related to dementia in other diseases classified elsewhere, moderate, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety. Lorazepam Oral Concentrate 2 mg / milliliters (ml), give 0.25 ml by mouth every 6 hours as needed for agitation. In review of R29's recent PARK - Psychoactive Medication Review (dated 3/5/26) indicated only that R29 was receiving lorazepam 0.5 mg [every] 6 [hours] [as needed] for agitation. The assessment did not document the regularly scheduled haloperidol three times a day, nor the as needed haloperidol dosing, which R29 was prescribed. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of R29's electronic medication administration records for March 2026 and April 2026, R29 received Lorazepam Oral Concentrate 2 mg / milliliters (ml), give 0.25 ml by mouth every 6 hours as needed for agitation on the following dates: March 26, 2026 at 12:30 a.m. March 27, 2026 at 1:44 a.m. April 2, 2026 at 7:35 p.m. April 3, 2026 at 5:19 p.m. April 12, 2026 at 11:06 p.m. April 13, 2026 at 3:52 a.m. In review of R29's electronic medical record, documented a progress not from the consulting pharmacist (PharmD), communicating with the facility which documented the following: Medication regimen reviewed. See communication to nursing regarding one nonsignificant irregularity and provider regarding one nonsignificant irregularity. A review of the communication form sent to the facility to address (dated 4/14/26), the PharmD requested the facility to follow up on the following recommendations: 1. This resident has an order for [as needed] lorazepam and [as needed] haloperidol. Just a friendly reminder the [as needed] lorazepam requires a 14day stop date per nursing home regulations. 2. To monitor her responses to these, recommend adding target behavior and side effects monitoring to the [treatment record - TAR]. During an interview on 4/24/26 at 9:23 a.m., the director of nursing (DON) stated she had not yet gone through all the PharmD recommendations from this month. DON stated the floor staff should have documented the 14 day documentation when the first dose was given and updated R29's primary physician. In a telephone interview on 4/27/26 at 12:54 p.m., the consulting pharmacist (PharmD) - stated that PRN psychotropic medications should be stopped and reviewed after 14 days of the first dose. The MD /NP needs to document rational for continued use, and a new order for the medication and instruction for a 14 stop date once it is again initially given. Per the CMS guidelines. During clarifying interview on 4/27/26 at 2:01 p.m., DON and the consulting registered nurse (C-RN) [NAME] Corporate, C-RN stated it would be the expectation of the facility when a resident's PRN (as needed) psychotropic medication is initially given, the nurse giving the dose should document a 14 day stop date. When the 14 day stop date occurs, the facility should contact the primary / nurse practitioner and have the medication and effectiveness reviewed and rationale for a continued order of the medication. C-RN further stated it would be the expectation of the facility that all pharmacy recommendations be handled within 7-10 days, while we wouldn't wait to have our medications reviewed. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R23's quarterly Minimum Data Set (MDS) dated [DATE], indicated R23 had severe cognitive impairment and was moderate to maximum assistance with activities of daily living (ADLs). The MDS also indicated R23 took an antipsychotic medication. R23's diagnoses included bipolar disorder, anxiety, major depression dementia, neurocognitive disorder with lewy bodies (a progressive, irreversible brain disorder caused by abnormal protein deposits that disrupt brain function), bradycardia, muscle weakness and osteoporosis. R23's care plan revised 2/2/26, indicated R23 used psychotropic medications Aripiprazole and Olanzapine related to behavior management, disease process bipolar disorder with delusions/hallucinations, and included an intervention to monitor/document for side effects and effectiveness. R23's physician orders printed 4/24/26, indicated R23 had orders for aripiprazole (antipsychotic medication) 10 milligrams (MG) by mouth daily for paranoid delusion/hallucinations, olanzapine (antipsychotic medication) 5 mg twice daily for bipolar disorder, and venlafaxine (used to treat depression and anxiety) 37.5 mg twice daily for bipolar disorder. R23's electronic medical record (EMR) was reviewed, located labs completed on 6/25/25 for cholesterol levels and on 9/3/24 with potassium and hemoglobin levels, however R23's EMR lacked evidence of other monitoring labs while prescribed antipsychotic medications. Consultant Pharmacist's Medication Regimen Reviews for the months of October 2024 to March 2026 were reviewed, each indicated medication was reviewed for irregularities and no significant irregularities were noted. Recommendations lacked direction to monitor labs. When interviewed on 4/27/26, at 1:54 p.m. assistant director of nursing (ADON) stated would have to look into labs for R23, ADON was unable to locate labs other than cholesterol levels, potassium and hemoglobin. When interviewed on 4/27/26, at 3:05 p.m. director of nursing (DON) stated would expect labs to monitor complete blood count (CBC) and liver function tests (LFTs) for residents that took antipsychotic medication at least yearly and if there had been a change in medications. DON reviewed R23's EMR, was unable to locate a CBC and/or LFTS. Facility Psychotropic Medications policy sated 7/25, was provided, however, policy failed to address monitoring of labs while on psychotropic medications. R11's comprehensive/annual Minimum Data Set assessment dated [DATE], identified R11 was admitted to the facility on [DATE], with diagnoses which included vascular dementia, aphasia (difficulty with speaking), hemiplegia/hemiparesis (loss of mobility on one side of the body), depression and anxiety, and personality change due to physiological condition. Although R11 was identified as having cognitive impairments, it is noted R11 was able to understand others and make self understood. R11 was identified as having received personal assistance with all aspects of cares. R11's physician orders indicated on 4/1/26, orders were received for Lorazepam (an antianxiety medication) 0.5 mg (a unit of measurement) was ordered by mouth as needed for anxiety prior to dental work. The prescription lacked an end date and extended beyond the 14-day period allowed for PRN (as needed) psychotropic (mood altering) medication. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The provider note of 4/1/26, identified R11 became anxious and resistant during dental procedures and initiated the order for Lorazepam, however, did not specify an end date for this prescription. R11's care plan, revised on 3/25/26, identified R11 had oral/dental problems related to poor nutrition and poor oral hygiene. Care plan identified further dental work was indicated and restoration was not recommended. R11 had historically refused dental exam/care and dentist recommended sedation. On 4/22/26 at 3:19 p.m., Assistant Director or Nursing (ADON) stated typically psychotropic medications had a duration of 14 days unless otherwise specified. ADON stated this one was for the dental work, so it is very time specific (only when dental work was to be provided). ADON stated with seizures and dental work, there can be a longer duration (beyond the 14 days), however, acknowledged a date for follow up review was not identified, which would have been the preferred way.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview and document review, the facility failed to ensure food inventory purchased and stored were rotated and utilized before the expiration dates. This had the potential to affect 82 out of 85 residents, and any visitors / staff who obtained meals from the facilities food services. Findings include - During full kitchen tour on 4/21/26 at 2:10 p.m., the dry storage room (the area of the kitchen where food items are stored which do not require refrigeration) of the kitchen was reviewed. On the top shelf of one of the storage racks the following items were noted: - a clear 5-gallon clear plastic food storage container which contained approximately 2 pounds of white rice. The container was covered with a loosely fitting piece of aluminum foil, with the date of 4/9 marked in green marker.- 2 1-gallon containers of salad dressing (similar to Miracle Whip) with the expiration date of March 2026- 3 1-gallon containers of prepared yellow mustard with the expiration date of November 2025 In an interview on 4/21/26 at 2:10 p.m., the kitchen manger (KM) and the clinical certified dietary manager (CDM) verified these findings. The CMS stated the rice container should have had a matching lid which would have sealed the container. The CDM further stated the gallons of salad dressing and prepared mustard should have been rotated and used before the expiration dates. CDM further stated the department had begun a marking system for a received date, which none of the none of the 5 condiment containers were marked with. KM confirmed. In a further interview on 4/21/26 at 2:27 p.m., a cook (Cook)-A stated when food items are needed from the dry storage, they do not always look at the expiration date, but they do check to see the containers are sealed and are not dented / leaking. In review of the facility policy, entitled: Date Marking for Food Safety (undated) documented the following: Policy:The facility adheres to a date marking system to ensure the safety of ready-to-eat, time/temperature control for food safety. Policy Explanation and compliance Guidelines for Staffing: 1. Refrigerated, ready-to-eat, time/temperature control for safety food (i.e.: perishable food) shall be held at a temperature of [41 degrees Fahrenheit] or less.2. Dry storage shall be marked to indicate the date in which food would expire and thus discarded prior to serving.3. The individual opening or preparing food shall be responsible for date marking the food at the time the food is opened or prepared. Prepared food shall be discarded 72 hours post opening.4. The Head Cook, or designee, shall be responsible for checking the refrigerator daily for food items that are expiring, and shall discard accordingly. References:Food and Drug Administration, U.S. Department of Health and Human Services. Food Code (2022)F. Section 3-501.17 Ready-to-Eat, Time/Temperature Control for Safety Food, Date Marking.

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to implement interventions to maintain dignity for 1 of 2 residents (R11) reviewed for dignity. Findings include: R11's comprehensive/annual Minimum Data Set assessment was completed on 2/28/26 and identified R11 was admitted to the facility on [DATE] with multiple medical diagnoses which included vascular dementia, aphasia (difficulty with speaking), hemiplegia/hemiparesis (loss of mobility on one side of the body), depression and anxiety, and personality change due to physiological condition. Although R11 was identified as having cognitive impairments, it is noted R11 was able to understand others and make self understood. R11 was identified as having received personal assistance with all aspects of cares.On 4/22/26 at 8:39 a.m., R11 was observed in his room, in bed, under covers, with lights out. R11's eyes were closed and respirations were easy. R11 resided on one side of a double room. On the unoccupied bed, nearest the door, and easily visible from the hallway was a large washable incontinence pad, and two incontinence briefs.On 4/23/2026 at 10:20 a.m., the unoccupied bed had four incontinence briefs, small, unused garbage bags, large washable incontinence pad, and shorts turned inside out at the foot of the bed, easily visible from the door.On 4/23/26 at 12:50 p.m., licensed practical nurse (LPN)-D provided care to R11. The bed was stripped and linens were placed on the opposite side of the room, nearest the door. LPN-D stated R11's bed was being repaired and that linens were on the other bed. The unoccupied bed had three incontinence briefs, small, unused garbage bags, large washable incontinence pad, and shorts turned inside out at the foot of the bed. R11 wore shorts previously on the bed. LPN-D stated R11's personal items should not be stored on the foot of the bed. R11 had lots of room to put away items. LPN-D stated this was important for R11's dignity. R11 stated he preferred his clothes not be left on the unoccupied bed. On 4/27/26 2:06 p.m., the assistant director of nursing (ADON) stated personal care items (incontinence products) were to be stored out of the site of others and not on the foot of an unoccupied bed where it could be easily visualized by others. ADON stated those supplies were generally kept in the closet for formality and to promote a nice appearance.The facility policy, Resident Rights, dated 10/22 indicated that all residents were provided with information both orally, and in writing of his rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facilities. The policy also identified all direct and indirect care staff members, including contractors and volunteers, were educated on the rights of residents and the responsibility of the facility to properly care for its residents. Although the policy identified provision of information to residents, and provision of education to staff and others, it lacked definition as to the definition of what resident rights were and how they were to be implemented.

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents were permitted to make choices regarding self-administration of medications and that physician orders and care processes reflected the residents' current abilities or choices, for 3 of 3 residents (R27, R48 and R43) reviewed for self-administration of medications. Findings include: R27's significant change Minimum Data Set (MDS), dated [DATE], identified R27 had intact cognition and required assistance with activities of daily living (ADLs). R27's diagnoses included chronic respiratory failure with hypoxia (long-term inability of the lungs to maintain adequate oxygen levels), schizophrenia (a chronic mental disorder affecting thinking, perception, and behavior), chronic obstructive pulmonary disease [COPD] (a chronic lung disease that obstructs airflow and makes breathing difficult), dysphagia (difficulty swallowing), parkinsonism (a condition causing movement symptoms similar to Parkinson's disease, such as tremors and stiffness), and dependence on supplemental oxygen (requires additional oxygen to maintain adequate breathing). The MDS also indicated R27 was receiving oxygen therapy. During observation on 04/20/2026 at 1:48 p.m., R27 was sitting in a recliner in his room with a nebulizer treatment running and the mask in place. The resident appeared to be sleeping, with his head slumped forward and the bottom of the mask positioned away from his chin. No nursing staff were present in the room at the time of observation. There was no evidence of a current self-administration of medication (SAM) assessment supporting the resident independently managing the treatment. During record review of R27's electronic medical record (EMR) on 4/22/26, the most current self-administration assessment (PARK–Self-Administration of Medication Quarterly Review – V3, dated 3/19/26) indicated the question, Does resident self-administer medication? was marked No, with the directive, If resident does not self-administer medication, DO NOT PROCEED. The remaining sections of the assessment were left blank, indicating the resident was not currently self-administering medications. Review of R27's EMR banner on his profile page, print date of 4/27/26, did not indicate R27 was approved or assessed to self-administer nebulizer treatments. Review of R27's physician orders on 4/22/26 identified an active order indicating it was okay to self-administer (SAM) nebulizer once set up by staff, every shift, dated 12/10/2025. Despite this order permitting self-administration, there was no evidence the order had been clarified, discontinued, or revised to reflect R27's current preference or competency. R48's annual MDS, dated [DATE], identified R48 had intact cognition and required assistance with ADLs. R48's diagnoses included Alzheimer's disease (a progressive brain disorder affecting memory and thinking), anxiety disorder (excessive worry or fear), depression (persistent sadness or loss of interest), and chronic obstructive pulmonary disease [COPD] (a chronic lung disease that obstructs airflow and makes breathing difficult). During observation and interview on 4/22/26 at 8:54 a.m., trained medication aide (TMA)-B sanitized (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	hands and entered R48's room with medications. An inhaler was observed on R48's bed within reach. TMA-B stated a physician order was required for medications to be left at bedside. R48 stated she used the inhaler as needed. The inhaler was identified as Levalbuterol Tartrate (a bronchodilator used to treat or prevent bronchospasm in individuals with asthma or COPD) 45 mcg (micrograms)/act (actuation). During record review of R48's EMR, the most current self-administration assessment (PARK–Self-Administration of Medication Annual Review – V3, dated 1/24/26) indicated the question, Does resident self-administer medication? was marked No, with the directive, If resident does not self-administer medication, DO NOT PROCEED. The remaining sections of the assessment were left blank, indicating the resident was not currently self-administering medications. Review of R48's EMR banner on her profile page, print date of 4/27/26, did not indicate R48 was approved or assessed to self-administer inhaler medication and/or to have it left at bedside. Review of R48's physician orders on 4/22/26 identified an active order for Levalbuterol Tartrate Inhalation Aerosol 45 mcg/act (Levalbuterol Tartrate), with instructions for 2 puffs inhaled orally every 4 hours as needed for shortness of breath (SOB) or wheezing, and indicating ok to leave at bedside, dated 04/18/2024. Despite this order permitting bedside access and potential self-administration, there was no evidence the physician order had been clarified, discontinued, or revised to reflect R48's current preference or competency. During interview on 4/22/26 at 8:52 a.m., TMA-A stated staff identified whether a resident could self-administer medications by reviewing the EMR banner, which indicated if the resident was able to do so. During interview on 4/22/26 at 9:08 a.m., TMA-B stated there were no residents in the facility who self-administered nebulizer treatments, as residents could remove the device or it may not be positioned correctly, resulting in ineffective treatment. TMA-B further stated there were no residents who self-administered medications; however, if a medication was permitted to be kept at bedside, this would be indicated in the EMR banner. During interview on 04/22/2026 at 2:09 p.m., TMA-A stated she set up nebulizer treatments and, if she believed the resident was able to tolerate it, she left the room while the treatment was in progress. During interview on 4/23/26 at 10:03 a.m., licensed practical nurse (LPN)-A stated staff completed a self-administration assessment to determine if a resident was able to self-administer medications and, if appropriate, the physician was contacted to obtain an order. LPN-A stated residents were reassessed at least quarterly as part of the MDS assessment process. During interview on 4/23/26 at 10:08 a.m., LPN-C stated residents were assessed to ensure they were able to safely self-administer medications. LPN-C stated staff set up R27's nebulizer treatment, initiated the treatment, set a timer, and returned to turn it off, and did not remain with the resident during the treatment. During interview on 4/27/26 at 1:48 p.m., director of nursing (DON) and consultant nurse (C-RN) stated the process for self-administration of medications required a physician order and a nursing assessment to determine if the resident wished to and was able to safely self-administer (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	medications. They stated the assessment was completed at least quarterly and should identify the specific medications approved for self-administration. They further stated the resident must demonstrate understanding and the ability to safely administer medications. The DON confirmed R27's and R48's most recent self-administration assessments were not accurate. The facility's Self-Administration of Drugs policy, dated 2/22, stated residents had the right to self-administer medications, and the facility was responsible for ensuring it was safe to do so. The policy required residents to be assessed on admission, quarterly, annually, with significant changes, and as needed to determine their desire and ability to self-administer. If a resident chose to self-administer, a safety assessment was to be completed, a medication-specific physician order obtained, and the self-administration plan was to be included in the resident's care plan. Findings include - On 4/22/2026 at 8:39 a.m., licensed practical nurse (LPN)-A, was talking with R43. R43 came to the medication cart requesting cough syrup, while resident was complaining of a productive cough, showing LPN-A his tissue full of phlegm. LPN-A reviewed his orders in the electronic medication administration record (eMAR) and provided R43 cough syrup them took his temperature. LPN-A asked R43 if he would (Albuterol Sulfate HFA Inhalation Aerosol Solution 108 90 micrograms actual per puff). R43 stated you don't have it here, I have it in my room. LPNA- responded, are you sure? You can't have it in your room unless they Oked it. LPN-A again reviewed R43's eMAR and the stated, it looks like you can have it at bedside. R43 then headed back to his room. R43's electronic medical record's admission Record documented the following diagnoses: senile degeneration of the brain, low back pain, chronic pain syndrome, chronic obstructive pulmonary disease (COPD - a progressive, treatable, but incurable lung disease, primarily caused by smoking, that makes breathing difficult), centrilobular emphysema (the most common form of smoking-related COPD) and Alzheimer's disease late onset. R43's most recent quarterly minimum data set (MDS), dated [DATE], documented R43 was independent with most activities of daily living and was moderately cognitively impaired. During an observation and interview with R43 on 4/22/26 at 10:07 a.m., R43 stated he was feeling better after the cough syrup from LPN-A and taking the inhaler when he returned to his room. When asked what type of inhaler R43 kept at bedside, resident pulled open his bedside stand drawer. Inside the drawer, R43 had the following medication: Albuterol Sulfate HFA Inhalation Aerosol Solution 108 [90 micrograms actual per puff] 2 puff inhale orally every 4 hours as needed for [shortness of breath]. Bengay Ultra Strength External Cream 4-10-30% (Camphor-Menthol-Methyl Salicylate) apply to shoulder, back , neck topically two times a day for low back pain Cortisone 10 Anti-itch Cream In review of R43's electronic medical record, most current self administration assessment (PARK-Self-Administration of Medication Quarterly Review - V 3, dated 2/22/26), the first questions: (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Does resident Self Administer medication?, it was marked 'No, followed by the direction If resident does not Self-Administer medication, DO NOT PROCEED. The remaining sections of the assessment were unanswered. In review of R43's previous PARK-Self-Administration of Medication Quarterly Review - V 3 (dated 11/23/25), had indicated resident was able to self administer all three medications observed in R43's bedside stand. In further review of R43's electronic medical record, during the assessment period of resident's PARK-BIMS (Brief Interview for Mental Status 3.0 V1 (dated 11/26/25), R43's BIMS score was 13 - Cognitively Intact. The most current PARK-BIMS (Brief Interview for Mental Status 3.0 V1 (dated 2/22/26), Resident's BIMS score was assessed at 8 - Moderately Cognitively Impaired. A review of R43's eMAR (print dated 4/24/26) documented R43's Albuterol Sulfate HFA and Bengay Ultra Strength External Cream were documented R43 was able to keep the two medications at bedside. However, R43's Cortisone 10 Anti-itch Cream was not listed on resident's eMAR. In review of R43's physician's orders (print date of 4/24/26), the medication orders for the medications R43 kept in his bedside stand were documented as follows: 1. Albuterol Sulfate HFA Inhalation Aerosol Solution 108 [90 micrograms actual per puff] 2 puff inhale orally every 4 hours as needed for [shortness of breath] replated to Chronic Obstructive Pulmonary Disease, unspecified (J44.9) May keep at Bedside 2. Bengay Ultra Strength External Cream 4-10-30% (Camphor-Menthol-Methyl Salicylate) apply to shoulder, back , neck topically two times a day related to Low Back Pain, unspecified (M54.50) unspervised self-administration Ok to have at bedside and to self [administer]. 3. Cortisone 10 Anti-itch Cream - okay to have at bedside and the resident self administer as needed for itching twice daily as needed. During interview on 4/22/26 at 2:40 p.m., the director or nursing (DON) stated, even with the last quarterly self administration assessment from 2/22/26, indicated R43 didn't self administer medications, the 11/23/25, was still valid while R43 had physician's orders he could. DON stated the facility staff knew R43 well enough, and knew if they were to remove the medications from his room, R43 would ask for them back. During a clarifying interview on 4/27/26 at 2:01 p.m., with the DON and consulting registered nurse (CRN), CRN stated the facility last self administration assessment was the most current, therefore, invalidating the assessment from 11/23/25. CRN further, with s significant change in R43's BIMS scoring between 11/23/25 score of 13 (cognitively intact) and the most recent BIMS, assessed 2/22/26 of 8 (moderately cognitively impaired). R43 should have been reassessed for self administration of medications.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure required information was provided to the resident or resident representative regarding bed-hold rights at the time of transfer to the hospital, including failure to discuss and document bed-hold options for a private pay resident, for 1 of 2 residents (R27) reviewed for transfer and discharge.Findings include:R27's significant change Minimum Data Set (MDS) dated [DATE], identified R27 had intact cognition and required assistance with activities of daily living (ADL)'s. R27's diagnoses included chronic respiratory failure with hypoxia (long-term inability of the lungs to maintain adequate oxygen levels in the blood) and COPD (chronic obstructive pulmonary disease; a lung disease that makes it hard to breathe). The MDS also indicated R27 received oxygen therapy. R27 was identified as private pay.During review of electronic medical record (EMR), it was identified: R27 was transferred to the ED on 12/15/25 for wheezing, chest tightness, and shortness of breath and was subsequently hospitalized . R27 returned to the facility on [DATE]. R27 was transferred to the ED on 1/1/26 for two days of increasing cough, shortness of breath, and dyspnea on exertion (abnormal, uncomfortable breathlessness during physical activity that improves with rest, often indicating underlying heart or lung dysfunction) and was subsequently hospitalized . R27 returned to the facility on 1/6/26. R27 was transferred to the ED on 2/9/26 for acute on chronic hypoxic respiratory failure (a sudden worsening of long-term low blood oxygen levels) and was subsequently hospitalized . R27 returned to the facility on 2/23/26.R27's EMR lacked documented evidence the facility provided written notification or verbal explanation of bed-hold rights at the time of transfer, and there was no evidence the option to hold the bed was discussed with R27 or the resident representative.Review of R27's clinical record, including transfer documentation and progress notes, lacked evidence the facility informed R27 of the right to reserve the bed during hospitalization, including applicable costs associated with bed hold for a private pay resident.During interview on 4/22/26 at 3:25 p.m., social worker (SW)-A and SW-B stated bed hold discussions were expected to be documented in the progress notes. SW-A and SW-B indicated they were unable to locate documentation of a bed hold discussion for R27 and stated a previous social services designee may not have documented the conversation. SW-A and SW-B further stated they were unable to locate documentation of a bed hold discussion for all three hospitalizations. SW-A stated she initially thought R27 was on MA; however, upon review, confirmed the record identified R27 as private pay. SW-A referred to a completed MA application and stated it had been completed on 2/20/26. SW-A and SW-B stated the facility provided the bed hold policy upon admission and indicated it was important for residents to understand potential financial responsibility for holding a bed, particularly if the resident was private pay.The facility's Bed Hold Notice Upon Transfer policy revised 7/25, indicated the facility would provide written notice to the resident and/or resident representative at the time of transfer (or within 24 hours for emergency transfers) that included the duration of the bed-hold period, any reserve bed payment requirements, and the resident's right to return to the next available bed, as well as conditions for return to the facility.

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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 observation, interview, and record review, the facility failed to develop and implement comprehensive, person-centered care plans to include Enhanced Barrier Precautions (EBP) for residents who met criteria for 2 of 4 residents (R2, R9) reviewed for infection control and care planning.Findings include:R2's quarterly Minimum Data Set (MDS) dated [DATE], identified R2 had severe cognitive impairment and required assistance with activities of daily living (ADL)'s. R2's diagnoses included pressure ulcer of right ankle, stage 4 (a severe wound with full-thickness tissue loss exposing muscle, bone, or supporting structures), malnutrition (lack of proper nutrition due to inadequate intake or absorption), and dysphagia (difficulty swallowing).Review of R2's electronic medical record (EMR) identified the presence of a stage 4 pressure ulcer, which met criteria for EBP per current infection control guidance.R2's Order Summary Report printed 4/23/26, did not contain a physician order for EBP.R2's care plan printed 4/27/26, identified a pressure ulcer to the right ankle, stage IV (a severe wound with full-thickness tissue loss exposing muscle, bone, or supporting structures), with initial interventions initiated on 03/12/2026. The care plan included general pressure ulcer management interventions such as monitoring skin condition, evaluating ulcer characteristics, maintaining skin integrity, monitoring nutritional status, and providing wound care per treatment orders. Review of the care plan identified EBP related to the wound was not initiated until 04/23/2026. These dates indicated a delay of over one month from the identification of the stage IV pressure ulcer on 03/12/2026 to the implementation of critical infection prevention interventions, resulting in a care plan that was not comprehensive and failed to reflect timely, person-centered interventions to address the resident's risk for infection transmission.During observation on 4/20/26 at 11:42 a.m., no signage was posted outside of R2's room to indicate EBP, and EBP precautions were not in place. A PPE cart was located in the hallway between two residents' rooms, without clear designation for use specific to R2.R9's quarterly MDS dated [DATE], identified R9 had moderate cognition and required assistance with ADL's. R9's diagnoses included urinary retention (inability to completely empty the bladder) and benign prostatic hyperplasia with lower urinary tract symptoms (enlarged prostate causing urinary symptoms such as difficulty urinating). The MDS also indicated R9 had a suprapubic catheter (a catheter surgically inserted through the abdomen into the bladder to drain urine).Review of R9's EMR identified the presence of a suprapubic catheter, which met criteria for EBP per current infection control guidance.R9's Order Summary Report printed 4/23/26, did not contain a physician order for EBP.Care plan identified R9 had a suprapubic catheter related to diagnoses including atonic bladder (loss of bladder muscle function), benign prostatic hyperplasia [BPH], and urinary retention (inability to empty the bladder), with interventions initiated on 12/03/2025. The care plan included interventions to monitor intake and output, assess for pain and discomfort, monitor for signs and symptoms of urinary tract infection (UTI), and ensure proper positioning of the catheter bag below the level of the bladder. Review of the care plan identified the intervention for EBP related to the suprapubic catheter was not initiated until 04/23/2026, with revision on 04/24/2026. These dates indicated a delay of over four months from the initiation of the suprapubic catheter care plan on 12/03/2025 to the implementation of EBP, despite the presence of an indwelling catheter which met criteria for EBP.During interview on 4/22/26 at 2:23 p.m., nursing assistant (NA)-A stated staff would know a resident was on precautions by a sign posted outside the resident's room and the presence of a cart containing gowns and gloves.During interview on 04/23/2026 at 10:08 a.m., licensed practical nurse (LPN)-C stated a resident on precautions would have a bin outside the door containing PPE, and signage would be posted to alert staff the resident was on precautions. LPN-C confirmed R2 was not on EBP prior to the morning of 04/23/2026 and stated R9 was on precautions; however, EBP was not included in the care plan and there was no corresponding physician order.During interview on 4/23/26 (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	at 3:35 p.m., assistant director of nursing (ADON) stated staff would know a resident was on precautions by the presence of a PPE cart outside the room and signage posted on the door. The ADON acknowledged precautions should be included in the care plan and that a physician order should be obtained and reflected in the medical record to ensure all staff were aware.During interview on 4/23/26 at 4:01 p.m., director of nursing (DON) stated EBP would be indicated by signage posted outside the resident's door and the presence of a PPE bin. The DON confirmed there was no physician order for EBP but acknowledged EBP should be included in the care plan and that the care plan should reflect the resident's care needs and guide staff in the provision of care.The facility policy titled Care Plan Policy and Procedure (revised 2/25, 7/25) indicated the facility was responsible to develop a baseline care plan within 48 hours of admission and a comprehensive, individualized care plan by day 21. The policy required care plans to include specific problems, goals, and interventions, and to be updated to reflect changes in the resident's condition. The policy further indicated care plans should be reviewed regularly, including significant changes, and should guide the care provided to the resident.

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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 observation, interview and document review, the facility failed to maintain an updated care plan for 1 of 2 residents (R11) reviewed for range of motion. Findings include: R11's comprehensive/annual Minimum Data Set assessment dated [DATE], identified R11 was admitted to the facility on [DATE], with diagnoses which included vascular dementia, aphasia (difficulty with speaking), hemiplegia/hemiparesis (loss of mobility on one side of the body), depression and anxiety, and personality change due to physiological condition. Although R11 was identified as having cognitive impairments, it is noted R11 was able to understand others and make self-understood. R11 was identified as having received personal assistance with all aspects of cares.R11's care plan, last revised on 6/5/25, identified R11 had an alteration in neurological status related to a stroke and history of temporal lobectomy (procedure that removes the front part of the temporal lobe of the brain to treat drug-resistant epilepsy) for seizures. R11's care plan identified the goal was for R11 to function at the fullest potential possible as outlined by the interdisciplinary team through the review date which was last revised on 2/28/26. The care plan interventions included provision of range of motion (ROM) /PROM (passive range of motion-exercises to maintain movement with either active or passive participation or actively in which the resident does not assist with) with am/pm (morning and afternoon/evening) care(s) daily to be completed by nursing/CNA (certified nursing assistant). The care plan lacked identification of the use of any splint to right hand.The resident care assignment sheet, dated 4/21/26, lacked directions to staff to provide assistance with range of motion, either active or passive, and lacked indication of a splint to right hand. The resident task tab lacked directions to the nursing assistants to perform range of motion exercises with am/pm cares. The resident task tab on the electronic medication record (EMR) identified Restorative Nursing Range of Motion, with directions to staff to indicate the number of minutes performed.On 4/21/26 at 2:41 p.m. R11 was observed in his room, resting on the bed with a splint noted on his right hand. R11 replied No when asked if staff provided assistance with exercises to his right side when performing his morning and evening cares. On 4/22/26 at 10:06 a.m. the restorative nursing aide (RNA)-A stated she assisted R11 with PROM three to five times a week.On 4/22/26 at 3:00 p.m., nursing assistant (NA)-H stated she was unaware of any directions for staff to complete twice daily ROM with cares, and indicated it was not on the care list, or task section for documentation. On 4/22/26 at 3:19 p.m. the assistant director of nursing (ADON) stated at one time, R11 had directions on the nursing assistant care list for ROM twice daily (14 times/week), however, that has now been changed to Restorative Nursing. ADON was unsure when that changed and would follow up on this.On 4/23/26 at 4:30 p.m. ADON provided the following documentation: A document, titled Restorative Nursing Program, dated 2/19/25 identified R11 was to receive right upper extremity PROM daily from shoulder to digits and was to have right palm protector on during AM and off with PM cares. Additionally, R11 was to receive lower extremities (plural) knee to chest, hip ABD (abduction)/ADD (adduction), and ankles. This would be a frequency of seven times a week, versus the previously identified frequency of 14 times a week. The document, Restorative Nursing Plan, with notes dated 4/15/25, 7/21/25, 10/27/25 directed staff to continue with PROM to maintain current ROM for activities of ADL's (activities of daily living-dressing, grooming, bathing).On 4/27/26 1:57 p.m. ADON stated he was unsure why the frequency of ROM decreased from twice daily to three to five times a week. ADON acknowledged the care plan identified twice daily ROM and did not reflect R11 received Restorative Nursing three to five times a week. ADON acknowledged the care plan should reflect the care provided to the resident.The facility policy, Care Plan Policy and Procedure, revised 2/25, identified the care plan was to ensure the resident has the appropriate care required to maintain or attain the resident's highest level of practicable function. The policy identified changes in the resident status would be identified in the care plan.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to provide assistance with personal cares, for 2 of 2 residents (R23 and R98) reviewed for assistance with activities of daily living (ADLs-including placement of hearing aids, set up for eating, and personal grooming including shaving) for dependent residents. Findings include: R98's Nursing Assessment/Initial Care Plan, initiated on 4/8/26, indicated R98 was admitted with encephalopathy (any disorder or disease that affects brain function. It can lead to altered mental status, memory loss, personality changes, and in severe cases, coma) and was alert and oriented times one to two (person and/or person and place), demonstrated forgetfulness, and was unable to use call light to summon staff. The nursing assessment/initial care plan identified R98 required assistance with mobility, transfers, personal dressing, grooming, and bathing. R98's care plan, initiated on 4/14/26, identified R98's additional medical diagnoses included: depression, anxiety, corary artery disease (narrowing of the coronary arteries), hypertension (high blood pressure), dementia (altered thought processes) and abnormality of gait (walking). The Nursing Assistant Care List, dated 4/22/26, identified R98 required assistance of one with grooming, which included own teeth, and glasses. The grooming column did not specify shaving, or preference for facial hair. The care list also identified R98 received total assistance of one to complete dressing and received assistance of one with mobility. On 4/20/26 at 12:37 p.m. R98 was observed to have 1/4 to 1/3 inch of facial hair present under his nose, cheeks, chin, and under chin. R98's family member (FM)-A stated she had brought a shaver to the facility, informed staff she had brought in the shaver, and requested routine shaving be completed, however, stated staff has not shaved R98 since his admission [DATE]). On 4/21/26 at 11:38 a.m. R98 was observed seated in room with FM-A and remains unshaved. On 4/22/26 at 9:00 a.m. licensed practical nurse (LPN)-J reviewed the resident care list which was noted to be on the nurse's station on the desk. Staff were directed to provide assistance of one for R98 with dressing and to use a gait belt with two assist. The assignment sheet identified staff were to assist R98 with personal grooming and identified R98 has his own teeth and glasses. The sheet lacked direction as to facial hair preference and directions for shaving. LPN-J stated R98 always had a bit of a rough appearance with facial hair unshaved, and she was unaware he wished to be shaved. LPN-J stated residents were only shaved upon request. LPN-J stated residents who resided in long term care unit were interviewed as to facial hair preference, and expressed desire for shaving, however, this was not completed on the transitional care unit (TCU) unit. LPN-J stated the information regarding cares to be provided was entered on the nursing assistant care sheets by the director of administrative services (DAS). On 4/22/26 at 9:10 a.m. nursing assistant (NA)-N stated she had not provided morning assistance on that day, however, had assisted on previous occasions. NA-M stated she had helped with personal grooming, however, not shaved recently, as FM-A was going to bring in an alternate shaver as initial shaver pinched R98's face. NA-N was unaware a new shaver had been brought in, however, did find one when drawer was checked. NA-A acknowledged R98 needed a shave. On 4/22/26 at 10:25 a.m., NA-M stated she was unaware of any concerns regarding R98's appearance (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	with facial hair, however, stated she would only shave R98 if she were directed to do so on the care list, and would not perform cares which were not on the list unless this was cleared with the nurse. On 4/23/26 at 8:47 a.m. DAS stated that she created the worksheet, using the information provided to her by the nurses from the initial care plan. DAS stated any changes to the care list is provided by the director of nursing (DON), assistant directed of nursing (ADON), the nurse who completed the Minimum Data Set (MDS) assessment, and the activities director (AD)-A. DAS stated AD-A completed an interview upon admission for those who resided on the long-term to identify personal preferences for grooming (facial hair, shaving, and makeup). This interview was completed only for those on the long-term care unit. DAS stated if there were preferences for those on TCU, they would have to be identified individually. DAS stated it was important to be aware of the preference for the preference for facial hair, as individuals may prefer to be clean shaven, or have a beard. DAS stated those residents with dementia may not be able to express this, and interviews with family members/responsible parties were to be completed. On 4/23/2026, at 11:09 a.m. activities director (AD)-A stated this was started previously when concerns were identified on the long-term care unit regarding preferences for personal grooming, however, this had not been implemented for TCU. AD-A stated grooming considerations are important for dignity, whether an individual wished to be clean shaven, or preferred facial hair. If the resident was unable to express this, the family member was consulted. On 4/27/26 at 2:13 p.m. ADON stated upon admission an assessment was completed to determine what assistance was required with provision of personal needs for residents. If able to respond, the resident was consulted, however, if unable the responsible party was asked. ADON acknowledged personal grooming and facial hair preference was not part of the assessment. ADON stated the expectation for morning cares was to include all aspects of grooming, including shaving. ADON stated this was asked upon admission by activities, and added to the care list. ADON stated it was important to be aware if the resident preferred to be clean shaven or have facial hair. ADON was unaware this was asked only of those residents on the long-term care unit. On 4/27/26 at 4:23 p.m. this was verified by the consultant registered nurse (C-RN) the preference interview was only completed for those residents who resided in the long-term care unit. An undated template of questions to be asked for Morning and Night Routine-V2 included What is your morning routine after you wake up? , as well as the Personal Hygiene Routine: 6. The resident prefers (Specify: being shaved (FREQ-frequency); having make-up applied (FREQ); hands washed; hair style). A policy was requested for completion of this document was requested, however, was not available. The facility policy, titled Activities of Daily Living (ADLs), revised 7/25, indicated the facility will, based on resident's comprehensive assessment and consistent with needs and choices, ensure a resident's ability in ADLs do not deteriorate unless deterioration is unavoidable. The policy goes on to state that care and services were to be provided for the following ADLs, which included dressing, grooming and oral care. The policy lacked personal preferences and choices for shaving and facial hair, however, the policy identified the facility was to maintain individual objectives of the care plan and periodic review and evaluation. R23's quarterly Minimum Data Set (MDS) dated [DATE], indicated R23 had severe cognitive impairment and was moderate to maximum assistance with activities of daily living (ADLs). The MDS also indicated R23 took an antipsychotic medication. R23's diagnoses included bipolar disorder, anxiety, major depression dementia, osteoarthritis, neurocognitive disorder with lewy bodies (a (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	progressive, irreversible brain disorder caused by abnormal protein deposits that disrupt brain function), bradycardia, muscle weakness and osteoporosis. R23's care plan revised 2/2/26, indicated R23 had a ADL self-care performance deficit related to cognitive concerns, bipolar disorder. Interventions included R23 used a wheelchair and required assistance to all destinations, R23 was able to propel wheelchair very short distances, when eating in the dining room R23 preferred to sit alone facing the window. During observation on 4/21/26, at 11:59 AM in dining room at over bed table facing the window, R23 asked surveyor if they were the hearing aid people, R23 stated he could not find the hearing aids. During observation on 4/21/26, at 12:27 p.m. R23 was in the dining room at an overbed table, while R23 attempted to eat the overbed table rolled away from him, R23 then had to move wheelchair forward to enable him to continue eating. R23 had difficulty propelling wheelchair forward, when R23 attempted to move the wheels would rock the wheels back and forth. At 12:31 p.m. R23 has difficulty propelling wheelchair forward to the overbed table, a staff member walked past R23, staff member did not provide assistance. On 4/21/26, at 12:36 p.m. R23 was attempting to propel the wheelchair past surveyor, R23 stated you can have that table, I'm done with that thing. On 4/21/26, at 4:46 p.m. R23 was in the dining room, no hearing aides observed in ears. During observation on 4/21/26, at 5:44 p.m. R23 was at overbed table in dining room, when R23 attempted to eat the overbed table rolled away, R23 had to repeatedly propel wheelchair forward to continue with meal. When observed on 4/22/26, at12:00 p.m. and at 2:16 p.m. R23 was not wearing hearing aids. When interviewed on 4/22/26, at 4:35 p.m. nursing assistant (NA)-B stated R23 preferred to sit alone and look out the window at meals, NA-B stated had not observed the table move while R23 attempted to eat. NA-B stated R23 did not have hearing aids. During observation on 4/23/26, at 9:18 a.m. R23 was at overbed table, overbed table repeatedly rolled away while R23 attempted to eat. R23 was not wearing hearing aids, R23 asked surveyor if they had them On 4/23/26, at 9:32 a.m. reviewed R23's electronic medical record (EMR) noted hearing aid delivery in scanned documents, hearing aids were delivered on 4/20/26, delivery slip indicated provider had educated a staff member on the care of the hearing aids slip had been signed by a licensed practical nurse (LPN). When interviewed on 4/23/26, at 10:06 a.m. NA-D stated if a resident had hearing aids it was noted on the care sheets, NA-D reviewed care sheet, stated there was no hearing aids for R23 indicated. NA-D stated R23 had meals at the overbed table and stated was aware the table rolled away from R23, he just had to roll back up to it when it did roll. NA-D acknowledged the table next to him could be raised and lowered for the level R23 required and did not have the ability to roll away. When interviewed on 4/23/26, at 11:12 a.m. assistant director of nursing (ADON) stated when the (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	ancillary service the facility used delivered new glasses or hearing aids staff signed for the item. ADON was not aware R23 received hearing aids. ADON reviewed scanned documents, noted hearing aids were delivered on 4/20/26. ADON returned at 12:15 p.m. stated hearing aids were located charging at the nurses desk. When interviewed on 4/27/26, at 3:05 p.m. director of nursing (DON) stated the expectation when new hearing devices were delivered was to place an order in the EMR to apply every morning, remove them every evening and charge them for R23 as he would need assistance. DON stated R23 preferred to sit alone and look out the window, DON was not sure why R23 was sitting at an overbed table rather than a regular table, DON stated most of the tables were able to be raised or lowered to meet the height needed., DON stated the overbed table that rolled away while eating was a safety concern. Policies regarding hearing aids and dining tables was requested, however none was provided.

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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 record review, the facility failed to ensure services were provided in accordance with professional standards of practice and physician orders, including failure to apply compression stockings as ordered and failure to ensure accurate documentation of care provided, for 2 of 2 residents (R27 and R46) reviewed for quality of care. Additionally, the facility failed to ensure proper positioning in her wheelchair for 1 of 1 residents (R23) observed leaning over in their wheelchair. Findings include: R27R27's significant change Minimum Data Set (MDS) dated [DATE], identified R27 had intact cognition and required assistance with activities of daily living (ADL)'s. R27's diagnoses included peripheral vascular disease (PVD; poor circulation due to narrowed blood vessels), localized edema (swelling caused by fluid buildup in tissues), and dependence on supplemental oxygen (requires additional oxygen to maintain adequate oxygen levels). The MDS also indicated R27 was receiving oxygen therapy. R27's Order Summary report, with a print date of 4/23/26, indicated physician's orders for compression stockings to be applied in the morning for edema, with an order start date of 12/14/2025, and to be removed at bedtime for edema, with an order start date of 12/13/2025. During observation on 4/20/26 at 12:35 p.m., R27 exhibited bilateral pitting edema in the lower extremities. R27 was wearing yellow gripper socks, which were indented above the ankles. No compression stockings were in place; only yellow gripper socks were observed. During observation on 4/21/26 at 11:16 a.m., R27 was sitting in a recliner with feet on the floor. Bilateral lower extremity edema was observed. No compression stockings were in place; only yellow gripper socks were observed. During observation on 4/21/26 at 3:12 p.m., R27 was sitting in a recliner in the room with legs crossed. No compression stockings were in place; only yellow gripper socks were observed. During observation on 4/21/26 at 4:45 p.m., R27 remained sitting in the recliner with feet on the floor. No compression stockings were in place; only yellow gripper socks were observed. During observation on 04/22/2026 at 8:43 a.m., R27 was sitting in a recliner with eyes closed and legs crossed. No compression stockings were in place; only yellow gripper socks were observed. During observation on 04/23/2026 at 7:27 a.m., R27 was sitting in a recliner in his room with his eyes closed. No compression stockings were in place; only yellow gripper socks were observed. Review of R27's Treatment Administration Record (TAR) for 4/20/26 to 4/23/26 indicated compression stockings were documented as applied as ordered. R46R46's quarterly MDS dated [DATE], identified R46 had severe cognitive impairment and required assistance with ADL's. R46's diagnoses included peripheral vascular disease (PVD; poor circulation due to narrowed blood vessels) and hemiparesis (weakness on one side of the body). The MDS identified R46 did not have any behaviors exhibited. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R46's Order Summary Report, print date of 4/23/26, indicated a physician's order, dated 11/3/2025, for knee-high TED stockings to be applied in the morning and removed at bedtime. The order specified use every day and evening shift, with ace wraps permitted as an alternative. The order was related to cellulitis of the left lower limb (a bacterial skin infection causing redness, swelling, and pain), blister (nonthermal), left foot, subsequent encounter (a healing skin lesion from a prior blister), and localized edema (swelling caused by fluid buildup in tissues). During observation on 04/20/2026 at 2:06 p.m., R46 exhibited bilateral lower extremity swelling. No compression stockings were in place; the resident was wearing fuzzy white socks. During observation on 04/21/2026 at 3:13 p.m., R46 was seated in the living room area and was observed fidgeting with clothing and attempting to swing legs off the left side of a Broda chair. R46 was wearing white socks, and bilateral lower extremity edema was noted. No compression stockings were in place; only white socks were observed. During observation on 04/21/2026 at 3:16 p.m., the administrator approached R46 and adjusted the strap of the Hoyer sling over the right arm of the wheelchair. During observation on 04/22/2026 at 2:05 p.m., R46 was seated in a Broda chair in the living room area, fidgeting with pant legs and leaning forward. R46 was wearing white socks. No compression stockings were in place; only white socks were observed. Review of R46's TAR for 4/20/26 through 4/23/26 indicated knee-high TED stockings were documented as applied as ordered. An exception was noted on 4/22/26, when a code of 9 was documented on the day shift; however, the TAR indicated the stockings were removed on the evening shift that same date, reflecting inconsistent documentation. During interview on 4/22/26 at 2:23 p.m., nursing assistant (NA)-A stated both R27 and R46 had compression stockings that should be worn daily and documented in PCC. NA-A stated staff were responsible for applying compression stockings per order and to report if unable to do so. NA-A confirmed neither R27 nor R46 were wearing compression stockings at that time. During interview on 4/27/26 at 1:17 p.m., licensed practical nurse (LPN)-G stated R46's compression stockings were discontinued that morning as they could not be located. LPN-G stated night shift staff typically applied them in the morning before the resident got out of bed. LPN-G acknowledged R27 did not have compression stockings on. During interview on 4/27/26 at 1:48 p.m., the director of nursing (DON) and consultant nurse (C-RN) stated compression stockings should be applied according to the physician's order, typically on in the morning and off at night, and documented accurately on the TAR. The DON stated residents have the right to refuse; however, the order should be followed unless refusal is documented. The facility's Compression & Intervention Management policy (revised 7/25) stated compression devices are used to manage edema, improve circulation, and prevent complications when ordered by a provider. The policy indicated staff are responsible to apply compression devices (e.g., compression stockings, ace wraps, Tubi grips) according to provider orders and instructions, with specific application roles based on staff training. The policy further required the use of compression devices to be documented in the treatment record. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R23's quarterly Minimum Data Set (MDS) dated [DATE], indicated R23 had severe cognitive impairment and was moderate to maximum assistance with activities of daily living (ADLs). The MDS also indicated R23 took an antipsychotic medication. R23's diagnoses included bipolar disorder, anxiety, major depression dementia, osteoarthritis, neurocognitive disorder with lewy bodies (a progressive, irreversible brain disorder caused by abnormal protein deposits that disrupt brain function), bradycardia, muscle weakness and osteoporosis. R23's care plan revised 2/2/26, indicated R23 had a mobility deficit related to cognitive concerns, bipolar disorder, pain, osteoarthritis and osteoporosis. Interventions included R23 used a wheelchair for mobility, required assistance to all destinations, R23 was able to propel wheelchair very short distances, R23 required assistance of two staff and mechanical lift for transfers. During observation on 4/20/26, at 12:07 p.m. R23 was sitting in wheelchair in dining room, R23 was leaned over toward right side, right side was rested on the arm rest, right arm hung over side of armrest. On 4/20/26, at 4:32 p.m. R23 was observed in hallway, R23 was leaning to right side, right side was resting on armrest of the wheelchair On 4/21/26, at 11:41 a.m. R23 was observed in the dining room participating in an activity. R23 was positioned leaned over to the right, right side rested against arm rest of wheelchair, right arm hung over arm rest with hand towards the floor. During observation on 4/21/26, at 5:44 p.m. R23 was in dining room, positioned leaning to right side with right side rested on arm rest, arm hung over the arm rest with hand hung towards the floor. On 4/22/26, at 3:09 p.m. R23 was observed in wheelchair in room, R23 was positioned leaned to the right side with arm hung over the arm rest, hand hung down towards the floor. When interviewed on 4/22/26, at 4:35 p.m. nursing assistant (NA)-B stated R23 tilted to the side a lot, when R23 was straightened would lean over again, NA-B stated they thought R23 preferred to lean and was comfortable. On 4/23/26, at 9:18 a.m. R23 was observed in the dining room, R23 was leaning to right side, right side rested on arm rest of wheelchair with arm hung down, hand was towards the floor. When interviewed on 4/23/26, at 10:06 a.m. NA-D stated R23 was repositioned to sitting upright several times throughout the day but continued to return to leaning to the one side. On 4/27/26, at 10:49 a.m. R23 was observed by the nurses station, R23 was seated in wheelchair positioned with right side leaning against the right arm rest of the wheelchair, right arm was hung over the armrest with hand hung towards the floor. When interviewed on 4/27/26, at 1:22 p.m. certified occupational therapy assistant (COTA)-A stated during morning meeting with management team someone might bring up a person that may benefit therapy then they would screen the resident to determine if they might benefit from therapy for positioning. COTA-A stated R23 hadn't been seen since they had been working in the facility. When interviewed on 4/27/26, at 3:05 p.m. director of nursing (DON) stated the expectation if a (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident leaned was to obtain an order for therapy to evaluate and treat for wheelchair positioning. DON stated she believed they had attempted positioning with R23 and had been seen by therapy. However, DON was unable to locate documentation regarding therapy and/or positioning devices. Facility Wheelchair Positioning policy revised 7/2025, indicated all residents who required use of a wheelchair would be provided with a suitable wheelchair that met their needs, the policy further indicated orders for occupation therapy (OT) would be requested for positioning and safety when appropriate.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to consistently provide assistance to complete range of motion (ROM) as outlined in plan of care for 1 of 2 residents (R11) reviewed for range of motion. Findings include: R11's comprehensive/annual Minimum Data Set assessment completed 2/28/26, identified R11 was admitted to the facility on [DATE] with multiple medical diagnoses which included vascular dementia, aphasia (difficulty with speaking), hemiplegia/hemiparesis (loss of mobility on one side of the body), depression and anxiety, and personality change due to physiological condition. Although R11 was identified as having cognitive impairments, it is noted R11 was able to understand others and make self-understood. R11 was identified as having received personal assistance with all aspects of care.R11's care plan last revised on 6/5/25, identified R11 had an alteration in neurological status related to a stroke and history of temporal lobectomy (procedure that removes the front part of the temporal lobe of the brain to treat drug-resistant epilepsy) for seizures. R11's care plan identified the goal was for R11 to function at their fullest potential possible as outlined by the interdisciplinary team through the review date, last revised on 2/28/26. The care plan interventions included provision of range of motion (ROM) /PROM (passive range of motion-exercises to maintain movement with either active or passive participation or actively in which the resident does not assist with) with am/pm (morning and afternoon/evening) care(s) daily to be completed by nursing/CNA (certified nursing assistant). The care plan lacked identification of the use of any splint to right hand.The resident care assignment sheet dated 4/21/26, lacked directions for staff to aid with range of motion, either active or passive, and lacked indication of a splint to right hand. The resident task tab lacked directions to the nursing assistants to perform range of motion exercises with am/pm cares. The resident task tab on the electronic medication record (EMR) identified Restorative Nursing Range of Motion, with directions to staff to indicate the number of minutes performed.A review of the documentation completed under the task tab in the electronic medical record (EMR) identified ROM was only completed on seven occasions in the previous 30 days.On 4/21/26 at 2:41 p.m., R11 was observed in his room, resting on the bed with a splint noted on his right hand. R11 stated staff did not provide assistance with exercises to his right-side during morning and evening cares. On 4/22/26 at 10:06 a.m., the restorative nursing aide (RNA)-A stated she assisted R11 with PROM three to five times a week. RNA-A stated there had been a problem with the EMR tasks tab and it did not accurately reflect the frequency. Further documentation provided identified R11 received assistance with PROM at the following frequency on the past weeks:Week of 3/2/26: R11 was offered therapy on four occasions, and refused on one occasion.Week of 3/9/26: R11 was offered therapy on three occasions, and accepted PROM on two.Week of 3/16/26: R11 was offered therapy on four occasions and accepted on three occasions.Week of 3/23/26: R11 was offered therapy and accepted on 3/23/26. RNA-A was not in facility the remainder of the week (identified as vacation).Week of 3/30/26: R11 was offered therapy on four occasions and refused on two occasions.R11 was offered therapy on 15 of 31 days in March.An additional document, titled Documentation Survey Report v2 identified for 4/1/26-4/6/26, therapy was not provided. R11 did not receive therapy on 4/7/26-4/10/26 (rationale not identified), and again 4/14/26-4/17/26 to total eight days of eighteen days documented.On 4/22/26 at 3:00 p.m., nursing assistant (NA)-H stated she was unaware of any directions for staff to complete twice daily ROM with cares, and indicated it was not on the care list, or task section for documentation. On 4/22/26 at 3:19 p.m., the assistant director of nursing (ADON) stated ROM for resident may be done by either nursing staff or restorative nursing. ADON stated R11 required more coaxing and encouragement and therefore received assistance from Restorative Nursing. ADON stated at one time, R11 had directions on the nursing assistant care list for ROM twice daily (14 times/week), however, (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	that had been changed to Restorative Nursing. ADON was unsure when that changed and would follow up on this.On 4/23/26 at 4:30 p.m., ADON provided the following documentation: A document, titled Restorative Nursing Program, dated 2/19/25 identified R11 was to receive right upper extremity PROM daily from shoulder to digits. Additionally, R11 was to receive lower extremities (plural) knee to chest, hip ABD (abduction)/ADD (adduction), and ankles. The document also reflected R11 was to have right palm protector on during AM and off with PM cares. This would be a frequency of seven times a week, versus the previously identified frequency of 14 times a week. The document, Restorative Nursing Plan, with notes dated 4/15/25, 7/21/25, 10/27/25 directed staff to continue with PROM to maintain current ROM for activities of ADL's (activities of daily living-dressing, grooming, bathing). ADON acknowledge the recommendations were for daily, however, Restorative Nursing was only in facility five days a week.On 4/27/26 1:57 p.m., ADON stated he was unsure why the frequency of ROM decreased from twice daily to three to five times a week. They were unsure where the initial direction for twice daily directions came from. ADON stated Restorative Nursing was present in the facility Monday through Friday. ADON stated he was unsure how Restorative Nursing was covered when RNA-A was away from the facility/on vacation. ADON acknowledged the discrepancy between the care plan, the care list, and the task tab within the EMR. ADON acknowledged the care plan should reflect the care provided to the residents.The facility policy, Restorative Nursing, last revised 7/25 identified the restorative nursing program referred to interventions which promoted resident's ability to adapt and adjust to living as independently as possible. The policy identified nursing personnel were responsible for care which would not require a qualified therapist, which included assisting residents with range of motion exercises, performing passive range of motion for residents who lacked active range of motion.

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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 record review and interview, the facility failed to ensure the recommendations from the monthly medication regimen review (MRR) conducted by the consultant pharmacist were reviewed and acted upon in a timely manner, in accordance with professional standards of practice, for 2 of 6 residents reviewed for unnecessary medications (R9 and R65).Findings include: R65's quarterly Minimum Data Set (MDS) assessment, completed on 2/23/26, identified R65 was admitted to the facility on [DATE] had impaired cognition, and required assistance with activities of daily living (ADL's-eating, dressing, grooming, bathing, and mobility). R65's medical diagnoses included: Alzheimer's disease and non-Alzheimer's dementia, anxiety, depression, hypertension (high blood pressure), orthostatic hypotension (a drop in blood pressure which occurred with a change in position and adult failure to thrive. A review of the consulting pharmacist reports was completed from the time of R65's admission date of 11/21/25. It was noted the consulting pharmacist's reviews were in place for the following dates: 11/24/25), 1/19/26, 2/17/26, 3/15/26 and 4/15/26. A consultant pharmacist review was not present for the month of December 2025. On 4/23/26, at 7:32 a.m. the director of nursing (DON) stated she had spoken with the Consultant Pharmacist (PharmD)-B and it was noted the review was missed in the month of December as R65 had moved from the transitional care unit to the long-term care unit. DON stated medical record reviews were expected to be reviewed by the Consultant Pharmacist monthly. On 4/27/26, at 12:59 p.m. it was noted by PharmD-A that R65 had changed units in December of 2025 and a record review was not completed that month. The facility's Pharmacy Recommendations policy, revised 7/25, required a review of resident medication regime is done monthly by the pharmacy consultant with recommendations addressed to the physicians and nursing. (Please add this to the front of Lanisha's policy information) Findings include: R9's quarterly Minimum Data Set (MDS) dated [DATE], identified R9 had moderate cognitive impairment and required assistance with activities of daily living (ADL)'s. R9's diagnoses included Alzheimer's disease with late onset (a progressive brain disorder affecting memory and thinking), non-Alzheimer's dementia (decline in memory and thinking not caused by Alzheimer's disease), anxiety disorder (excessive worry or fear), and COPD (chronic obstructive pulmonary disease; a lung disease that makes it hard to breathe). Review of the consultant pharmacist's monthly medication regimen review (MRR), dated 1/19/26, identified recommendations related to R9's medication regimen, indicating, resident is receiving citalopram and olanzapine. Please make sure we have patient specific target behavior monitoring, side effect monitoring, and orthostatic blood pressure monitoring in place. Review of the consultant pharmacist's MRR, dated 2/16/26, identified recommendations related to R9's medication regimen, indicating, the resident has an order for trazodone, citalopram, and (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	olanzapine and to monitor his response to these, recommend adding appropriate target behavior, orthostatic blood pressure, and side effect monitoring to the TAR. Review of R9's electronic medical record (EMR) and physician order records lacked evidence the facility reviewed, acknowledged, or acted upon the consultant pharmacist's recommendations in a timely manner. There was no documented evidence the recommendations were communicated to the physician, implemented, or that a rationale was provided for not implementing the recommendations. During interview on 04/27/2026 at 12:53 p.m., consultant pharmacist (CP) stated monthly medication regimen reviews were conducted to identify irregularities and ensure safe and appropriate medication use. The CP stated MRR recommendations were typically expected to be addressed within the following month, unless the provider had not yet seen the resident, in which case it could extend up to two months. The CP stated recommendations should be addressed as soon as possible. The CP further stated if recommendations were not addressed by the following month, a pending report would be issued, which included the same recommendations for follow-up and resolution. During interview on 4/27/26 at 1:48 p.m., director of nursing (DON) and consultant nurse (C-RN) stated the expectation was for MRR recommendations to be addressed within 30 days. The DON and C-RN further stated R9's MRR would have been considered a nursing MRR, which should have been addressed immediately or within a few days. The DON and C-RN confirmed the recommendations for R9 were missed and not followed up in a timely manner. The facility's Pharmacy Recommendations policy, revised 7/25, required that monthly medication regimen review (MRR) recommendations made by the consultant pharmacist be communicated to nursing and physicians, documented in the medical record, and addressed timely. The policy indicated physicians were to respond by either implementing recommendations with orders or documenting rationale for disagreement. Unresolved recommendations were to be tracked, re-reviewed the following month, and followed up by nursing, with ongoing non-response escalated to the medical director for further action.

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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 record review, the facility failed to ensure medications were administered in accordance with professional standards of practice, including failure to follow physician orders to monitor blood pressure and pulse parameters prior to administration of a beta-blocker medication, for 1 of 1 resident (R16) reviewed for unnecessary medications.Findings include:R16's admission Minimum Data Set (MDS) dated [DATE], identified R16 had intact cognition and was independent with activities of daily living (ADL)'s. R16's diagnoses included hypertension (high blood pressure), atrial fibrillation (an irregular heart rhythm), coronary artery disease (narrowing or blockage of the heart's blood vessels), heart failure (a condition where the heart cannot pump blood effectively), and end stage renal disease (advanced kidney failure requiring dialysis).Review of R16's physician orders printed 4/22/26, identified an order for Metoprolol Tartrate 50 MG (milligram), give 50 mg by mouth two times a day for ESRD, with parameters to hold the medication for systolic blood pressure (SBP) less than 90 or pulse less than 50, initiated on 3/20/2026.R16's medication administration records (MAR) from 3/20/26 to 4/22/26, identified Metoprolol Tartrate was administered as ordered; however, there was no documentation to indicate R16's blood pressure or pulse were obtained prior to administration, as required by the physician's order.During interview on 4/22/26 at 2:09 p.m., trained medication aide (TMA)-A reviewed R16's medication record, confirmed Metoprolol had parameters to hold for SBP (systolic blood pressure) less than 90 or pulse less than 50, and stated they were not obtaining blood pressure or pulse prior to administration.During interview on 4/23/26 at 10:08 a.m., licensed practical nurse (LPN)-C stated there were no residents, to her knowledge, who currently had medication parameters requiring vital signs prior to administration. LPN-C further stated she did not obtain any vital signs that morning related to medication administration.During interview on 4/23/26 at 3:35 p.m., assistant director of nursing (ADON) stated Metoprolol had parameters on the order to hold the medication based on vital signs and confirmed vital sign monitoring was not in place and was not being completed prior to medication administration for R16.During interview on 4/27/26 at 1:17 p.m., LPN-G confirmed blood pressure and pulse should be obtained prior to administering medications with parameters and acknowledged this was not initiated for R16 until 4/23/26.During interview on 4/27/26 at 1:48 PM, director of nursing (DON) and consultant nurse (C-RN) stated staff were expected to follow physician orders, including obtaining vital signs prior to administration of medications withhold parameters. The DON stated when medications have parameters for holding, vital signs must be obtained prior to administration and the medication should be held if the resident is outside of those parameters, as this is a provider order.Review of the facility's Medication Administration policy, revised 7/25, identified medications were to be administered by licensed or authorized staff in accordance with physician orders and professional standards of practice. The policy required staff to obtain and document vital signs when indicated by the order and to hold medications if vital signs were outside prescribed parameters. The policy further required adherence to the six rights of medication administration and accurate documentation on the medication administration record (MAR), including recording required vital signs and any medication refusals.

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	04/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Park River Healthcare and Rehabilitation Center LL	9899 Avocet Street Northwest Coon Rapids, MN 55433

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to ensure recommended influenza, pneumococcal, and Covid-19 vaccinations, as outlined by the Centers for Disease Control (CDC), were offered and/or provided in a timely manner to reduce the risk of severe disease for 2 of 5 residents (R16 and R19) reviewed for immunizations. Findings include: R16's comprehensive/admission Minimum Data Set (MDS) assessment, completed on 4/2/26, indicated he was admitted to the facility on [DATE], and was cognitively intact, and was independent with activities of daily living (ADL's-dressing, grooming, mobility, and hygiene), however, used a walker/wheelchair. R16's medical diagnoses included end stage renal disease (ESRD-a chronic kidney disease where kidneys can no longer function properly)with dependence on renal dialysis (a process to help the body rid the wastes the kidney is no longer able to remove), multiple cardiac diseases including coronary artery disease, heart failure, hypertension, and aortic stenosis. On 4/21/26 at 4:40 p.m. a review of R16's immunization status identified R16 had received the Pneumococcal Conjugate Vaccine (pneumonia vaccine) on 7/2/15 and 12/22/22, however, the documentation lacked indication as to what vaccination had been given (PCV13, PCV15, and PCV20-varied types available). A review of consents was completed with no indication that any additional Pneumovax was offered, nor was a review of vaccinations identified within the electronic medical records (EMR) to indicate which vaccines were provided, nor a determination made as to whether or not additional pneumonia vaccine(s) should have been offered. On 4/23/26, at 10:20 a.m. during an interview with the director of nursing (DON) regarding the process of review of resident's immunization status upon admission. DON had identified during interview that both she and Information Technologist (IT)-A had access to MIIC (Minnesota Immunization Information Connection) and were responsible for review of the registry to assure that all immunizations were current the time of admission. This process was to verify which immunizations had been completed for the residents, as well as to identify if there were further immunizations recommended, aside from what has been completed. DON stated if the resident was cognitively able to choose which vaccinations they wished to receive, the resident was consulted. If they were unable to choose independently, the responsible party was consulted regarding vaccination. DON stated the immunizations reviewed included the following vaccines: Pneumococcal, Influenza, and Covid.On 4/23/26 after 5:00 p.m. a review of the electronic medical record (EMR) was completed and it was noted that there was additional information added to R16's Immunization Record which included an additional pneumovaccine, PPSV2, given historically on 8/25/11. Additionally, there was subsequent information added which identified on 7/2/15 it was the PCV13 pneumonia vaccine given, and on 12/22/22, the PCV20 was given.In light of this, upon review of PneumoRecs (a resource which identified which vaccinations should be given, based on what the resident has had previously), their pneumococcal vaccinations were complete, however, this information had not been identified prior to interview with director of nursing (DON), and the third dose had not been listed for 8/25/11. R19's comprehensive/admission Minimum Data Set (MDS) assessment, completed on 4/30/26, indicated she was admitted to the facility on [DATE], had some level of cognitive impairment, and received assistance to complete activities of daily living (ADL's), and used a wheelchair for mobility. R19's medical diagnoses included hypertension (high blood pressure), diabetes (a disease which impacts the body's ability to manage sugar in the diet), and Klebsiella pneumoniae (the causative agent of a disease that is (e.g., pneumonia, sepsis, urinary tract infection). On 4/21/26 at 4:40 p.m., a review of R19's EMR identified under the Immunization Record tab, indicated R19 had received a Pneumovax 23 pneumonia vaccine on 6/4/07. Upon review of the documentation, there had not been documentation reflective of review of the pneumonia vaccine provided, and what was subsequently indicated, as well as what information was provided. to the resident's responsible party. The documentation lacked indication as to whether R19 had received PCV13. Upon review of PneumoRecs identified it was the (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 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	recommendation to give one dose of PCV15 or PCV20 at least one year after last dose of PPSV23, with the last vaccine given 6/4/07.On 4/23/26 at 10:20 a.m. the DON stated there was no indication of any vaccines having been offered. A review of vaccine consents was also completed at this time, and lacked indication further vaccines were offered. An email received from DON at 4/24/26 at 9:44 a.m. indicated R19's record had been reviewed, and a consent was to be sent out regarding the Pneumovax vaccine. This had not been completed prior to the interview completed.The facility policy, Infection Prevention and Control Policy and Procedure, reviewed 1/25, identified the elements of the program included definition of, and management of, appropriate resident health initiatives, such as the immunization program (influenza, pneumonia, etc.); and Tuberculosis screening on admission and following the discovery of a new case, and management of active cases consistent with State requirements.An additional policy, Group Vaccination (Influenza/Pneumococcal) Notification, revised 8/18, identified all residents admitted to the facility will be screened to determine if they are current on adult immunizations. The policy further indicated the documentation was to be maintained in the resident's medical record. The Notification of Group Vaccination, which included notification of benefits and potential side effects, was to be given to the resident or responsible part and was to be documented in the resident's medical record.