STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245483	A. Building B. Wing	02/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The North Shore Estates LLC	7700 Grand Avenue Duluth, MN 55807

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review the facility failed to ensure the following infection prevention measures occurred: utilization of proper isolation signage, handwashing, appropriate utilization of personal protective equipment (PPE) by staff, proper handling of laundry to prevent bacteria growth, and proper hand sanitization during meal tray pass to residents in their rooms. These deficient practices had the potential to impact all residents who resided at the facility. Isolation Signage and PPE Usage R9's quarterly Minimum Data Set (MDS) dated [DATE], indicated R9 was cognitively intact with diagnoses of hypertension, acute kidney failure, bipolar, and schizophrenia. R35 quarterly MDS dated [DATE], indicated R35 was cognitively intact with diagnoses of end stage renal disease with dialysis, diabetes and hypertension. R56's comprehensive MDS dated [DATE], indicated R56 was cognitively intact with the diagnoses of heart failure, acute kidney failure, and diabetes. The facility document Residents Currently on Precautions sent on 2/10/26, identified 34 residents on precautions including: R9: contact and droplet precautions for cough, runny nose congestion, negative influenza, covid and RSV. R35: enhanced barrier precautions for dialysis and wound and contact and droplet precautions for human metapneumovirus. R56: contact and droplet precautions for human metapneumovirus. Facility isolation signs from the Centers for Disease Control and Prevention (CDC) instructed staff to do the following: -Droplet Precautions: everyone must clean their hands, including before entering and when leaving the room. Make sure their eyes, nose and mouth are fully covered before room entry. Picture of face mask and eye protection. Remove face protection before exit. -Contact Precautions: Everyone must clean their hands before entering and when leaving the room. Providers must also put on gloves before entry and discard gloves before room exit. Put on gown before room entry and discard gown before exit. Do not wear the same gown and gloves for the care (continued on next page)

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

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

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	of more than one person. Use dedicated or disposable medical equipment. Clean and disinfect reusable equipment before use on another person. -Enhanced barrier precautions: everyone must clean their hands including before entering and when leaving the room. Providers and staff must also wear gloves and a gown for the following high-contact resident care activities: dressing, bathing/showering, transferring, changing lines, providing hygiene, changing briefs or assisting with toileting. Device care or use for: central line, urinary catheter, feeding tube, tracheostomy and wound care: any skin opening requiring a dressing. Do not wear the same gown and gloves for the care of more than one person. The CDC Appendix A Guidelines for Isolation Precautions last updated 9/2024, recommended Contact precautions plus standard precautions for mask use when caring for individuals with human metapneumovirus. During an observation on 2/9/26 at 12:53 p.m., the following signs were on the following resident doors door: -R9: contact and droplet precautions -R35: contact and droplet precautions -R56: contact and droplet precautions During an observation on 2/9/26 at 1:00 p.m., of the low two hundred wing it was noted the hallway did not have any wall mounted hand sanitizer dispensers. There were 9 isolation carts in the hallway. Only one cart was noted to have a small bottle of hand sanitizer on top of the cart. During an observation on 2/9/26 at 1:00 p.m., nursing assistant (NA)-B entered R9's room. Prior to entry NA-B did not sanitize hands, or apply gown, gloves, or a mask as the contact and droplet precautions signs on R9's door instructed. During a follow-up interview on 2/9/26 at 6:52 p.m., NA-B stated they believed they had a mask on, but if they were just bringing in food or something, then they would not put all the PPE (personal protection equipment) on. NA-A stated masks and PPE were important to wear for infection prevention reasons. During an observation on 2/9/26 at 6:45 p.m., registered nurse (RN)-Centered R9's room which now only had a droplet precautions sign on the door (the contact precautions sign was gone). RN-C exited the room with a standing transfer device and parked it in the hallway. Prior to entering the room RN-C did not sanitize hand, apply mask, gown, or gloves. At 6:47 p.m., RN-C applied gloves and used sanitizing wipes to clean the standing transfer device parked in the hallway. At 6:48 p.m., RN-C entered R35's room which now only had a droplet precautions sign on the door. Prior to entering the room RN-C did not apply mask, gown, or gloves. RN-C exited R35's room at 6:51 p.m. During an interview on 2/9/26 at 6:56 p.m., RN-C looked at R9's door and confirmed they saw the (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	droplet sign and stated they should have put a mask on before they entered R9 and R35's room. In their mind the residents were on enhanced barrier precautions. RN-C stated it would be important to wear a mask for droplet precautions to prevent the spread of what the residents had. On 2/9/26 at 7:01 p.m., RN-C returned and stated they had checked, and R9 and R35 were probably done with isolation, but they needed to have their rooms deep cleaned before they could come off droplet precautions. During an observation on 2/10/26 at 9:50 a.m., R9 and R35 and R56's doors had droplet precautions signs on the door. During an observation on 2/11/2026 at 7:24 a.m., R9 and R25's rooms had droplet isolation signs on their doors. There were no contact isolation signs on the door. During an observation on 2/11/26 at 7:30 a.m., laundry aide (LA)-F knocked on resident door (with a contact precautions sign on the door) to deliver laundry. LA-F opened the top drawer of the isolation cart and then proceeded down the hallway checking several carts for hand sanitizer. NA-C instructed LA-F to look in the storeroom for hand sanitizer bottles. LA-F exited the storeroom without hand sanitizer and proceeded down the hallway checking carts. LA-F found a bottle of hand sanitizer, sanitized hands, applied gown, gloves and then entered the resident room. During an observation on 2/11/26 in the a.m., NA-C came down the hallway from the nursing station area, applied a mask only and entered R35's room. NA-C asked R35 if they would put a mask on, R35 stated they never had before, but agreed and placed a mask on before being wheeled down the hallway by NA-C for an outside appointment. During an interview on 2/11/26 at 2:15 p.m., NA-C stated staff went by the isolation signs on the door to know what PPE to wear and the night nurse had also given a rundown of what residents were in isolation for. NA-C confirmed R35 and R9's doors had droplet isolation signs only on them. NA-C stated they knew they should also gown and glove in addition to droplet precautions to go into those rooms because of shift hand off from the night nurse. During an interview on 2/11/26 at 3:40 p.m., the director of nursing stated (DON) the company infection prevention tool indicated droplet precautions should be used for residents with Human Metapneumovirus. The DON looked at the company tool and stated it did not cite any sources of information. The DON stated they had had contact and droplet precaution signs on R9 and R35's doors but due to an internal discussion on signage, the contact precaution signs must have been taken down by another staff member. During an observation with the DON on 2/12/26 at 8:27 a.m., the DON went through the isolation carts on the low 200 hallway. One of seven carts had a small bottle of hand sanitizer in the top drawer, the rest of the carts had none. The DON stated all the carts should be stocked with hand sanitizer and then asked health information manager (HIM)-H to stock all isolation carts with hand sanitizer. During an interview on 2/12/26 at 8:30 a.m., both the DON and an infection preventionist licensed practical nurse (LPN-A) were present. The DON stated they had reviewed CDC Appendix A and discovered their company reference tool was incorrect and needed to be updated. Contact precautions and masks should be used for human metapneumovirus, not just droplet precautions. LPN-A reviewed the facility isolation signs and confirmed the droplet precautions sign only instructed staff to wear (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	face and eye coverings. The DON stated their original signage of contact and droplet precautions covered correct PPE but the current droplet signage for R9, R35, and R56 was not adequate. The DON confirmed enhanced barrier precautions should be continued for residents requiring additional precautions. Contact precautions would cover enhanced barrier precautions, but droplet precautions alone did not direct staff to wear appropriate PPE for resident cares. The DON listed expectations for the following isolation types: -Enhanced barrier precautions: staff should follow the direction on the sign and wear appropriate PPE based on task performed. -Contact precautions: staff are expected to always put on the PPE listed on the sign before they entered a contact precaution room for any reason. -Droplet: staff should be putting on PPE before entering the room even if they are just going in to ask a question. Regarding hand sanitization, the DON stated it was their expectation that staff would sanitize their hands either at a sink or with hand sanitizer before and after entering resident rooms. They also expected staff to keep each isolation cart stocked with hand sanitizer at all times. LPN-A stated they had done isolation and PPE education during a recent respiratory outbreak and during their September 2025, skills fair. During an observation on 2/12/26 at 9:36 a.m., all of the isolation carts in the low 200 hallway had hand sanitizer bottles. R9 and R35's doors had contact precautions signs on the door. The droplet precaution signs had been removed. There was no signage that indicated staff should wear face covering (mask). The facility Infection Prevention and Control Program dated 11/2024, included implementing appropriate isolation precautions when necessary and following established general and disease-specific guidelines such as those of the Centers for Disease Control as important facets of infection prevention. Laundry Department During an observation on 2/10/26 at 1:07 p.m., housekeeper (H)-A opened the laundry area door and stated the laundry staff were gone for the day. The second washing machine closest to the clean laundry side of the room had a load of laundry washing. During an interview on 2/11/26 at 9:44 a.m., LA-F confirmed they had put a load of laundry in at the end of their shift on 2/10/26. They had been told they could not leave the dryer running when they left for the day, but it was okay for them to put a load of laundry in at the end of the day to take care of in the morning. LA-F stated they were not aware of any infection prevention concerns with leaving laundry in the washing machine overnight. During an interview on 2/11/26 at 10:10 a.m., the house keeping supervisor (HS) stated they had been in their position about a year. In the training they had received, they were told it was okay to start a load at the end of the day to process in the morning, but it was not okay to leave the dryer running (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	when staff left for the day. During an interview on 2/12/26 at 8:30 a.m. both the DON and LPN-A were present. The DON stated laundry should not be left in washing machines overnight because it gave mold and/or bacteria an opportunity to grow. If laundry got left over night, it should be re-washed before going into the dryer. Hand Hygiene and PPE Use R3's annual MDS dated [DATE], identified intact cognition and diagnoses of infection and inflammatory reaction of left knee prosthesis, a multidrug-resistant organism (MDRO), and direct infection of the right elbow. R3 was dependent with transfers, set-up assistance for eating, and partial to moderate assistance for dressing and grooming. R3's care plan identified a focus statement dated 1/12/26, identifying R3 had a current infection and included an intervention for isolation precautions. On 2/9/26, a focus statement for contact isolation precautions identified staff to follow isolation precautions, infection control precautions per protocol, sign on resident's door, and treatment for current infection per order. R3's provider order dated 1/12/26, identified an order for staff to follow contact precautions every shift. During an observation on 2/9/26 at 2:36 p.m., NA-H knocked and entered R3's room, which had a Contact Precautions sign on the outside of the door, and then exited shortly after with a water mug. At 2:38 p.m., NA-H returned with a water mug and went back into the room. NA-H stated the sign was there because R3 has had surgeries and incisions, a line and some wounds. NA-H explained you wouldn't need to wear a gown if you were just going in there. During an observation on 2/10/26 at 11:24 a.m., two unidentified NAs entered R'3 room with a mechanical sling lift. Neither NA donned PPE at the PPE station in the hallway outside R3's door. During an observation and interview on 2/11/26 at 7:23 a.m., trained medication aid (TMA)-A entered R3's room with a vitals stand and didn't don PPE. At 7:26 a.m., TMA-A stated R3 had wounds, so you had to gown up to do her wounds. During an interview on 2/12/26 at 12:05 p.m., RN-A, a nurse manager for the first floor, stated R3 was on contact precautions because she had methicillin-resistant staphylococcus auris (MRSA) in a wound and has had multiple surgeries. RN-A described contact precautions would be used any time you are coming in physical contact with their belongings or things in their room, but if you were just setting down a tray you wouldn't need to. On 2/9/26 at 4:55 p.m., the evening meal cart arrived on the second floor. The cart was brought to the East hallway. There were clothing covers on the top of the cart, no evidence of hand wipes. - at 4:58 p.m., nursing assistant NA-B brought a tray into R55's room and exited with a different tray. - at 4:59 p.m., NA-B wearing gloves exited R8's room carrying a tray and placed it on the bottom rack of the meal cart. NA-B, wearing the same gloves went back into R8's room carrying a different tray into the room. Upon exiting the room NA-B was still wearing gloves and pushed the cart further down the hall (no glove change or hand hygiene was performed). NA-B brought a tray into R25's room, (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	exited the room still wearing gloves and placed the entrée cover on the bottom rack of the cart, next picked up two packets of sour cream and brought them into R25's room. NA-B was heard offering to open the sour cream packets, the response was no, NA-B exited the room with the sour cream packets and placed them back on the cart. NA-B, still wearing the same gloves, closed the cart and moved it down the hall. NA-B, wearing the same gloves, brought a tray into R53's room after knocking on the door. -at 5:05 p.m., NA-B still wearing the same gloves picked up a tray that was on a cart in the hallway, placed the tray in the food cart, closed the cart and moved it down the hallway. -at 5:06 p.m., NA-B removed the gloves they had been wearing and held them in their left hand. -at 5:07 p.m., NA-B answered R23's call light and adjusted their overbed table so they could eat their meal. During an interview on 2/9/26 at 5:08 p.m., NA-B stated they usually wore gloves when they delivered meal trays. NA-B verified they wore the same gloves while delivering new trays and when they picked up used trays. NA-B verified they did not perform hand hygiene after removing their gloves. During an interview on 2/12/26 at 3:53 p.m., the director of nursing (DON) verified staff should perform hand hygiene before and after delivering each resident tray. The DON verified she would expect staff to wear gloves if they were going to touch any food. The DON stated it was important to follow good hand hygiene to prevent infection and the spread of bacteria. The policy Handwashing dated 2/2024, identified proper hand-washing techniques should be used to protect the spread of infection. The policy identified hand washing should be completed before and after caring for someone who is sick.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to ensure allegations of abuse were reported within 24 hours to the State Agency (SA) for 1 of 1 resident (R11) reviewed for abuse.Findings include:R11's five-day Minimum Data Set (MDS) dated [DATE], identified R11 had diagnoses which included displaced intertrochanteric fracture of left femur with routine healing, paroxysmal atrial fibrillation (an irregular and often fast heart rhythm), insomnia, anxiety, and chronic pain. In addition, R11's MDS identified she was cognitively intact and received scheduled and as needed pain medications for frequent pain.A complaint was submitted to the state agency on 10/28/25, at 1:11 p.m., related to misappropriation of property. It was reported that R11 had stated she had slept through the night without any pain medication. The reporter noted pain medications had been signed out twice overnight for the resident.The facility was made aware of the allegation by the reporter on 10/20/25, the facility completed an investigation at the time but did not report the allegation to the SA.During an interview on 2/11/26 at 2:27 p.m., nurse practitioner (NP)-B recalled the reporter telling her about the concerns they had. NP-B gave the reporter the phone number to the SA and advised them to report their concerns. The NP-B recalled discussing the concern with the nurse manager and recalled the facility completed an investigation.During an interview on 2/11/26 at 2:58 p.m., registered nurse (RN)-A stated they could not recall any recent concerns related to a possible problem with narcotics.During an interview on 2/11/26 at 3:06 p.m., the administrator verified they completed an investigation related to potential narcotic diversion in October of 2025. The administrator verified they did not report the allegation to the SA.The Abuse Prohibition/Vulnerable Adult Policy dated 11/2025, identified the following, If the suspected Neglect, Exploitation, or Misappropriation of resident property did not result in serious bodily injury, the reports must be made within 24 hours.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review the facility failed to ensure proper procedure, documentation and accounting procedures were followed for controlled substances reviewed for narcotic diversion. Findings include:During an interview on 2/11/26 at 12:46 p.m., trained medication aide (TMA)-A stated R11 had told them they were proud they had not taken any narcotics over the weekend. TMA-A looked in the narcotic book and saw there had been oxycodone (a strong prescription opioid analgesic) signed out to R11. TMA-A reported this to the facility on [DATE], and to R11's provider.During an interview on 2/11/26 at 2:27 p.m., nurse practitioner (NP)-B stated she recalled the TMA talking to her about their narcotic concerns, she advised them to report the concern, she discussed it with the facility and modified narcotic orders for residents to reflect what residents were using in regard to narcotics.During an interview on 2/12/26 at 8:37 a.m., the administrator stated the alleged perpetrator (AP)-B did not show any signs of impairment and administered a lot of pain medication because they worked a lot. The administrator stated they investigated the concern, but they did not report the allegation to the state agency.Narcotic book page 28 hydrocodone/APAP [acetaminophen] (a combination prescription opioid with a non-opioid pain reliever) 10-325 milligrams (mg) dated 8/25/25 at 0945 dropped on floor signed by AP-B, no second signature.Narcotic book page 105 oxycodone 15 mg dated 10/9/25 at 5:18 a.m., dropped signed by AP-B and second staff.Narcotic book page 146 hydrocodone (opioid pain medication)12/20/25 at 00:41 a.m., dropped on floor signed by AP-B, no second signature.Narcotic book page 57 lorazepam (short-acting benzodiazepine [central nervous system depressant])0.5 mg 11/10/25, no time documented, destroyed signed by AP-B and second staff.Narcotic book page 47 lorazepam 2 mg dated 12/25/25 at 3:45 p.m., med destroyed signed by AP-B and second staff.Narcotic book page 57 lorazepam dated 12/28/25 at 3:45 p.m., med destroyed signed by AP-B and second staff.A review of R45 progress notes dated11/10/25, 12/25/25, and 12/28/25, did not reveal any progress notes identifying why the lorazepam was destroyed on those dates.Narcotic book page 110 oxycodone 5 mg dated 1/25/26 at 7:49 a.m., number 3 pill missing from card.During an interview on 2/12/26 at 2:30 p.m., the administrator stated they did not know what number 3 pill missing meant.During an interview on 2/12/26 at 2:49 p.m., registered nurse (RN)-D stated when she discovered pill number 3 missing, she called the on call nurse to report the concern. RN-D stated the count at change of shift was totally unfocused, alarms were going off and they didn't notice there was a pill missing from the bubble pack. RN-D stated she heard later from AP-B that it had been taken care of, and the missing pill was found in the suboxone box.During an interview on 2/12/26 at 3:56 p.m., the director of nursing (DON) reviewed page 110 where the oxycodone pill number three was noted to be missing. The DON checked her text messages and verified she was informed about the missing medication. She was not able to recall anything else about the incident stating she believed she asked RN-D if she found it. She could not verify if the missing medication was investigated. Narcotic book page 71 morphine (a potent opioid analgesic) 15 mg dated 2/10/26at 6:00 p.m., not signed out, a sticky note was attached to the page, AP-B please sign for 2/10/26. The residents electronic medical record documented the time given as 4:13 p.m., two hours prior to the medication being signed out.A review of four narcotic books in use did not have any other staff wasting, destroying or dropping medications on the floor except for AP-B.During an interview on 2/12/26 at 12:52 p.m., R35 stated she could not recall any staff dropping medications, she stated she did not drop her medications either. R35 stated specifically AP-B, doesn't' drop anything.During an interview on 2/12/26 at 4:40 p.m., AP-B stated the process for wasting a narcotic was to have an RN witness the destruction. AP-B stated it was not part of the process to write a progress note explaining why a medication was destroyed and not given. For page 105 wrong card, they said they must not have followed the five rights of medication administration. AP-B stated for (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	page 105 the resident would drop the medication on the floor. For page 146, they stated they did not know why there was not a second signature documented. For pages 7, 47, 57, said sometimes the resident would be sleeping and they couldn't wake them to give the medication again stating there was no protocol requiring a progress note but stated it would be good to document why a medication was not given. For page 28 was again not sure why there was not a second signature documenting the waste.During an interview on 2/12/26 at 3:35 p.m., the consultant pharmacist (CP)-J stated they had not been made aware of the facility's investigation of possible narcotic diversion. CP-J stated they should have been involved in the investigation.During an interview on 2/12/26 at 3:56 p.m., the DON stated a nurse should assess a resident prior to a TMA giving an as needed narcotic and there should have been a progress note documenting the assessment.The policy Disposal of Medications and Medication-Related Supplies dated 2025, identified the following, When a dose of a controlled medication is removed from the container for administration but refused by the resident or not given for any reason, it is not placed back in the container. It is destroyed in the presence of [two licensed nurses], and the disposal is documented on the accountability record/book on the line representing that dose.IIA2: Discrepancies, loss and/or diversion of Medications dated 2025, identified this would be reported to the DON and CP immediately, a facility incident report would be filed, an investigation would occur, corrective action would be taken, and appropriate agencies would be notified. In addition, the policy identified the following, If the loss involves a controlled substance, all the controlled drug accountability procedures and documentation should be reviewed and audited.Preparation and General Guidelines dated 2025, identified the following, If a dose of regularly scheduled medication is withheld, refused, not available, or given at a time other than the scheduled time (e.g., the resident is not in the facility at scheduled dose time, or a starter dose of antibiotic is needed), the space provided on the front of the MAR for that dosage administration is [initialed and circled]. If electronic MAR is used, documentation of the unadministered dose is done as instructed by the procedures for use of the eMAR system. An explanatory note is entered on the reverse side of the record. If [XX consecutive doses] of a vital medication are withheld, refused, or not available the physician is notified. Nursing documents the notification and physician response.Addendum: Trained Medication Aide (TMA) dated 10/3/20, identified the following, Documents after administration the date, time, dosage and method of administration of all medications or reason for not administering the medication as ordered, including the signature of the nurse or physician who is authorized to administer.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The North Shore Estates LLC	7700 Grand Avenue Duluth, MN 55807

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, and document review the facility failed to ensure medications were properly stored and secured during medication pass. In addition, the facility failed to ensure floor stock melatonin, 3 milligrams (mg) administered to residents was pharmaceutical grade. These deficient practices had the potential to impact all residents on or who could access the second floor and/or receive melatonin 3 mg.Findings include:Med Pass:During an observation on 2/11/26 at 8:39 a.m., registered nurse (RN)-B stepped away from their medication cart located in the hallway and entered a resident room. The medication cart was unlocked. The following items were on top of the cart: inhaler, several bottles of eye drops, and two medication cups containing multiple pills. At 8:43 a.m., RN-B was back setting up medications at their medication cart.At 8:44 a.m., RN-B went into another resident room. The medication cart was left unattended and unlocked. The 2nd large cart drawer was partially open. The two cups of pills and the inhaler were still on top of the cart along with a card of pills. During an interview on 2/11/26 at 8:48 a.m., RN-B confirmed they had left the medication unattended with medications on the surface of the cart. RN-B stated they knew they were supposed to lock the medication when they walked away from it, but they didn't always do that when they were just running into a room. RN-B stated the medication cups had been set up to administer but one resident was still out and about and the other one didn't want to wake up yet to take their medications.During an interview on 2/11/26 at 3:40 p.m., the director of nursing (DON) stated medication carts should never be left unlocked and unattended, nor should medications ever be left on the surface of carts unattended. It was the medication nurse's responsibility to make sure medications were properly secured at all times to prevent unauthorized individuals such as other residents or visitors from accessing resident medications.The facility policy Medication Storage in the Facility dated 6/2022, directed Medication rooms, carts, and medication supplies are locked when not attended by persons with authorized access.The facility policy Preparation and General Guidelines dated 2025, section Preparation and General Guidelines Number 16 instructed: During administration of medications, the medication cart is kept closed and locked when out of sight of the medication nurse or aide. No medications are kept on top of the cart. The cart must be clearly visible to the personnel administering medications, and all outward sides must be inaccessible to residents or others passing by.Melatonin:During a review of a first-floor medication cart on 2/12/26 at 12:45 p.m., trained medication aide (TMA)-A removed two sealed and one open bottle quantity 60 of Basic Brands melatonin 3 mg from the cart. TMA-A confirmed the bottles did not have an expiration date; the bottles only had a manufacture date of 6/2024. TMA-A called health information manager (HIM-H) over. HIM-H stated they ordered the stock medications, and the bottles came loose. HIM-H confirmed the bottles did not have an expiration date on them. At 1:02 p.m., the administrator walked up, looked at the bottle and confirmed there was not an expiration date.During the review of a second-floor medication cart on 2/12/26 at 1:43 p.m., RN-B removed a bottle of melatonin 3 mg from the cart and confirmed the bottle did not have an expiration date.During an interview on 2/12/26 at 3:50 p.m., the consultant pharmacist (CP) stated all pharmaceutical grade medications and supplements had to have an expiration date. When a medication bottle like melatonin or vitamins did not have an expiration date it meant they were being treated as a food product or supplement. These products were not intended to be used as medications because they did not undergo the same quality control processes as pharmaceutical grade medications. The facility should not be administering melatonin without an expiration date; the melatonin should be replaced with pharmaceutical grade melatonin.On 2/12/26 at 4:13 p.m., the administrator reported the following quantities of melatonin 3 mg with manufacture date 6/2024, in each medication cart:1 [NAME] - 46 tabs in open bottle, 60 in unopened bottle1 East - 32 tabs in open bottle, 60 in unopened bottle2 [NAME] - 27 tabs2 East - 19 tabsA list of residents who (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	received floor stock melatonin 3 mg was also requested but not received.The facility policy Medication Storage in the Facility dated 6/2022, directed no expired medications will be administered to residents. The nurse will check the expiration date of each medication before administering it. Nursing staff should consult with the dispensing pharmacist for any questions related to medication expiration dates.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to serve food that remained at palatable temperatures through delivery of the food to the residents for 2 of 2 residents (R3, R61) reviewed for food quality concerns.Findings include:R3:R3's admission minimum data set (MDS) dated [DATE], identified intact cognition and diagnoses included methicillin susceptible staphylococcus aureus (MRSA, a type of bacterial infection causing infections which are resistant to many antibiotics) infection, acquired absence of right leg below the knee, infection and inflammatory reaction due to internal left knee prosthesis and rheumatoid arthritis. R3 was independent with eating and dependent for transfers.R3's care plan dated 10/17/24, identified a focus statement for alteration in nutritional status related to current increased caloric needs due to wound status and healing purposes and included interventions of assisting with set up of meals as needed, culinary director to consult as needed, record nutritional intakes per facility protocol, and R3 kept snacks in her room.R3's provider's order dated 2/5/26, identified an order for a two-gram sodium diet with regular texture and thin liquids.During an interview on 2/9/26 at 7:14 p.m., R3 stated the food was not hot when it gets to her, she had been told by dietary if she would eat in the dining room it would be warmer, but she did that once and it was only marginally warmer and added she didn't like going down there because it was a hassle for her. R3 added she had talked with management about her food concerns, and she has now joined the Food Committee. R61:R61's quarterly MDS dated [DATE], identified intact cognition and diagnoses of gastroesophageal reflux disorder (GERD), diabetes mellitus (DM), anemia, congestive heart failure (CHF), protein-calorie malnutrition, chronic kidney disease (CKD) stage 3. Section K identified no chewing or swallowing difficulty and unplanned weight loss. R61 was independent with eating.R61's care plan dated 11/26/25, identified a focus statement for potential alteration in nutrition related to altered diet texture or consistency but didn't contain a focus for swallowing difficulty.During an interview on 2/9/26 at 5:24 p.m., R61 was sitting in her recliner with her dinner tray in front of her on a tray table. R61 stated she didn't care for the food here, confirmed she normally ate her meals in her room, and stated the food was often not hot by the time it got to her.During observations and interviews on 2/11/26 at 11:40 a.m., the hot food for lunch was held in a steam table, the cook removed the covers and foil from the food and took temperatures of each item. Each meal was then placed on heated plates, which nested on an insulated base and an insulated cover over it. Each tray was loaded into a speed cart (a non-insulated metal box on wheels) for the residents on that cart's designated hallway. The order the carts went out was second-floor east side, first-floor east side, second-floor west side, second floor east side. At 11:53 a.m., the cart for first-floor east side was starting to be loaded with plated food. At 12:15 p.m., the cart reached the far end of the first-floor east hall, where R3 and R61 resided, the surveyor received a test tray and observed the chicken and green beans to be barely warm. Regional culinary director (RCD)-D tried a bite of the chicken breast and stated if it were any cooler he would not be happy with it. RCD-D stated his minimum temperature expectation would be 135 degrees; however, a thermometer wasn't immediately available, and he would need to go to the basement and get one. RCD-D further stated he wouldn't send it back at a restaurant, but it was at the low end of his expectations.During an interview on 2/11/26 at 12:49 p.m., R61is sitting in a chair in her room with her lunch tray on a tray table in front of her. R61 stated the chicken was barely warm.During an interview on 2/12/26 at 8:53 a.m., nursing assistant (NA)-A stated R61 did complain about the food a lot. NA-A explained she often gets her something else to eat, like the alternate meal or a peanut butter and jelly sandwich. NA-A was making R61 some new toast because what came up from the kitchen wasn't able to be cut by the resident.During an interview on 2/12/26 at 10:57 a.m., the dietary manager (DM)-E stated she thought food temperatures had come up from everybody here, if they could get them to eat in the dining room, the food would be served right off the steam table and would be hot. DM-E added they have tried things to keep the food hot, like not (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	letting the carts sit as long. During an interview on 2/12/26 at 2:35 p.m., the administrator stated residents could always ask to have their food heated up. The residents are welcome to come eat in the dining room where they would be served all at one time, that way they know they would immediately get a hot tray.A document, Menu or Food Committee Minutes dated December 25th, identified sometimes food was cold before it got to the end of the hall.

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure meals and snacks are served at times in accordance with resident?s needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times. Based on interview and record review, the facility failed to ensure residents were offered a substantial snack when there were more than 14 hours between the dinner and breakfast meals.Findings include:A facility-submitted document, dated 11/1/25, identified breakfast was from 7:45 a.m. to 8:15 a.m., lunch was from 11:45 a.m. to 12:15 p.m., and dinner was from 4:45 p.m. to 5:15 p.m.During an interview on 2/12/26 at 10:51 a.m., dietary manager (DM)-E stated she wasn't aware there were more than 14 hours between meals, and they did normally send snacks upstairs to be stocked on each floor around 3 p.m. and starting today they will be sending up diabetic snacks at around 6 p.m. The facility didn't have a process for ensuring residents were offered a substantial evening snack. A policy, Frequency of Meals dated 7/2017, identified the facility would serve at least three meals or their equivalent daily at scheduled times. There will not be more than a 14-hour span between the evening meal and breakfast. Meals would be served four to six hours apart to help assure that residents receive nutritional requirements. The following mealtimes have been established by our facility for residents, however the chart with breakfast, lunch and dinner is blank. A schedule of mealtimes and snacks will be posted in resident areas. Nourishing snacks will be available for residents who need or desire additional food between meals. Evening snacks will be offered routinely to all residents. Timing of the snack will consider relevant factors. Residents will also be offered nourishing snacks if the time span between the evening meal and the next day's breakfast exceed 14 hours. Nourishing snacks are items from the basic food groups, offered either separately or with each other. The facility will choose the snacks that are received at bedtime. However, the dietician and food services manager will solicit input from the residents and/or the resident council. An email from DM-E to the administrator titled Resident Food Council 1/29/26, identified the second floor said they don't have much for snacks at night and DM-E was concerned some individuals were getting multiple items and leaving nothing for the rest. DM-E identified she would encourage nursing to keep dry items behind the desk to distribute and felt it was necessary to begin snack pass delivery in the evening but didn't have the dietary staff to support that and asked if nursing could do a specific evening snack pass. Documents, Menu or Food Committee Minutes, identified the following: 1/9/26, identified more diabetic snacks for the second floor. 12/25/25, identified additional snacks as they get eaten up quickly. September 2025, identified diabetic snacks were being hoarded.

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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 was properly labeled and stored to prevent food-borne illness. In addition, the facility failed to ensure kitchen cleanliness was maintained in areas where food was prepared. These deficient practices had to potential to affect anyone who ate food prepared by the facility.Findings include:During an observation and interview on 2/9/26 at 11:45 a.m., dietary aide (DA)-A confirmed the commercially-prepared container of coleslaw was dated as opened on 1/21/26; a bag of shredded parmesan cheese was open but not labeled with an opened-on date; a commercially-prepared bag of diced onions was opened, folded, and saran wrapped without an opened-on date. DA-A stated opened food should say the date it was opened and how long it was shelf stable. The dietary manager (DM)-E stated those items should have been labeled when they were opened. DM-E confirmed a bag of cake mix had been opened and not secured or labeled. The DM-E stated that it should be labeled with the date opened and put in a sealable package. In the cook's refrigerator there was another container of prepared coleslaw opened without a date. The DM-E stated these items would be thrown out, and the risk of keeping food too long would be it could make you sick.During observations in the main kitchen on 2/11/26 at 11:15 a.m., in the room where the steam table and tray line were, the floor had areas of visible soil and foot traffic, visible with shoe prints, small brown and black dried spots on the floor. On the steam table, the inside of the glass nearest to the hot food, was covered with different color splatters and drips dried to it from one side to the other and the top to the bottom. On the serving side of the steam table where the cook stood there was a square pillar, with each of the four sides being about one foot wide, right up against the work surface of the steam table. The pillar was missing the corner guards so that dried glue and small pieces of missing sheetrock were exposed, and the side of the pillar adjacent to the cook was stained brownish-black colors from about hip to shoulder height. On top of the upper cabinets directly above the counter behind the steam table had a steel cleaning pad on top of it which was half hung over the edge of the cabinet above a counter used for food preparation. In the steam table room, there was an area where staff staged the beverages to go on the meal trays. Two ceiling tiles above this area had one-to-two-inch strips of peeling plastic along the edge of the tile. Next to the beverage area, there was an approximately four foot by five foot air-handling system about six inches off the floor, there was a four to five inch long one inch wide collection of hair and dust hanging on the bottom blowing in the wind.During an observation and interview on 2/12/26 at 12:37 p.m., the administrator stated maintenance looked at the kitchen at least weekly and as needed if someone noticed something. At the beverage station, the flaking ceiling tile had the loose pieces scraped off. The administrator stated the pillar didn't meet her expectations. MW-A stated he was aware the corner protectors were off the pillar, and he had repaired a leak in the ceiling where the peeling ceiling tiles were. During an interview on 2/12/26 at 10:45 a.m., DM-E stated she had a monthly, weekly and daily cleaning duties list. Mopping should be done every evening, and spot mopped as needed during the day, and she would not expect to have dust bunnies. The DM-E added her expectation was that the glass on the steam table was cleaned after every meal service and confirmed it didn't appear to have been cleaned after the last meal service.A policy, Food Receiving and Storage dated 10/2017, identified all foods stored in the refrigerator or freezer will be covered, labeled and dated by a use-by date. Other opened containers must be dated and sealed or covered during storage.A policy, Cleaning and Disinfection dated 09/2012, identified counter tops, work surfaces, hard surfaces, serving carts, cupboards, tabletops, walls, etc. would be wiped off with a damp cloth to remove food particles, sprayed with a disinfectant solution diluted to manufacturer recommendation until wet. Allow to remain wet 10 minutes to airdry. Tile floors would be swept, wet mopped with disinfectant solution using figure eight strokes and allowed to remain wet 10 minutes to air dry.

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review, the facility failed to ensure residents without an assessment and order to self-administer medications (SAM) were not left with prescription medications to take on their own for 1 of 1 resident (R61) reviewed for self-administration of medication.Findings include:R61's quarterly minimum data set (MDS) dated [DATE], identified intact cognition and diagnoses of gastroesophageal reflux disorder (GERD), diabetes mellitus (DM), anemia, congestive heart failure (CHF), protein-calorie malnutrition, chronic kidney disease (CKD) stage 3. R61's care plan dated 11/26/25, didn't contain a focus statement and interventions for SAM.R61'a provider orders effective 2/12/26, didn't contain an order for self-administration of any medication.During an observation on 2/12/26 at 8:51 a.m., R61 was setting up in bed eating with her tray table in front of her with her breakfast tray on it. There was a cup of pills on her tray, and R61 stated those pills were hers, she had to take them with her orange juice. No facility staff were present in the room.On 2/12/26 at 9:19 a.m., nursing assistant (NA)-A stated she knew how to care for the residents by looking at the care guide, which she demonstrated was in her pocket. NA-A looked at the instructions for R61 and stated there were no special instructions for eating. On 2/12/26 at 12:19 p.m., registered nurse (RN)-A stated she didn't know of R61 being someone approved for SAM, which she then verified in the medical record. RN-A stated she would expect there to be an assessment and order for SAM, the risk of having her self-administer would be whether or not she actually took the medication.During an interview on 2/12/26 at 3:24 p.m., the director of nursing (DON) stated she would expect only residents with SAM, assessed and doctor-ordered, to be taking their medications on their own.A policy, Self-Administration of Medications dated 2/2024, identified as part of the evaluation comprehensive assessment, the interdisciplinary team (IDT) assesses each resident's cognitive and physical abilities to determine whether self-administering medications is safe and clinically appropriate for the resident. If it is deemed safe and appropriate for a resident to self-administer medications, this is documented in the medical record and the care plan. The decision that a resident can safely self-administer medications is reassessed periodically based on changes in the resident's medical and/or decision-making status.

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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, interviews and document review the facility failed to ensure diabetic snacks were provided to 2 of 2 residents (R7, R57) reviewed for food service. Findings include:R7:R7's quarterly Minimum Data Set (MDS) dated [DATE], identified R7 had diagnoses which included diabetes mellitus, depression and anxiety. In addition, R7 was cognitively intact.R7's current order summary report dated 2/12/26, identified the following orders:-provide a snack at bedtime Deli sandwich dated 1/18/22-consistent carbohydrate diet dated 1/3/25-blood sugar checks before meals and at bedtime dated 3/18/25-continuous blood glucose sensor - freestyle libre sensor system dated 12/29/23-monitor for signs and symptoms of hyper/hypoglycemia including but not limited to lethargy, sweating, weakness, confusion, pale, vomiting and excessive thirst dated 9/5/25-one carton boost glucose control or Glucerna as needed twice daily as desired dated 1/14/26-Lantus 100 units per milliliters inject 48 units in the morning dated 12/30/25-metformin 500 milligrams by mouth two times a day dated 9/15/25-Ozempic 2 milligrams every dayshift on Wednesday dated 10/1/25R7's care plan dated 11/30/21, identified he had a potential for alterations in blood sugar related to diagnosis of diabetes. Interventions included to encourage diabetic bedtime snack.R57:R57's quarterly Minimum Data Set (MDS) dated [DATE], identified R57 had diagnoses which included iron deficiency anemia, diabetes mellitus and depression. In addition, R57 was cognitively intact.R57's current order summary report dated 2/12/26, identified the following orders:-consistent carbohydrate diet dated 7/21/25-blood sugars before meals and at bedtime for diabetes mellitus dated 7/21/25-monitor for signs and symptoms of hyper/hypoglycemia including but not limited to lethargy, sweating, weakness, confusion, pale, vomiting and excessive thirst dated 7/21/25-Humalog insulin 6 units subcutaneously with meals for type 1 diabetes mellitus dated 11/19/25-Humalog insulin subcutaneously sliding scale for type 1 diabetes mellitus dated 12/22/25-Lantus 26 units subcutaneously at bedtime for type 1 diabetes mellitus dated 8/13/25R57's care plan dated 8/26/25, identified he had a potential for alterations in blood sugar related to diagnosis of diabetes. Interventions included to encourage diabetic bedtime snack.A review of R57's evening meal ticket dated 2/12/26, did not have any information regarding a bedtime snack.A review of the facility's food council notes revealed the following:1/29/26, Residents stated they did not have much for snacks at night. The notes identified there were not any dietary staff to pass an evening snack.11/25/25 and 9/25/25, residents identified they would like more fresh fruit.On 2/10/26 at 1:39 p.m., with nursing assistant (NA)-D a review of snacks available in the first-floor dining room was conducted. NA-D opened the refrigerator, NA-D verified there were not any sandwiches available for snacks. They did, however, point out the bread on the counter and jelly packets.On 2/10/26 at 1:45 p.m., with licensed practical nurse (LPN)-B a review of snacks available in the second-floor dining room was conducted. LPN-B stated the key to the refrigerator was kept in the nurse's office which was locked, the freezer had ice cream available, the refrigerator had juices but no sandwiches. There was however bread, jelly, and a jar of peanut butter on the counter. LPN-B stated there was not often any meat or cheese in the refrigerator to make sandwiches and stated after 7:00 p.m., there was no one in the kitchen to make a sandwich for residents.On 2/10/26 at 2:02 p.m., a tour of both dining room refrigerator was conducted with dietary manager (DM)-E, there were not any sandwiches in the refrigerators. DM-E stated sometimes there were sandwiches, she also stated sandwiches would need to be requested prior to 7:00 p.m., because that was when the kitchen staff left for the day. DM-E verified there was not any sugar free Jello or puddings for diabetic residents.On 2/10/26 at 2:29 p.m., cook-A arrived at the nursing unit, she stated she was told to come up and check the refrigerators. C-A stated she did not usually do the re-stock which would include juices, med pass (a nutritional drink), fresh fruit. C-A stated meat and cheese was not part of the re-stock for the dining room refrigerators.On 2/11/26 at 12:29 p.m., a tour of the available snacks on the second floor identified the following snacks: (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	applesauce, Jello, pudding, popcorn, [NAME] buddy, peanut butter crackers, and graham crackers.On 2/11/16 at 12:46 p.m., a tour of the available snacks on the first floor identified the following snacks: unsweetened applesauce, peanut butter and crackers, oatmeal creme cookies, graham crackers, [NAME] cookies, [NAME] buddy.During an interview on 2/9/26 at 1:55 p.m., R57 stated he did not think he was getting a diabetic diet, stated too many carbs (carbohydrates).During an interview on 2/9/26 at 4:47 p.m., R7 stated there were not sandwiches in the refrigerator for a bedtime snack, then stated if there were sandwiches, they only had one slice of meat and one slice of cheese, R7 further stated there were no snacks for diabetic residents.On 2/10/26 at 1:55 p.m., DM-E verified the snacks available on the nursing units were chips, granola bars, Jello pudding, cookies, cake. DM-E stated there were also cheese sticks, lunch meat, and cheese. When the refrigerators were checked there were no cheese sticks, lunch meat or cheese.During an interview on 2/10/26 at 2:28 p.m., nursing assistant (NA)-G stated sometimes there was meat and cheese to make a sandwich, rarely fresh fruit, said there used to be carrots and celery but not in the last couple of months.During an interview on 2/10/26 at 2:34 p.m., NA-E stated the refrigerators rarely had fresh fruit, celery, carrots, or meat and cheese available for residents.During an interview on 2/11/26 at 12:01 p.m., NA-C stated sometimes they would see an extra sandwich on the evening meal tray wrapped up. NA-C stated they should put the sandwich in the refrigerator, but they didn't. NA-C stated they didn't have meat and cheese to make an evening snack, just peanut butter and jelly.During an interview on 2/11/26 at 12:02 p.m., NA-F stated they had not seen any extra sandwiches come up from the kitchen on the evening meal pass.During an interview on 2/11/26 at 12:03 p.m., R7 stated there was never an extra sandwich on his meal tray at dinner time for his bedtime snack.During an interview on 2/11/26 at 12:46 p.m., registered nurse (RN)-A stated if the kitchen sent up a diabetic snack on the evening meal tray the residents would eat it right away. RN-A stated the kitchen was supposed to send up meat and cheese so staff could make a sandwich but stated this was not consistently occurring.During an interview on 2/12/26 at 12:58 p.m., RN-A described a diabetic snack as a sandwich, fruits, vegetables, food low in sugar. RN-A verified R57's care plan directed staff to encourage R57 to eat a diabetic snack. RN-A verified there was not a snack cart that was taken room to room at bedtime.During an interview on 2/12/26 at 3:51 p.m., the director of nursing (DON) stated a diabetic snack would be fruit, vegetables, and maybe a meat and cheese sandwich. The DON stated if a diabetic snack was ordered she would expect the resident to receive the diabetic snack as ordered. The DON stated it was important for residents with diabetes to get a bedtime snack to help keep their blood sugars stable.A policy on Physician Orders was requested but not provided.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245483	A. Building B. Wing	02/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The North Shore Estates LLC	7700 Grand Avenue Duluth, MN 55807

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure provider-ordered interventions were in place for safe swallowing for 1 of 3 residents (R61) reviewed for accident hazards.Findings include:R61's quarterly minimum data set (MDS) dated [DATE], identified intact cognition and diagnoses of gastroesophageal reflux disorder (GERD), diabetes mellitus (DM), anemia, congestive heart failure (CHF), protein-calorie malnutrition, chronic kidney disease (CKD) stage 3. Section K identified no chewing or swallowing difficulty and unplanned weight loss. R61 was independent with eating.R61's care plan dated 11/26/25, identified a focus statement for potential alteration in nutrition related to altered diet texture or consistency but didn't contain a focus for swallowing difficulty or interventions with instructions for eating and drinking.R61's provider order dated 9/5/25, identified an order for feeding details: regular thin liquids, alternate sips and bites, small single sips and bites, oral care after all oral intake, upright for 30 to 60 minutes following all oral intake, effort swallow and medications as tolerated. On 9/30/25, upright 90 degrees during oral intake, alternate sips and bites, offer small single sips and bites, and an order for a regular diet with regular texture and thin liquids.A hospital Discharge summary dated [DATE], identified an admission diagnosis of aspiration pneumonia (an infection caused from inhaling food, fluid or vomitus) of both lower lobes.During an observation on 2/10/26 at 12:58 p.m., R61 was sitting in her recliner in her room with a tray table and meal tray in front of her. R61 stated she ate the garlic toast, but the crusts were too tough for her to chew. R61 stated staff bring her the tray and then come back to get it when she is done, no one checks back with her. There were no facility staff in the room.During an observation on 2/11/26 at 12:49 p.m., R61 was sitting in her recliner in her room with a tray table and meal tray in front of her today. She was eating a salad with dressing, and a chicken breast with no sauce or gravy. There were no facility staff in the room with her. During an observation on 2/12/26 at 8:51 a.m., R61 was sitting in her bed with the head of the bed up at about 20 degrees, she had her tray table set up over her bed with a breakfast tray on it. R61 had a full glass of orange juice and half-eaten bowl of hot cereal and stated she had the girl make her more toast because hers was so hard she couldn't cut it. During an interview on 2/12/26 at 9:19 a.m., nursing assistant (NA)-A stated she knew how to care for the residents by looking at the care guide, which she demonstrated was in her pocket. NA-A looked at the instructions for R61 and stated there were no special instructions for eating. NA-A was in the first-floor kitchenette making toast for R61 because what she got from the kitchen wasn't cuttable. During an interview on 2/12/26 at 12:19 p.m., registered nurse (RN)-A confirmed feeding instructions in R61'a provider orders, RN-A stated she would expect the orders to be followed; the risk for R61 could be choking and aspiration. During an interview on 2/12/26 at 3:24 p.m., the director of nursing (DON) stated her expectation would be to follow the orders, or if the resident was having a hard time with the instructions to provide education and have a new speech evaluation to see if the interventions were still appropriate for them. The DON stated the risk for R61 could be aspiration.