STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245491	A. Building B. Wing	05/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Moose Lake Village	710 South Kenwood Avenue Moose Lake, MN 55767

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 0568 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Properly hold, secure, and manage each resident's personal money which is deposited with the nursing home. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42587 Based on interview and document review, the facility failed to provide a financial statement to 1 of 2 residents (R4) who had requested to receive a quarterly statement of their personal funds account. Findings include: R4's annual Minimum data Set (MDS) dated [DATE], identified R4 was cognitively intact. During an interview on 5/12/25 at 3:27 p.m., R4 stated she had a personal trust account but was not getting any statements. R4 stated she was not sure how much money she had in the account. During an interview on 5/14/25 at 1:46 p.m., business office manager (BOM)-F verified R4 had a personal trust account and identified the statements were going to her old home address. BOM-F verified R4 should have been receiving her statements. During an interview on 5/14/25 at 2:12 p.m., the administrator verified the facility should follow the procedure in their policy. During a phone interview on 5/14/25 at 2:27 p.m., the corporate associate vice president of revenue cycle management verified R4's statement should have been going to R4 and not to her former home address. The Trust fund policy and forms dated 11/15/24, identified the resident or financially responsible person would receive quarterly statements detailing deposits, withdrawals and interest earned.

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 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** 47263 Based on observation, interview, and record review the facility failed to identify and update the care plan with resident specific fall prevention interventions for 1 of 2 residents (R49) reviewed for multiple falls at the facility. Findings include: R49's admission Minimum Data Set (MDS) dated [DATE], indicated R49 was cognitively intact. R49's Resident Profile dated 5/15/25, included diagnoses of osteomyelitis, pain, chronic respiratory failure, congestive heart failure, diabetes type II, repeated falls, muscle weakness, unsteadiness on feet, and unspecified abnormalities of gait and mobility. R49's Care plan dated 3/27/25 to 5/15/25, included the following: Resident needs assistance with ADL's, start date 3/27/25 ---Dressing: staff to provide assist of one for dressing. ---Toileting: staff to provide assist of one with toileting. ---Transfers: -----assist of 1 for transfers using a gait belt and hemi-walker (edited 4/7/25, from mod I) -----provide limited/extensive assist of one with walker for transfers. Cue before and after transfer (initiated 3/27/25) Falls, start date 3/27/25 ---follow toileting and repositioning schedule ---gripper socks or non-skid footwear ---monitor and assess if fall occurs, document circumstances/possible cause and notify MD and family ---monitor for medication side effects ---observe and meet resident needs ---OT and PT to treat Behaviors, start date 3/27/25 (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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	---resident does not exhibit adverse behavior symptoms R49's care plan showed the facility had changed R49's transfer assistance level to assist of one after R49's fall on 4/7/25. The care plan lacked evidence to show the facility had modified or implemented fall prevention interventions after review of 5 other falls that occurred at the facility between 4/2/25 and 5/8/25. Event Reports for falls at the facility included: 4/2/25 unwitnessed fall resident found on floor. Fall occurred in bathroom 4/7/25 unwitnessed fall, resident found on floor in bathroom. Nursing note indicated R49 was sent to the emergency room to rule out shoulder dislocation/fracture. IDT review indicated R49 had fractured their clavicle bone and R49 was down graded from mod I in room per therapies. 4/16/25 unwitnessed fall in resident room, Nurse note indicated R49 was found on floor in front of recliner. R49 indicated they had been attempting to pull pants up and lost their balance. Call light was on, R49 did not have slipper socks on. 4/17/25: witnessed fall resident lowered to the floor Nursing Note: indicated resident was in recliner with feet resting on their wheelchair. Resident had slipped down between recliner and wheelchair and staff were not able to reposition resident back to chair, so resident was lowered to the floor. 4/19/25: witnessed fall in resident room, resident lowered to floor with staff assistance during transfer 5/8/25: unwitnessed fall in resident bathroom. Nurse note indicated R49's call light was ringing and R49 was found sitting on the floor between the toilet and their wheelchair. R49 stated they lost their balance and bumped their head. Small, raised area on crown noted. During an interview on 5/14/25 at 1:46 p.m., R49 stated when they were in their room, they moved themselves between their wheelchair and bed, recliner and wheelchair and their wheel chair and toilet. However, if they had urgency to go, they called staff for help because when they rushed, they sometimes lost their balance. R49 stated they didn't think staff seemed to be concerned if they moved themselves from their chair to the wheelchair or if they went to the bathroom on their own. During an interview on 5/15/25 at 8:30 a.m., R49 stated they had therapy at 9:00 a.m., so they were going to get dressed and ready for therapy. R49 stated staff did not come in each morning and offer to assist her to the bathroom or with dressing, they got themselves to the bathroom and dressed on their own. During an interview on 5/15/25 at 8:33 a.m., nursing assistant (NA-A) stated R49 was independent with dressing and transfers. NA stated they got information on how residents transferred and dressed etc. during shift report from the off going shift. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/15/25 at 10:57 a.m., licensed practical nurse (LPN-A) stated if they noticed a resident was starting to transfer themselves, they would bring that forward to physical therapy (PT) and occupational therapy (OT) so they could re-evaluate the resident's transfer status and either advance them, or confirm they still needed assistance for transfers. R49 did try to transfer themselves on their own, because R49 wanted to be independent, however R49 knew they required assistance for transfers. Due to falls, R49 was moved closer to the nursing station. LPN-A stated when they went into R49's room, they educated R49 on calling for help for transfers and encouraged R49 to leave their door open for safety. During an interview on 5/15/25 at 12:38 p.m., the physical therapist assistant (PTA) stated R49 still required stand by assist for transfers. R49 should not be transferring themselves alone. The PTA indicated they had tried ambulating R49 without their oxygen on, but R49's had not tolerated it well, their oxygen saturation had dropped. The PTA stated R49 had been on oxygen for years, and based on observation, the PTA felt R49 was very aware of the positioning of their oxygen tubing. The occupational therapist (OT) stated agreement with PTA, and said R49 was very aware of their oxygen tubing when they worked on transfers with R49. The OT also confirmed R49 should not transfer alone and explained R49 should also have standby to minimum assist with dressing and toileting. During an interview on 5/15/25 at 3:51 p.m., NA-B stated R49 did everything on their own and indicated if R40 needed help they would put their call light on, but otherwise R49 was doing everything by themselves for transfers and dressing. During an interview on 5/15/25 at 3:04 p.m. registered nurse (RN-A) stated all staff should know how a resident transfers. The transfer status is in the care plan and is also handed off at shift report. For short term rehabilitation residents if OT or PT updated a transfer status the change would get posted for staff to see and then it would also get updated in the care plan. Each resident fall is reviewed by the interdisciplinary team. The team reviews the fall and looks at what interventions can be implemented to prevent falls from happening again. Therapy may be involved too. After, the care plan should be updated, for instances if anti roll backs are added to the wheelchair, that would get updated on the care plan. RN-A indicated interventions didn't necessarily have to go in the care plan. When reviewing R49's care plan, RN-A stated they had reviewed R49's care plan after each of R49's fall, but they hadn't marked it as reviewed. They normally just marked reviewed when changes were made to the care plan that staff needed to know about. For instance, R49 was moved closer to the desk after their fall on 4/16/25, but that was not put in the care plan. RN-A reviewed the EMR documentation for each of R49's six falls and confirmed R49 had had four unwitnessed falls related to self-transferring, three of which occurred in the bathroom, with one resulting in a collar bone fracture. RN-A stated they had changed R49's transfer status in the care plan from modified independence, to assist of one after the fall on 4/7/25. The IDT team had not identified any other fall prevention interventions to add to R49's care plan after they had reviewed each fall. There were other interventions not on the care plan. RN-A stated they could have added interventions to round on R49 more frequently and/or added interventions to address toileting needs to help prevent falls in the bathroom. RN-A indicated the IDT usually did look at bowel and bladder to see how the toileting schedule could be modified to prevent falls. It is possible our short-term staff may not know the transfer status of a resident but they should be checking the care plan. We need to have a process in place to make sure staff know when residents need transfer assistance. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/15/25 at 4:13 p.m., the director of nursing stated staff need to follow the care plan and indicated R49's care identified R49 required assistance for transfers. Each fall gets reviewed by the IDT team. The fall is discussed, possible contributing factors are identified and reviewed, the resident and staff involved may be interviewed for additional information. We would then determine appropriate actions were taken or do further actions to prevent future falls. R49 prefers to be independent and does not accept help very well. As an intervention R49 was moved closer to the desk. R49's transfer status was modified on 4/7/25, after R49's fall that resulted in a broken collar bone. The DON confirmed no other modification or fall prevention interventions had been added to R49's care plan after subsequent falls. The DON reviewed R49's EMR fall documentation and stated the facility had done interventions, but they were not things that the DON would put in the care plan. During a follow-up interview at 5/15/25 at 4:49 p.m., the DON stated they had reviewed R49's care plan and indicated they did not feel any additional fall prevention interventions should have been added to R49's care plan, however R49's self-transfer behaviors should have been added to the care plan under behaviors. The facility policy Fall assessment and managing fall risk dated 11/6/23, included the following: --residents are assessed for fall upon admit, quarterly, with significant changes and as needed --fall risk and appropriate interventions to minimize the risk of falls/injury from falls are included in the care plan --each fall is investigated as soon as possible --based on fall review, interventions in the care plan are updated as indicated --interventions to reduce/prevent falls are reviewed with the resident and representative The facility policy Care plan and baseline care plan dated 10/14/25, included the following: --the interdisciplinary team in conjunction with the resident and their support people will develop a comprehensive person-centered care plan for each resident --the resident care plan is constantly changing. It is to be updated routinely to reflect the resident's current condition.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 48109 Based on observation, interview and document review, the facility failed to ensure hot water temperatures were at safe temperatures at point-of-use for 27 of 27 residents who resided on the 200 hallway and the specialty care unit. In addition, the facility failed to ensure staff provided adequate supervision for transfers and activities of daily living for 2 of 2 residents (R49 and R40) and the facility further failed to follow the care plan related to transferring for the prevention of falls for 3 of 5 (R49, R40, R44) residents at risk for falls. Findings include: During a resident screening on 5/13/25 at 10:19 a.m., the hot water in bathroom of R34 felt very hot to touch after running the hot water for a couple of minutes. R34 stated the water takes a while to get hot, but then it gets very hot, and she had to blend it with cold water to use it. R34 stated she and nursing assistants (NA)s had talked about it before. During an observation and interview on 5/14/25 at 2:17 p.m., maintenance worker (MW)-A, who identified as the director of maintenance, ran the hot water in R34's room and used a thermometer to measure the temperature at 134 degrees Fahrenheit (F). MW-A stated that was too hot and he felt 105 to 110 degrees F seemed to be a good spot for the hot water, but MW-A wasn't sure what the upper limit of the hot water should be. During an interview on 5/14/25 at 2:41 p.m., MW-A reported the blender valve that feeds the 200 hallway and specialty care unit was showing the temperature as 110 degrees, so it must not be working. At 2:50 p.m., room [ROOM NUMBER]'s hot water measured 129 degrees F; the dirty utility room across the hall from room [ROOM NUMBER] had hot water temperatures of 131 degrees F; the handwashing sink in the common area of the specialty care unit measured 127 degrees F. MW-A stated he had called a contractor to come take a look at it as soon as possible, and he turned down the blender valve 10 degrees F. At 3:10 p.m., the administrator stated all of the alert residents, and all of the staff had been updated on not using the tubs until they can consistently hold the temperatures below 120 degrees. MW-A stated he would continue to take the water temperature to ensure it got below 120 degrees. During an interview on 5/15/25 at 8:23 a.m., trained medication aid (TMA)-A stated she had started her shift at 3 a.m. this morning and had taken hot water temperatures in all the resident rooms and common areas and reported the temperatures were as low as 110 and up to 120 degrees F. A review of facility-submitted Monthly Water Temperature Chart for 2/7/25 revealed the following temperatures (recorded in degrees F): room [ROOM NUMBER] was 128 room [ROOM NUMBER] was 130 room [ROOM NUMBER] was 126 (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	room [ROOM NUMBER] was 126 room [ROOM NUMBER] was 126 North nursing station sink was 130 West nursing station sink was 130 The kitchen sink in the specialty cares unit was 130 A review of the facility-submitted Event Summary Reports from 5/13/24 to 5/14/25 revealed no burn incidents. During an interview on 5/15/25 at 4:13 p.m., the administrator stated hot water temperature was taken monthly and recorded on the Monthly Water Temperature Chart. This would be done by MW-A or he may have delegated to another maintenance worker, but MW-A should be the one who reviewed the temperatures. The administrator stated she wasn't aware there had been temperatures above 120 degrees F in the past months, and unless there was an issue she wouldn't necessarily look through the temperature logs. She would expect it to be brought to her attention if there were temperatures above 120 degrees F. During an interview on 5/15/25 at 4:33 p.m., MW-A confirmed he was responsible for taking hot water temperatures monthly, if there were an instance where he was gone the other maintenance worker would take them. MW-A stated he noticed the temperatures creeped up a little bit in February, but it wasn't too extreme, and he speculated maybe they had been adjusting things. MW-A stated making sure the water wasn't too hot was important because it could mean hazards and burns. MW-A further stated he had continued to monitor the hot water temperatures, and they were coming in consistently under 120 degrees F and the new mixing valve had been ordered. He stated he would continue to monitor the temperatures until the valve was replaced. A policy, Preventative Maintenance Program SNF and AL dated 2/5/25, identified all Cassia sites shall have a standard preventative maintenance program that includes safety rounds, inspections and audits of all areas to maintain a safe, clean and well-maintained environment. This preventative maintenance program will also include a systematic method for reporting repairs and on-going mitigation of all safety risks. Maintenance tasks will be conducted as part of a systematic program to meet all local, state and federal regulations and additional Cassia standards of practice for building/grounds code compliance and general maintenance. The audit procedures didn't contain a line item for testing hot water. 47263 R49: R49's admission Minimum Data Set (MDS) dated [DATE], indicated R49 was cognitively intact. R49's Resident Profile dated 5/15/25, included diagnoses of osteomyelitis, pain, chronic respiratory failure, congestive heart failure, diabetes type II, repeated falls, muscle weakness, unsteadiness on feet, and unspecified abnormalities of gait and mobility. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R49's Care plan dated 3/27/25 to 5/15/25, included the following: Resident needs assistance with ADL's, start date 3/27/25 ---Dressing: staff to provide assist of one for dressing. ---Toileting: staff to provide assist of one with toileting. ---Transfers: -----assist of 1 for transfers using a gait belt and hemi-walker (edited 4/7/25, from mod I) -----provide limited/extensive assist of one with walker for transfers. Cue before and after transfer (initiated 3/27/25) Falls, start date 3/27/25 ---follow toileting and repositioning schedule ---gripper socks or non-skid footwear ---monitor and assess if fall occurs, document circumstances/possible cause and notify MD and family ---monitor for medication side effects ---observe and meet resident needs ---OT and PT to treat Behaviors, start date 3/27/25 ---resident does not exhibit adverse behavior symptoms R49's Event Reports for falls at the facility indicated R49 had sustained 6 falls at the facility between the dates of 4/2/25 and 5/8/25. noted. During an interview on 5/14/25 at 1:46 p.m., R49 stated when they were in their room, they moved themselves between their wheelchair and bed, recliner and wheelchair and their wheelchair and toilet. However, if they had urgency to go, they called staff for help because when they rushed, they sometimes lost their balance. R49 stated they didn't think staff seemed to be concerned if they moved themselves from their chair to the wheelchair or if they went to the bathroom on their own. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 5/15/25 at 8:30 a.m., R49 stated they had therapy at 9:00 a.m., so they were going to get dressed and ready for therapy. R49 stated staff did not come in each morning and offer to assist her to the bathroom or with dressing, they got themselves to the bathroom and dressed on their own. During an interview on 5/15/25 at 8:33 a.m., nursing assistant (NA-A) stated R49 was independent with dressing and transfers. NA stated they got information on how residents transferred and dressed etc. during shift report from the off going shift. During an interview on 5/15/25 at 10:57 a.m., licensed practical nurse (LPN-A) stated if they noticed a resident was starting to transfer themselves, they would bring that forward to physical therapy (PT) and occupational therapy (OT) so they could re-evaluate the resident's transfer status and either advance them, or confirm they still needed assistance for transfers. R49 did try to transfer themselves on their own, because R49 wanted to be independent, however R49 knew they required assistance for transfers. Due to falls, R49 was moved closer to the nursing station. LPN-A stated when they went into R49's room, they educated R49 on calling for help for transfers and encouraged R49 to leave their door open for safety. During an interview on 5/15/25 at 12:38 p.m., the physical therapist assistant (PTA) stated R49 still require stand by assist for transfers. R49 should not be transferring themselves alone. The occupational therapist (OT) stated R49 should not transfer alone and explained R49 should also have standby to minimum assist with dressing and toileting. During an interview on 5/15/25 at 3:51 p.m., NA-B stated R49 did everything on their own and indicated if R40 needed help they would put their call light on, but otherwise R49 was doing everything by themselves for transfers and dressing. R40: R40's admission MDS dated [DATE], indicated R40 was cognitively intact. R40's Resident Profile dated 5/15/25, included diagnoses of unspecified fracture of upper end of right tibia, anemia, history of falling, repeated falls, weakness, unsteadiness on feet, and abnormalities in gait and mobility. R49's Care plan dated 3/29/25 to 5/15/25, included the following: Resident needs assistance with ADL's, start date 3/29/25 ---Resident to ambulate with therapy only --- Bed mobility: Assist of one ---Eating: Resident does require assist with setup ---Grooming: staff to provide 1 assist with grooming. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	---Oral care: staff to provide 1 assist with oral care ---Dressing: staff to provide assist of one for dressing. ---Toileting: staff to provide assist of one with toileting. ---Transfers: Cue resident before/during, assist of 1 stand pivot using gait belt grab bars and w/c arm rest. Falls, start date 3/29/25 ---follow toileting and repositioning schedule ---gripper socks or non-skid footwear ---monitor and assess if fall occurs, document circumstances/possible cause and notify MD and family ---monitor for medication side effects ---observe and meet resident needs ---OT and PT to treat Behaviors, start date 3/29/25 ---resident does not exhibit adverse behavior symptoms During an interview on 5/12/25 at 3:39 p.m., R40 was wheeling self out of bathroom and indicated they had just finished using the restroom. R40 pointed to the transfer belt on the counter and stated therapy staff used the transfer belt but only one out of ten staff used it when they helped with transfers. R40 stated they had not had a fall at the facility and indicated they transferred themselves in the bathroom even though they had been told to call for help. During an interview on 5/15/25 at 8:33 a.m., NA-A stated R40 was independent with dressing and transfers. NA stated they got information on how residents transferred and dressed etc. during shift report from the off going shift. During an interview on 5/15/25 9:24 a.m., R40 stated they had washed and dressed themselves this morning, staff did not come in and help with getting dressed. R40 stated they had transferred themselves this morning. During an interview on 5/15/25 at 10:36 a.m., NA-C confirmed they were working on the transitional care unit (TCU). NA-C explained the residents on the TCU typically needed less assistance. NA-C stated they hadn't had to assist R40 with anything this a.m. They were not sure if R40 needed assistance with transfers/cares, but they could find that information in R40's care plan if they needed it. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 5/15/25 at 10:57 a.m., licensed practical nurse LPN-A stated R40 was an assist of one for transfers. R40 called when they needed assistance for transfers. During an interview on 5/15/25 at 12:38 p.m., with PTA and OT, PTA stated R40 had not been approved for self-transfers yet. The OT stated R40 required stand by assist with dressing. During an interview on 5/15/25 at 3:51 p.m., NA-B stated R40 needed partial assistance with stand pivot transfers but could dress self. NA-B stated they always used a transfer belt when they transferred residents. During an interview on 5/15/25 at 3:04 p.m., registered nurse (RN-A) stated R49 and R40 were not independent with transfers and could call for assistance. RN-A indicated all staff should know how a resident transferred. The transfer status was in the care plan and also got handed off at shift report. For TCU residents if OT or PT updated a transfer status the change would get posted for staff to see and then it would also get updated in the care plan. It is possible our short-term staff may not know the transfer status of a resident; they should be checking and following the care plan. We need to have a process in place to make sure staff know when residents need transfer assistance. During an interview on 5/15/25 at 4:13 p.m., the director of nursing (DON) stated R49 and R40 were not independent with transfers, and indicated they expected staff to follow the care plan for patient transfer status and activities of daily living. The facility policy Fall assessment and managing fall risk dated 11/6/23, included the following: --residents are assessed for fall upon admit, quarterly, with significant changes and as needed --fall risk and appropriate interventions to minimize the risk of falls/injury from falls are included in the care plan --based on fall review, interventions in the care plan are updated as indicated --interventions to reduce/prevent falls are reviewed with the resident and representative The facility policy Care plan and baseline care plan dated 10/14/25, included the following: --the interdisciplinary team in conjunction with the resident and their support people will develop a comprehensive person-centered care plan for each resident --the resident care plan is constantly changing. It is to be updated routinely to reflect the resident's current condition R44: R44's quarterly Minimum Data Set (MDS) dated [DATE], identified R44 was cognitively intact and had no behaviors or refusals of care. In addition, R44's MDS identified R44 had a diagnosis of paraplegia (a condition characterized by paralysis of the lower body typically the legs), schizophrenia, and neurogenic bladder (condition that causes loss of bladder control due to nerve, spinal cord, or brain issue). (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R44's Care area assessment (CAA) dated 8/11/24, identified R44 had the following risk factors for falls: psychotropic medication use, cognitive impairment related to schizophrenia, bowel incontinence, and presence of a foley catheter. R44's care plan dated 2/6/23, identified R44 required assistance with transfers and ambulation due to falls risk. Interventions included an assist of one staff for pivot transfers with a gait belt. R44's fall risk assessment dated [DATE], identified R44 was a moderate risk for falls related to toxic encephalopathy, cramp and spasms, pain, use of antipsychotic and antidepressant medications, Foley catheter. Last fall was 11/24/24. During an observation on 5/14/25 at 7:02 a.m., nursing assistant (NA)-D assisted R44 to the side of the bed, brought the wheel chair close to the bed locked the brakes on the wheel chair assisted R44 to stand, pulled up his pants and transferred R44 to the wheel chair. The gait belt was on the bedside table but was not used during the transfer. During an interview on 5/14/25 at 7:23 a.m., NA-D stated interventions for transfer did not include a transfer belt only needed to have him stand and pivot and needed to remind him to stand tall. During an interview on 5/15/25 at 10:30 a.m., licensed practical nurse (LPN)-A verified R44 could be transferred with the assist of one staff and a transfer belt needed to be used. During an interview on 5/15/25 at 11:05 a.m., the director of nursing (DON) verified staff should follow the care plan and use a transfer belt for safety with transfers as identified in care plans. Fall assessment and managing fall risk dated 11/6/23, identified Transfer/gait belt use is required during any transfer or ambulation where the resident needs stand by or higher level of assistance during transfers or ambulation.

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48109 Based on interview and document review, the facility failed to assess post-traumatic stress disorder (PTSD) symptoms and triggers and carry them forward to the care plan for 1 of 1 resident (R19) reviewed for trauma informed care. Findings include: R19's admission Minimum Data Set (MDS) dated [DATE], identified intact cognition and diagnoses of anxiety, major depressive disorder, psychotic disorder, PTSD, frontotemporal neurocognitive disorder, severe dementia with agitation, delusional disorder, and paranoid delusions. The MDS also identified R19 had hallucinations, delusions, verbal behavior toward others, and had behavior which significantly disrupted the living environment. R19's care plan dated 2/11/25, identified a problem statement for trauma-informed care related to a history of trauma of physical abuse as a minor from alcoholic parents including being tied up by the arms and legs to a bed, having socks placed in her mouth due to screaming, and was burned with cigarettes. The goal for R19 was for care provided to mitigate the risk of re-traumatization. The intervention on 2/11/25 was that R19 was fine with both male and female caregivers. Other problem statements related to behavior, psychotropic medication use, and mood state did not contain triggers or symptoms for PTSD. R19's electronic medical record (EMR) didn't contain an assessment of PTSD symptoms or triggers. During an interview on 5/15/25 at 9:49 a.m., social services designee (SSD)-A stated the facility didn't have a specific assessment for PTSD, it was screened for when a person was admitted by reading their history and diagnoses. SSD-A added she also would ask the resident on admission if there was anyone they didn't want to contact them, or if they had had any trauma. R19's daughter had talked with SSD-A about R19's history of abuse and learned one thing not to do would be to make her feel confined, so something she wouldn't like would be when you closed a door on her. SSD-A reviewed R19's care plan and confirmed this wasn't an intervention on her care plan, nor did the care plan indicate what may trigger her PTSD, and that would be helpful to put on there. SSD-A stated she had verbally talked with the staff about not closing doors on her. During an interview on 5/15/25 at 10:21 a.m., nursing assistant (NA)-E confirmed she worked in the specialty care unit and was familiar with R19. She stated approach was important for R19, and she would tell you who she liked and didn't like, and that you can't try to correct her. NA-E stated she was aware of R19's PTSD diagnosis, but wasn't aware of triggers, just knew she was abused by her parents. NA-E stated she would look in the care plan or ask social services if she had questions. During an interview on 5/15/25 at 10:25 a.m., trained medication aid (TMA)-A confirmed she worked in the specialty care unit and was familiar with R19. TMA-A stated she was aware of R19's PTSD, and knew R19 can't feel trapped. TMA-A provided an example where R19 wheeled her wheelchair backwards into a corner of the hallway and started to freak out because she thought she was stuck. TMA-A added it was important for staff not to close her bedroom door, R19 herself could close it, but staff could not. TMA-A stated she knew these things about R19 from word of mouth. (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/15/25 at 3:57 p.m., the director of nursing (DON) stated they didn't have a PTSD assessment, but they did do a psychosocial history where abuse was asked about. The DON stated R19's PTSD interventions fell under psychotropic medications and/or mood and behavior on the care plan because it got complicated. A policy, Trauma Informed Care dated 11/15/24, identified as part of the admission comprehensive assessment the facility will identify history of trauma or interpersonal violence when possible, using the social history and psycho-social observation tool. If a resident shares a history of trauma, a trauma-informed care plan will be developed with appropriate information to help guide staff in an effort to avoid re-traumatization.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48109 Based on interview and document review, the facility failed to ensure medication orders for residents contained an indication for the medication for 3 of 5 (R19, R37, R49) residents reviewed for unnecessary medications. Findings include: R19: R19's admission Minimum Data Set (MDS) dated [DATE], identified intact cognition and diagnoses of frontotemporal neurocognitive disorder (a type of dementia), severe dementia with agitation, delusional disorders, paranoid delusions, hypothyroidism, asthma, restless leg syndrome, urinary incontinence, post-traumatic stress disorder (PTSD), major depressive disorder, weakness, and fatigue. R19's MDS also identified hallucinations, delusions, verbal behavior toward others, and behavior significantly disrupts the living environment. R19's care plan last reviewed 5/13/25, didn't identify diagnoses or problem statements for hypertension, constipation, fluid retention, or issues with the skin in the perineal area. R19's provider orders identified the following medications without indications: -2/11/25 Miralax (a powder medication used to treat constipation) 17 grams daily as-needed (PRN) daily -2/11/25 furosemide (a medication that helps rid the body of excess fluid) 40 mg daily -2/11/25 hydrocortisone cream (topical corticosteroid used to treat mild inflammatory skin conditions) 2.5% perineal application with non-pharmacologic interventions to wash and dry affected area thoroughly, warm bath, and lotion area two times a day PRN -2/12/25 Magnesium oxide (a mineral used to treat a variety of conditions from constipation to low blood levels of magnesium) tablet 400 mg give orally before morning meal -4/1/25 docusate (a stool softener) 200 mg daily -4/1/25 Senna S (a stool softener plus a stimulant laxative) daily PRN -4/7/25 lisinopril (a medication used primarily to treat hypertension) 5 mg daily R37: (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R37's quarterly MDS dated [DATE], identified severely impaired cognition and diagnoses of left-sided hemiplegia and hemiparesis after a cerebral vascular accident (CVA, or stroke), dysphagia (difficulty swallowing), diabetes mellitus, long-term use of insulin, major depressive disorder, hypertension, gastroesophageal reflux disorder (GERD), hyperlipidemia (high cholesterol), low back pain, urinary incontinence, thrombocytopenia (abnormally low number of platelets in the blood), hearing loss, and dementia with psychotic disturbance. R37's care plan dated 4/8/25, didn't identify diagnoses or problem statements for sleep disturbance or nausea. R37's provider orders identified the following medications without indications: -11/7/23, melatonin (a hormone that regulates sleep-wake cycle) 6 mg at bedtime -2/7/25, ondansetron (medication used to treat nausea) 4 mg every six hours PRN During an interview on 5/15/25 at 1:40 p.m., the assistant director of nursing (ADON) stated they had recognized there weren't diagnoses with the medications, and found the issue was that every time an order changed the diagnosis wasn't being carried forward with the medication. The ADON stated they had implemented education with their health unit coordinators (HUC)s, and with the providers so that moving forward the medications would have indications. The ADON stated it was important to have the indication, so they knew they were giving the right medication. A policy, Transcription of Orders dated 2/12/24, identified all resident orders would be transcribed per policy and procedure. Item number six of the policy indicated per regulations and practice standards all medication orders must include the name of medication, dosage, route, and frequency. Each medication must also include a diagnosis for usage. Under item 8b, the policy indicated the nurse who verified the order would review order documentation and ensure the full transcription of orders had been completed and was accurate and updated EHR via acknowledgment order is verified.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 47263 Based on observation and interview the facility failed to utilize beard coverings in the kitchen to ensure sanitary conditions were maintained in food preparation areas. This deficient practice had the potential to impact all residents who received nourishment from the facility dietary services. Findings include: During an observation on 5/12/25 at 1:26 p.m., the food service consultant (FSC-A) was in the main kitchen area without a beard covering. FSC-A provided a tour of the kitchen food prep area, food dry and cold storage areas, the dishwashing area, and dish storage area while not wearing a beard covering. During an observation on 5/14/25 at 8:00 a.m., the culinary director (CD) was located behind the cook's prep table and did not have a beard covering on. During a continuous observation on 5/14/25 at 10:42 a.m. to 11:46 a.m., both the CD and FSC-A did not wear a beard covering during the following observed events: --10:43 a.m. to 1048 a.m., FSC-A stood in front of the cook's prep area without a beard covering as cook (C-A) pulled food from the oven and temped it. --10:51 a.m., dietary aide DA-A entered the kitchen without placing a beard covering over their beard. DA-A remained in the kitchen and wrapped silverware in napkins without a beard covering. --10:57 a.m. to 11:10 a.m., FSC-A remained in front of cook's area without a beard covering. --10:59 a.m., DA-A was still wrapping silverware without beard covering on. --11:17 a.m., CD walked behind the prep area between C-A and the oven without a beard covering and returned with a plastic bin. C-A put chicken in the bin and CD removed the bin from the cook's work area. --11:23 a.m. the CD sanitized hands, applied gloves and removed a utensil from the cook's prep table and brought it over to where C-A was pureeing food. --11:24 a.m., FSC-A was at a workstation without a beard cover on placing dessert bars into lidded serving containers. --11:40 a.m., DA-A, CD, and FSC-A remained in the kitchen area without beard coverings. --11:41 a.m. CD removed chicken from the oven and temped the chicken and returned the chicken to the oven. --11:46 a.m., FSC-A removed chicken from the oven and temped it (no beard covering). (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 5/15/25 at 10:00 a.m., the CD was in the kitchen without a beard covering standing at the cook prep table with C-B. During an interview on 5/14/25 at 12:01 p.m., the CD and FSC-A stated culinary staff get education on safe food preparation and handling, hand washing, infection prevention, and they also complete other required facility and food service topics. In addition, staff get training and coaching on the job. During an observation on 5/15/25 at 9:15 a.m., the CD was in the cook's area of the kitchen without a beard covering. During a follow-up interview on 5/15/25 at 12:14 a.m., the CD confirmed staff had not been wearing required beard coverings in the kitchen areas between 5/12/25 and 5/15/25. The CD explained they had just had mandatory mask wearing lifted and they had not implemented the switch back to wearing beard coverings. The CD stated beard coverings were required in the kitchen for sanitary and infection prevention reasons. The CD indicated beard coverings had been ordered and placed at the entrances to the kitchen and were to be worn by any staff with a beard who entered the kitchen area.