STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245502	A. Building B. Wing	06/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Benedictine Care Community	201 9th Street West Ada, MN 56510

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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to provide sufficient nursing staff to meet residents' assessed needs and provide required care and services. The facility's staffing shortages resulted in delayed toileting assistance, delayed eating assistance, loss of dignity, and transfers performed contrary to assessed needs and facility policy for 2 of 6 residents (R23, R24) reviewed in the sample requiring staff assistance with quality-of-care needs. The facility's ongoing staffing shortages had the potential to affect all 36 residents residing in the facility. Findings include:The Centers for Medicare and Medicaid Services (CMS) PBJ Staffing Data Report CASPER Report 1705 D identified the following:FY [fiscal year] Quarter 3 2025 (April 1 - June 30) identified the metric for excessively low weekend staffing was triggered. The trigger is defined as submitted staffing data that was excessively low.FY Quarter 4 2025 (July1 -September 30) identified the metric for excessively low weekend staffing was triggered. The trigger is defined as submitted staffing data that was excessively low.FY Quarter 1 2026 (October 1 - December 31) identified the metric for excessively low weekend staffing was triggered. The trigger is defined as submitted staffing data that was excessively low.On 6/7/26 at 11:40 a.m., the survey team approached the facility at the entrance door, and it was locked. The phone on the wall was used to call to gain entry into the building. The call was answered and then immediately hung up. the survey team knocked on the glass door and licensed practical nurse (LPN)-A could be seen standing at the medication cart. LPN-A looked at the team but did not respond. The team attempted to call again and was immediately given an entry code for the lock, and the call was disconnected. The team attempted several times to enter the code, but eventually nursing assistant (NA)-A let the team in. At that time, LPN-A stated the facility was working short, as a day shift nurse did not show up that morning to work. The night nurse stayed until 10:30 a.m. but then left the facility. LPN-A stated she attempted to call staff in to work but had been answering call lights, assisting the nursing assistants (NA) as much as possible and trying to complete her own duties as well. LPN-A stated she had two nursing assistants in the facility. LPN-A showed a binder that contained a phone tree but stated she just hadn't had time to call anyone. LPN-A was visibly frustrated with facial grimacing, and she was rubbing her forehead. The nursing assistants were busy in rooms. Many resident room doors were shut.FACILITY ASSESSMENT and SCHEUDLE REVIEW:The Facility Assessment updated 1/22/26, identified the following staffing needs with an average daily census of 42: Licensed nurses providing direct care, every day of the week for AM and evening shift had two staff and night shift had one staff. Unlicensed staff (nursing assistant/trained medication assistant), every day of the week for AM and evening shift had four staff and night shift had 2 staff.The facility provided a working schedule for the week of survey and identified the Sunday 6/7/26, AM shift 6:00 a.m. to 2:30 p.m., had one nurse working and two nursing assistants (NA) working. The nurse staff posting dated 6/7/26 identified the resident census was 36. The working nursing schedules from FY Quarter 1 2026 (October 1 - December 31) were reviewed for weekend staffing patterns and identified the following:Saturday 10/4/25, AM shift 6:00 a.m. to 10:00 a.m. and PM shift 2:00 p.m. to 10:30 p.m., only 3 NAs scheduled on each of the identified shifts.Sunday (continued on next page)

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

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	10/5/25, AM shift 6:00 a.m. to 10:00 a.m. and PM shift 2:00 p.m. to 11:30 p.m., only 3 NAs scheduled on each of the identified shifts.Saturday 10/11/25, AM shift 6:00 a.m. to 10:00 a.m. and PM shift 2:00 p.m. to 10:30 p.m., only 3 NAs working on each of the identified shifts.Sunday 10/12/25, AM shift 6:00 a.m. to 2:30 p.m., only 2 NAs were scheduled. On PM shift 2:00 p.m. to 10:30 p.m., only 3 NAs were scheduled on the identified shifts.Saturday 10/18/25, AM shift 6:00 a.m. to 2:30 p.m., only 3 NAs were scheduled on the identified shift.Sunday 10/19/25, AM shifts from 11:00 a.m. to 2:30 p.m., and PM shift 2:00 p.m. to 6:00 p.m., only 3 NAs were scheduled on the identified shifts.Saturday 10/25/25, PM shift 2:00 p.m. to 10:30 p.m., only 3 NAs were scheduled on the identified shift.Sunday 10/26/25, AM shift 6:00 a.m. to 10:00 a.m., only 2 NAs were scheduled . At 11:00 a.m. to 2:30 p.m. and PM shift 2:00 p.m. to 10:30 p.m., only 3 NAs were scheduled on the identified shifts.Saturday 11/1/25, AM shift 11:00 a.m. to 2:30 p.m. and 2:00 p.m. to 6:00 p.m., only 3 NAs were scheduled on the identified shifts.Sunday 11/2/25, AM shift 6:00 a.m. to 10:00 a.m. and PM shift 2:00 p.m. to 6:00 p.m., only 3 NAs were scheduled on the identified shifts.Saturday 12/6/25, AM shift 10:00 a.m. to 2:30 p.m. and PM shift 2:00 p.m. to 10:30 p.m., only 3 NAs were scheduled on the identified shifts.Sunday 12/7/25, AM shift 6:00 a.m. to 10:00 a.m. and PM shift 2:00 p.m. to 10:30 p.m., only 3 NAs were scheduled on the identified shifts.Saturday 12/13/25, AM shift 6:00 a.m. to 10:00 a.m., only 3 NAs were scheduled on the identified shift.Sunday 12/14/25, AM shift 6:00 a.m. to 10:00 a.m., only 3 NAs were scheduled on the identified shift.Saturday 12/20/25, AM shift 6:00 a.m. to 2:30 p.m., only 3 NAs were scheduled on the identified shift.Sunday 12/21/25, AM shift 6:00 a.m. to 2:30 p.m., only 2 NAs were scheduled and PM shift 6:00 p.m. to 10:30 p.m., only 3 NAs were scheduled on the identified shifts.See also F677: Based on observation, interview, and document review, the facility failed to provide activities of daily living (ADL) care and services necessary to maintain residents' abilities by failing to provide timely toileting assistance for 1 of 6 residents (R24) reviewed who required staff assistance with toileting and transfers; and failed to provide timely supervision and assistance with eating for 1 of 6 residents (R23) reviewed who required staff assistance during meals.R24:R24's admission Minimum Data Set (MDS) dated [DATE], identified R24 had mild cognitive impairment and was dependent on staff for toileting and transfers and was frequently incontinent with bowel and bladder. Diagnoses included non-traumatic spinal cord dysfunction, diabetes, and dementia. R24's care plan revised 5/27/26, R24's care plan dated 5/27/26 identified she was dependent on staff for transfers and toileting, required a full-body mechanical lift with assistance of two staff for transfers, and was to be offered toileting every three hours and upon request to maintain skin integrity and dignity.During an observation on 6/7/26 at 11:30 a.m., R24 was lying in bed with her head of bed (HOB) at 30 degrees. R24 was wearing a dusky purple sweatshirt and no pants. There was a fleece blanket across the foot of R24's bed but it was not covering R24. R24 was wearing an incontinent brief with no pants and had her knees bent with her feet resting on the bed. R24 was crying and stated staff told R24 she had to stay in bed and couldn't get up. I don't know why. R24 then stated, they told me to pee my pants, and they'd clean me up here. R24 stated this happened all the time. At that time, nursing assistant (NA)-B stepped into the room and told R24 NA-B needed to help another resident and would be back. NA-B turned off R24's call light and left the room. R24 continued to cry and stated nursing assistants said that and shut off R24's call light just about every day and they say they're short. R24 sobbed and stated I hate it here. It's awful. I hate peeing in my pants.At 12:10 p.m., NA-B entered R24's room and told R24 she was wet, so she needed to be cleaned up. NA-B put on gloves then told R24 she didn't need to cry because she was there. R24 stated I want to get up.At 12:11 p.m. NA-B unfastened R24's incontinent brief and used disposable wipes to clean R24's skin of feces and urine. R24 stated that her skin was itchy, NA-B told R24 that R24 had pooped and NA-B would clean R24's skin well.At 12:13 p.m., NA-B rolled R24 to the right and R24 began crying and stated, I can't do this. NA-B told R24 that they were almost done. R24's skin on her upper thighs and buttocks was reddened but had no open areas. NA-B applied barrier cream then a clean brief. At 12:16 p.m., NA-B put on R24's pants. NA-B then removed her gloves and removed the trash from the trash containers and asked for assistance (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	with R24's transfer over the walkie. NA-B exited the room.At 12:19 p.m., NA-B returned with a full body mechanical lift sling and placed it under R24. NA-B told R24 that she needed another staff person to assist with the transfer and left the room. At 12:22 p.m., NA-A and NA-B entered the room and used the ceiling lift to transfer R24 from her bed to her wheelchair. NA-B then brought R24 to the dining room for her noon meal. During an interview on 6/7/26 at 12:28 p.m., NA-B stated the facility was working short that day. You just do the best you can. NA-B stated R24 did get up into her chair for breakfast that morning, but staff laid R24 down to do incontinent care after breakfast. NA-B stated R24 was encouraged to stay in bed because NA-B had other residents to care for. R24 did turn on her call light and asked to get up, but R24 was assistance of two and NA-B was providing care to another resident. R23:R23's quarterly MDS dated [DATE], identified R23 was cognitively intact and independent with eating. R23 had diagnoses of obesity and mass/lump on abdomen. R23's care plan dated 5/26/26 identified R23 was independent with eating. However, R23's mini nutritional assessment dated [DATE], identified R23 normally ate 51-75% of most meals. R23 was assisted with meals for optimal intake. During observations on 6/7/26 at 1:04 p.m., there were not enough staff in the dining room to assist residents with eating. At 1:05 p.m., there were at least two residents who were sitting there with food in front of them and were not eating nor were staff helping them. At 1:09 p.m., R23 was identified as one of the residents sitting at the table where staff are supposed to assist residents with eating. At 1:12 p.m., R23 still had her plate of food in front of her, and she had not attempted to eat. R23's potatoes and meat had formed a crust on them. R23 waited 45 minutes before staff assisted her to eat. At 1:15 p.m., R23 ate well with staff assistance. During an interview on 6/9/26 at 2:02 p.m., NA-A stated R23 had changed over the weekend, previously she just required supervision with eating. R23 had seemed to decline and had started to pocket food and had moved to a different table to assist with eating because R23 needed more help with meals. During lunch on Sunday 6/7/26, the facility was short staffed and the residents in the dining room had to wait for assistance to eat and some had to wait an extended period of time before they received help. See also F550: Based on observation, interview, and record review, the facility failed to ensure dignified care was provided for 1 of 1 resident (R24) reviewed for dignity. Staff encouraged R24 to remain incontinent rather than assisting her to the toilet when requested, resulting in embarrassment, and loss of dignity. R24's admission Minimum Data Set (MDS) dated [DATE], identified R24 had mild cognitive impairment and was dependent on staff for toileting and transfers and was frequently incontinent with bowel and bladder. Diagnoses included non-traumatic spinal cord dysfunction, diabetes, and dementia. R24's care plan revised 5/27/26, R24's care plan dated 5/27/26 identified she was dependent on staff for transfers and toileting, required a full-body mechanical lift with assistance of two staff for transfers, and was to be offered toileting every three hours and upon request to maintain skin integrity and dignity.During an observation on 6/7/26 at 11:30 a.m., R24 was lying in bed with her head of bed (HOB) at 30 degrees. R24 was wearing a dusky purple sweatshirt and no pants. There was a fleece blanket across the foot of R24's bed but it was not covering R24. R24 was wearing an incontinent brief with no pants and had her knees bent with her feet resting on the bed. R24 was crying and stated staff told R24 she had to stay in bed and couldn't get up. I don't know why. R24 then stated, they told me to pee my pants, and they'd clean me up here. R24 stated this happened all the time. At that time, nursing assistant (NA)-B stepped into the room and told R24 NA-B needed to help another resident and would be back. NA-B turned off R24's call light and left the room. R24 continued to cry and stated nursing assistants said that and shut off R24's call light just about every day and they say they're short. R24 sobbed and stated I hate it here. It's awful. I hate peeing in my pants.During an interview on 6/7/26 at 12:28 p.m., NA-B stated the facility was working short that day. You just do the best you can. NA-B stated R24 did get up into her chair for breakfast that morning, but staff laid R24 down to do incontinent care after breakfast. NA-B stated R24 was encouraged to stay in bed because NA-B had other residents to care for. R24 did turn on her call light and asked to get up, but R24 was assistance of two, and NA-B was providing care to another resident. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	See also F689: Based on interview and document review, the facility failed to ensure transfers were performed in accordance with assessed needs, care plan interventions, and facility policy for 1 of 3 residents (R24) reviewed for accidents. Staff performed transfers using a full-body mechanical lift with one staff member rather than the required two staff members, creating the potential for falls, entrapment, and transfer-related injury. R24's admission Minimum Data Set (MDS) dated [DATE], identified R24 had a mild cognitive impairment and had diagnoses that included non-traumatic spinal cord dysfunction, diabetes, and dementia. R24 was dependent on staff for toileting and transfers and was frequently incontinent with bowel and bladder. R24's care plan revised 5/27/26, identified R24 had self-deficit with transferring. Staff were directed to provide assistance with two staff with all transfers to and from bed, wheelchair and toilet. R24 used a full body mechanical lift. During an interview on 6/9/26 at 11:29 a.m., trained medication aide (TMA)-A stated staffing was awful. The facility used a lot of agency staff and the schedule frequently got messed up which added to the problem. Staff did the best they could with what they had. TMA-A tried her hardest when they had to work short to prioritize work and to help the nursing assistants as much as she was able. R24 could not wait when R24 asked to use the bathroom because she would be incontinent. TMA-A stated she wasn't going to lie and transferred R24 using the full body mechanical lift by herself. TMA-A did this because R24 had a right to get up and use the bathroom. It was also harmful to R24 skin to void in her pants. TMA-A stated she felt the transfer was safe doing that.During an interview on 6/9/26 at 11:57 a.m., R24 stated sometimes there was not enough staff at the facility, and they transfer her with the lift with only one staff member. R24 stated they say there's not enough staff and it was against the rules, but they do it. R24 never felt unsafe but knew she was not supposed to tell anyone to get anybody in trouble. I'm just thankful to get to the toilet. STAFF INTERVIEWS:During an interview on 6/8/26 at 4:44 a.m., RN-A stated she was the unit manager and was covering night shift because the facility was short on staff. During an interview on 6/9/26 at 11:29 a.m., TMA-A stated staffing was awful. The facility used a lot of agency staffing and the schedule would get screwed up. On 6/9/26, TMA-A had to work a double shift because her relief was scheduled on the electronic module but not on the printed schedule. The Pioneer unit needed at least 2 aides because the cares were heavier over there. There should be a float that goes between the Pioneer unit and the Wild [NAME] unit, but they don't like to do it and refuse to help on Wild Rose. They just don't do it. The agency staff don't know what to do when a staff member calls in for their shift. The agency staff don't have access to the texting app but they have the staff list and the have the phone tree. TMA-A was not called to work on Sunday. TMA-A had heard nothing about the staff being short staffed on 6/7/26. Staff working the medication cart were expected to assist the nursing assistants with answering call lights and resident care, but some of the agency staff would not do it.During an interview on 6/9/26 at 11:42 a.m., NA-C stated she worked as needed, but didn't work much. Stated the facility did call her at approximately 1:00 p.m. on 6/7/26 but NA-C could not work that day. NA-C worked 6/8/26, 6/9/26 and was scheduled to work 6/10/26 because state was there. Usually when I'm working, we have everybody here because I'm the one who picked up.During an interview on 6/9/26 at 1:36 p.m., LPN-A stated she was an agency staff person so that right there should tell you what staffing is like. Stated the facility worked short like they were on 6/7/26 a lot. Every week. LPN-A stated the nurse who was supposed to work on 6/7/26 comes to work late often. The night nurse stayed to cover, but the nurse never arrived. That's when LPN-A realized she wasn't coming. LPN-A was trying to call staff to come in to work but was getting pulled in every direction because the nursing assistants needed help, plus she had nursing duties she had to attend to.During an interview on 6/9/26 at 1:49 p.m., NA-A stated the facility worked short staffed all the time and even if NA-A had a float, the float wasn't much help, so she was working alone anyway. Some of the floats just didn't want to work. They liked the social aspect of the role, but they didn't want to listen to direction, or they were slow in their tasks. Some didn't answer call lights. For example, one float wanted to sit with the residents and drink coffee and visit. The float routinely didn't look at the bath list and didn't want to answer call (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	light. When NA-A would tell this person what to do, NA-A would get ignored. NA-A stated she had reported this to administration many times and not had a response.During an interview on 6/9/26 at 2:06 p.m., RN-A stated she had been told there were float staff ho were resistant to working on the Wild [NAME] unit. The floats had worked at the facility for years and believed they didn't have to. RN-A had spoken to the float staff individually and informed administration but had never documented this. During an interview on 6/9/26 at 2:49 p.m., the DON stated she expected staff to answer call lights when they can safely leave the person they are caring for to check on the call light to ensure it's not a safety concern. The DON also stated she had recognized the float staff didn't have accountability because the float didn't have an assigned resident group. The DON planned to change assignments so each nursing assistant, including the float, would have an assigned group of residents. This would include the float assigned residents from each unit. That way, the float would be assisting on each unit and there would be a way to hold the float accountable for their work.

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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 establish and maintain an infection prevention and control program that included a system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases. Specifically, the facility failed to timely initiate and consistently implement transmission-based precautions for 2 of 2 residents (R12. R24) reviewed who exhibited signs and symptoms of potentially infectious diarrhea; failed to consistently identify and monitor residents exhibiting signs and symptoms of potential infection through the facility's surveillance system for 2 of 2 residents (R7, R24) reviewed for infection surveillance; failed to ensure staff adhered to infection prevention practices related to hand hygiene for 1 of 3 residents (R24) reviewed for activities of daily living; and failed to implement enhanced barrier precautions for 2 of 5 residents (R6, R7) reviewed who met criteria for enhanced barrier precautions. These deficient practices had the potential to affect all 36 residents residing in the facility. Findings include: TRANSMISSION BASED PRECAUTIONS R12 R12's annual Minimum Data Set (MDS) dated [DATE], identified R12 had severe cognitive impairment, and included a diagnosis of chronic kidney disease. R12 required partial/moderate assistance with toileting and was always incontinent with bowel and bladder. R12's care plan revised 5/28/26, identified R12 had acute gastroenteritis (inflammation that spreads from your stomach into your intestines, causing pain, vomiting and diarrhea) as evidenced by diarrhea and/or vomiting. Placing R12 at risk for dehydration, electrolyte imbalance, impaired skin integrity, and infection transmission. Staff were directed to: Administer antiemetics, antidiarrheals, or antibiotics as ordered by provider. Monitor for medication effectiveness and side effects. Assess for abdominal pain, cramping, nausea, fever, or discomfort; report concerns to the resident's provider and treat as ordered. Assist with toileting as needed, provide perineal care after diarrhea, and apply barrier cream/protective ointments as indicated. Initiate appropriate isolation precautions per facility policy, minimize resident movement outside of room, and clean and disinfect high-touch surfaces and shared equipment. Monitor frequency, consistency, and volume of stools and/or emesis. R12's Clostridium difficile (C. diff) by Molecular Detection dated 5/27/26, identified R12 was was positive for C. diff (a highly contagious bacterium that causes diarrhea and colitis. It often infects people who've recently taken antibiotics. Antibiotics that kill other bacteria in your gut but don't kill C. diff allow it to quickly grow out of control, (Cleveland Clinic dated 11/19/24)). (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	R12's Enteric Pathogens by Molecular Detection dated 5/27/26, identified R12 was positive for norovirus. (Norovirus is a highly contagious virus that causes acute gastroenteritis (inflammation of the stomach and intestines). Often mistaken for the stomach flu or food poisoning, it results in explosive vomiting, watery diarrhea, and stomach cramps. It is notoriously difficult to kill and spreads rapidly through contaminated food, surfaces, or close contact, Cleveland Clinic dated 2/3/23) R12's nurse progress notes identified the following: 5/18/25 at 5:05 p.m., social work designee (SWD) met with resident on 5/18/26 and completed PHQ-9 Assessments (a screening tool for depression). PHQ-9 score was 3/27 indicating minimal depression. R12 answered yes to feeling down, depressed, and hopeless. R12 stated he doesn't know why he feels this way at times, but stated he was glad that his legs were getting better and was working with therapy. R12 also stated yes for poor appetite, he stated he wasn't eating much when he was feeling sick and stated he had been having loose stools these last couple of days. R12 stated he ate better today. Case manager notified about loose stools, no other concerns for R12 at this time. 5/19/26 at 9:15 a.m., Discussed at Interdisciplinary Team (IDT): weight variance. Will be followed up with provider today during rounds. 5/19/26 at 4:52 p.m., PROVIDER UPDATE: Regarding concerns with loose stools. Reviewed by provider with orders received as follows: comprehensive metabolic panel (CMP) (measures 14 different substances in your blood and is primarily used to evaluate organ function and metabolism), magnesium (Magnesium is a vital electrolyte that your nerves, muscles, and heart need to function properly), complete blood count (CBC), C-reactive protein (CRP) (CRP is a protein made by your liver that increases when there is inflammation in your body). Orders updated. However, the nursing progress note failed to identify if R12 was placed into contact precautions. 5/20/26 at 5:15 a.m., R12 at baseline. No complaints. Incontinent of stool one time. 5/20/26 at 10:30 a.m., LAB RESULTSCRP: 2.6RBC: 3.82HGB: 12.2MCV: 102.1MCHC: 31.3RDW: 16.3BUN: 37Creatinine: 1.58GFR: 40Glucose: 128Albumin: 3.0Alkaline Phosphatase: 224Alanine Aminotransferase: 7Provider updated. No further orders at this time. 5/20/26 at 12:30 p.m., per provider, CRP was elevated but substantially improved compared to a few weeks ago in the hospital. Electrolytes and kidney functions look okay for R12. Alkaline Phosphatase was elevated but had been elevated over the last year. Add a Gamma-glutamyl transferase (GGT) to see if the Alkaline Phosphatase elevation was likely from the liver or bone. GGT lab order added. Writer called lab to inform of add-on lab. However, the nursing progress note failed to identify if R12 was placed into contact precautions. 5/21/26 at 7:15 a.m., staff interviewed for Assessment Reference Date (ARD) ending 05/22/2026: Staff reported continence level for bladder as incontinent and bowel as incontinent. R12 was incontinent in briefs at this time and required check and change in bed or on toilet. Staff reported R12 had frequent loose stools daily since hospital stay. Provider aware. Imodium (anti-diarrhea medication) is in use as needed. 5/26/26 at 5:12 a.m., loose stools twice. Imodium given. However, the nursing progress note failed to identify if R12 was placed into contact precautions. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	5/26/26 at 9:06 a.m., some difficulty with therapies due to loose stools per therapy. Will see about stool sample today. 5/27/26 at 11:12 a.m., spoke to R12's doctor about ongoing problems with loose stools and incontinence since hospitalization. Received order for stool culture and C-diff labs. [NAME] 5/27/26 5:53 p.m., R12 at baseline. No concerns noted. Obtained stool specimen and dropped off to lab as ordered for occult parasite and C-diff. However, the nursing progress note failed to identify if R12 was placed into contact precautions. 5/28/26 at 6:20 a.m., writer received lab results this morning indicating R12 was positive for C-Difficile - Norovirus strain. Staff were updated immediately and isolation precautions implemented. Writer spoke to R12 and strongly encouraged him to stay in his room today so as not to spread the illness. Provider was updated. Communication sent out to facility staff. However, the nursing progress note failed to identify R12 cohorting with a roommate. 5/28/26 at 6:27 a.m., LAB RESULTSClostridium Difficile: PositiveNorovirus GI/GII: Detected 5/28/26 at 8:48 a.m., writer contacted R12's doctor regarding positive stool results. Orders received as follows:1. Oral Vancomycin (an antibiotic that kills C. diff) 125 milligrams (mg) 4 times a day for 10 days. 5/28/26 10:02 a.m., discussed at IDT: R12 was diagnosed with C-Diff and norovirus. Isolation precautions in place. Notifications made. However, the nursing progress note failed to identify R12 cohorting with a roommate. 5/28/26 at 10:05 a.m., Antibiotic(s) prescribed:: VancomycinStart Date:: 05/29/2026Dose:: 125 mgRoute:: OralDuration:: 10 daysStop Date:: 06/07/2026Reason Antibiotic(s) Prescribed:: Other (List) C-Diff/NorovirusReview Event: Did resident meet McGeer's Criteria to treat?: YesReview Event: Did culture or imaging tests confirm infection?: YesRisk Factors/Concerns:: No Risk Factors/ConcernsDoes resident still have symptoms?: YesAre signs and symptoms improving?: YesRed Flags:: Antibiotic is ordered for more than 7 daysActions to Take:: Notify nurse manager or facility supervisor, Update providerHas attending provider been updated?: Yes 5/28/26 at 6:32 p.m., no concerns or complaints noted. R12 was on contact precautions due to c-diff. 5/29/26 at 11:30 a.m., Annual Nutrition Review: R12 had just been diagnosed with norovirus and C diff. R12 may benefit from the addition of a probiotic. Nutritional care plan reviewed. Goal for weight maintenance is 230-250 pounds (lbs). Nutritional needs were being met by weight trend. No changes were needed. Encourage fluids related to kidney disease. 5/30/26 at 6:02 p.m., No concerns or complaints noted. Continued to be in contact isolation due to C-diff, no loose stools noted, antibiotic continued with no adverse effect noted. 6/3/26 at 12:26 p.m., regarding active Loperamide prescription (PRN), writer received orders as follows:1. Hold Loperamide for duration of C-Diff infection 6/7/26 at 5:42 a.m., R12 at baseline, no concerns. Continued with contact precautions. R12 stated was ready to come out of that. (continued on next page)

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	245502	A. Building B. Wing	06/10/2026

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	6/7/26 at 7:09 p.m., continued contact precautions for C-diff. R12 was noncompliant. R12 came from his room to dining room at times, staff continued to redirect. 6/8/26 at 3:47 a.m., R12 self-transferred to bathroom twice during the night. R12 was reeducated on the need to use his call light for assistance. During a continuous observation on 6/8/26 at 7:46 a.m., R12 had a 3-drawer plastic cart outside his room. A Contact Precautions sign, bleach disposable wipes and red biohazard bags were sitting on top. The top drawer contained gloves and surgical masks, the second drawer had eye and face protection, and the bottom drawer was empty. Inside the doorway, there was a 13-gallon trash bin. R12 was sitting on the edge of his bed. R12's roommate, R7, was in bed with the privacy curtain pulled. At 8:26 a.m., R12 continued sitting on the side of his bed. R12 was dressed and had his wheelchair and overbed table in front of him in reach. 8:41 a.m., LPN-A stated she did know who the facility's infection prevention nurse was. There have been too many changes. R12 began hollering at LPN-A. LPN-A asked dietary aide (DA)-A if R12 had eaten breakfast. DA-A stated no, half the residents in the unit had not eaten breakfast and stated after 9:00 a.m., you have to deliver it. DA-A continued to the dining room. At 8:48 a.m., R12 continued to sit on the side of his bed. R12 did not have his breakfast. At 9:04 a.m., the health unit coordinator (HUC) delivered gowns and placed them in R12's cart in the bottom drawer. At 9:14 a.m., NA-B entered R12's without any personal protective equipment (PPE). R12 began yelling what the hell is going on? I haven't had my breakfast yet. NA-B stated she would go check. Left room and went to the dining room. NA-B did not use hand sanitizer. At 9:19 a.m., NA-B returned with R12's breakfast tray. NA-B put on a gown, gloves and a surgical mask then brought the tray to R12. NA-B placed R12's tray on the overbed table and set up R12's meal, touching items on his overbed table. NA-B removed her gloves and made to leave the room when R12 stopped her and stated, no coffee? NA-B stated R12 had already had some coffee that morning. R12 stated yes, he had, but that was a while ago. Ok, that's fine. I'll get some later. NA-B removed her washable gown and placed it into the trash can at the door, then used hand sanitizer. At 9:24 a.m., NA-B stated staff only needed to wear a gown and gloves when doing anything with R12 and did not need to wear anything if they were caring for R7. NA-B then reentered the room to care for R7 without a gown or gloves. At 10:42 a.m., the wellness activity director (WAD)-A and culinary manager (CM)-A entered R12's room without gown or gloves. WAD-A and CM-A are touching R12's personal items such as his overbed table, wheelchair, closet and bedding. The bedding was brushing WAD-A's clothing. WAD-A told R12 they were going to help R12 with his bath. CM-A removed clothing from R12's closet for R12 to pick out. WAD-A put a gait belt on R12 and assisted R12 to transfer to his wheelchair. At 10:47 a.m., CM-A stated R12 had been removed from contact precautions that morning. They knew this because it was discussed in the IDT that morning and staff just had not gotten around to (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	R24's Urinary Incontinence and Indwelling Catheter Care Area assessment dated [DATE], identified R24 required assistance for transfers. Care area was triggered due to prescribed medication, impaired mobility, health history and ADL review. She was to be observed for changes in her elimination pattern and peri care to be completed with incontinent episodes. R24's care plan revised 5/27/26, identified the following: R24 was frequently incontinent of urine. Staff were directed to document incontinent episodes. Bladder assessment at least quarterly. Monthly 24-hour (hr) bladder/bowel record. Provide with appropriate incontinence products. R24 required an extensive partial assistance of one (PAO1) using a gait belt (GB) and a wheeled walker to transfer, wipe, adjust clothing and manage incontinence. R24 was to receive peri cares twice daily and as needed after any incontinent episode. Protective ointment to skin as needed. Observe for signs/symptoms of urinary tract infection (UTI): pain or burning with urination, fever, increased incontinence, cloudy/odorous urine in small amounts, increased confusion/lethargy. Encourage adequate fluids. However, the care plan failed to direct staff regarding precautions related to R24's loose stools. R24's nursing progress notes identified the following: On 5/13/26 at 8:30 p.m., R24 was complaining of pain. As needed (PRN) Ibuprofen given per orders and effective. R24 was given Imodium (an anti-diarrhea medication) per order after 2 loose stools. So far effective. On 5/15/26 at 1:33 p.m., R24 complained of some pain especially during transfers. R24 some diarrhea. Ibuprofen and Imodium given per orders. On 5/17/26 at 12:48 p.m., R24 had loose stools. PRN Imodium given per order. R24 verbalizing pain but refuses all interventions. On 5/24/25 at 1:49 p.m., R24 refused some of her medications this morning. Loperamide given at 1015 for loose stools, medication was effective. On 5/27/26 at 1:20 p.m., R24 had a loose stool before lunch and was given 4 mg of PRN loperamide at 11:09 a.m. No further loose stools noted. On 5/28/26 at 1:33 p.m., R24 has loose stools. PRN Imodium given and effective. R24 also complaining of pain. Scheduled Tylenol was given a little early due to condition. No other concerns. On 5/29/26 at 9:31 a.m., IDT review: R24 having loose stools, will contact provider for stool sample. On 5/29/26 at 1:33 p.m., R24 had PRN Imodium per order. No other concerns. On 5/29/26 at 2:26 p.m., writer contacted R24's doctor regarding concerns of loose stools. Received order as follows: 1. Stool C-diff 2. Stool culture. On 6/2/26 at 10:43 a.m., stool sample was collected. On 6/3/26 at 11:25 p.m., stool tests were negative, and results were sent to R24's doctor. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	eye protection and face shields is not routinely a part of contact precautions, however, just as with Standard Precautions, these items are worn during resident care activities that are likely to create splashes or sprays of blood, body fluid, secretions, and excretions. 5. Hand hygiene is perfom1ed between glove changes and when removing gloves. The facility policy Standing House Orders for Symptoms Management revised February 2025, identified the following: Bowel and Bladder Management Bowel: Diarrhea (Perform steps sequentially) Perform rectal check to determine if impaction is present; If impacted, follow guidelines for constipation; If not impacted, hold all cathartic-related (constipation) meds and observe for 24 hours. If diarrhea is resolved, resume cathartic-related (constipation) med. If diarrhea continues: Notify Provider of the change in condition to determine if sending a stool specimen for C. difficile toxin A and [NAME] indicated; If testing for C. difficile toxin is ordered, collect only diarrheal (unformed) stool; and Encourage fluids to help maintain hydration. However, the policy failed to direct staff to place the resident into precautions until testing and/or loose stools were resolved. The Center for Disease Control and Prevention (CDC) About C. diff dated 5/13/26, identified Clostridioides difficile [klos–TRID–e–OY-[NAME] dif–uh–SEEL], also known as Clostridium difficile and often called C. difficile or C. diff, is a bacterium (germ) that causes diarrhea and inflammation of the colon. Symptoms include: Diarrhea, Fever, Stomach tenderness or pain, Loss of appetite, and Nausea.C. diff infection (CDI) is more common among patients in healthcare settings, such as hospitals and nursing homes. This is because many people who have C. diff stay or get treated in those facilities. Other risk factors include: Older age (65 or older); A weakened immune system, such as people with cancer or organ transplants taking drugs that suppress the immune system; and Previous infection with C. diff or known exposure to the germs When C. diff germs are outside the body, they become spores. These spores are an inactive form of the germ and have a protective coating allowing them to live for months or years on surfaces and in the soil. Spores become active again after being swallowed and reaching the intestines. Once there, they can cause infection if your immune system is weak or you've recently taken antibiotics. However, most healthy people don't get infected even if spores reach their intestines. If a patient has had three or more stools in 24 hours; Isolate patients with possible C. diff immediately, even if you only suspect CDI; Order a C. diff test if other etiologies of diarrhea such as stool softener or laxative were not used; Wear gloves and a gown when treating patients with potential infectious diarrhea, including C. diff infection, even during short visits. Gloves are important because hand sanitizer doesn't kill C. diff. In addition, handwashing alone may not be sufficient to eliminate all C. diff spores; and Reassess appropriateness of antibiotics in C. diff patients. SURVEILLANCE The facility surveillance log dated 2/25/26 through 6/2/26, identified resident name, room number and unit, admit date , event closed date, infection type, body system of infection, origin of infection, onset date, resolved date, was surveillance met, was there a hospital admission, was the infection reportable, signs and symptoms, was it a device related infection, risk factors, laboratory results, type of tests, test dates, culture source/radiology site, test results, treatment, medication class, dose, route, frequency, treatment start date, treatment end date, total days of therapy, did the infection meet criteria and was transmission-based precautions implemented. The log identified the following infections: 12 Urinary tract infection (UTI) (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review the facility failed to develop comprehensive, person-centered care plan to include enhanced barrier precautions (EBP) for 3 of 5 residents (R6, R7, R1) reviewed who were identified to be on EBP.Findings include: R6 R6's annual Minimum Data Set (MDS) dated [DATE], identified R6 had intact cognition and required moderate assistance with bathing. R6 had an abdominal feeding tube (G-tube). Diagnoses included Parkinson's disease, narcolepsy, anxiety, and dysphagia (difficulty swallowing). R6's care plan with review date 6/1/26, identified R8 was frequently incontinent of bladder. Approaches included for staff to provide peri care two times per day and as needed (PRN) when incontinent. R8's care plan also identified R8 has special treatment/procedures related to the presence of a G-tube. Approaches included to provide daily care and observance of R8's G-tube to ensure patency and usefulness. The care plan failed to include instructions for EBP related to when staff provided G-tube and/or personal cares. R6's undated Active Order Report reviewed 6/9/26, identified numerous medication orders, all with instruction to crush and administer the medication through her feeding tube. On 6/8/26, at 6:34 a.m. a plastic cart was observed outside of R6's room. The cart contained disposable gloves and masks. A sign on top of the cart identified R6 was on enhanced barrier precautions and directed staff to wear a gown and gloves when performing direct care, including G-tube care. During interview on 6/8/26, at 10:38 a.m. the director of nursing (DON) stated providing G-tube care would be one instance when EBP should be used. EBP should be on resident's plan of care when it was required to be used. The DON stated it was important for staff to put on a gown when indicated for direct care to prevent transmission of multidrug-resistant organisms (MDRO), protect other residents and to keep the staff uniform clean from splashes. The required use of EBP's should be care planned on the resident's plan of care because it did affect the resident's care. The DON thought it used to be on the resident's care plan as well as in the physician orders, but she had not gotten all resident's charts audited and so it may not be on every resident's chart as needed. R7 R7's annual Minimum Data Set (MDS) dated [DATE], identified R5 had severe cognitive impairment and diagnosis included obesity. R7 had an unstageable pressure ulcer and moisture associated skin damage (MASD). R7's wound assessment dated [DATE], identified the coccyx ulcer was stable and measured 1.5 centimeters (cm) x 0.3 cm x 0.3 cm deep. R7's care plan dated 5/22/26, lacked any guidance of use for EBP. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During observations on 6/8/26 at 7:46 a.m., there was an isolation cart outside of R7's room with a contact precaution sign for R7's roommate and did not address if R7 was on EBP. The cart had gloves and masks in the first drawer, eye/face protection in second drawer, and the third drawer was empty. There were no gowns on the cart. During an interview and observation on 6/8/26 at 9:19 a.m., nursing assistant (NA)-A stated they did not need to wear a gown or gloves when caring for R7, we only needed to wear that for R7's roommate. NA-A then entered R7's room and proceeded to get R7 ready for the day. NA-A was not wearing a gown or gloves. R1 R1's quarterly MDS dated [DATE], identified R1 had moderate cognition and had an indwelling catheter. Diagnoses included renal insufficiency, urinary retention. R1's care plan dated 5/22/26, included instructions to change catheter monthly, complete catheter care daily, and monitor for signs and symptoms of infection. The care plan failed to include instructions for EBP related to catheter. During observation on 6/9/26 at 7:23 a.m., a plastic cart was outside R1's room. The cart contained disposable gowns and gloves, and a sign identifying R1 was on enhanced barrier precautions. The sign included instructions for staff to wear gowns and gloves when performing direct care, including catheter care. During interview on 6/10/26 at 5:16 p.m., DON stated EBP was used to prevent the spread of infections between staff/residents and helped to reduce the spread of multidrug-resistant organisms (MDRO's) whether they are known, suspected or potential. The DON stated staff were expected to follow resident care plans and the facility policy regarding wearing PPE for EBP. The Enhanced Barrier Precautions policy, revised 3/28/24, identified the purpose was to decrease transmission of CDC-targeted and other epidemiologically important MDRO's, and EBP would be used for residents actively infected or colonized with CDC-targeted and other epidemiologically important MDRO's. Additionally, residents at risk for MDRO's, specifically those with an indwelling medical device and/or chronic wounds requiring a dressing would be required to use EBP. The Comprehensive Assessments and Care Planning policy revised 2/26/26, identified a comprehensive person-centered care assessment of the resident's condition was completed in order to develop consistent quality care that would attain or maintain the highest practicable physical, mental and psychological functioning possible.

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure dignified care was provided for 1 of 1 resident (R24) reviewed for dignity. Staff encouraged R24 to remain incontinent rather than assisting her to the toilet when requested, resulting in embarrassment, and loss of dignity. Findings include: R24's admission Minimum Data Set (MDS) dated [DATE], identified R24 had a mild cognitive impairment and had diagnoses that included non-traumatic spinal cord dysfunction, diabetes, and dementia. R24 was dependent on staff for toileting and transfers and was frequently incontinent with bowel and bladder.R24's Activities of Daily Living (ADLs) Functional/Rehabilitation Potential Care Area Assessment (CAA) dated 5/11/26, identified R24 was a recent admit from another care center and had diagnoses of dementia, depression, heart failure and asthma. R24 had clear speech and was understood and usually understood. R24 denied shortness of breath. R24 stated she had pain per medication administration record (MAR) review. R24 had a history of refusing medications per staff. R24 was frequently incontinent of bowel and bladder and had some moisture-associated skin damage (MASD) noted with ointment/cream to apply. R24 required assistance for transfers. Care area was triggered due to ADL review. R24 would be assisted per need and per request. R24 was to be encouraged to be as independent as able and observed for changes in her abilities. Peri care completed with incontinence episodes.R24's Urinary Incontinence and Indwelling Catheter Care Area assessment dated [DATE], identified R24 required assistance for transfers. Care area was triggered due to prescribed medication, impaired mobility, health history and ADL review. She was to be observed for changes in her elimination pattern and peri care to be completed with incontinent episodes.R24's care plan revised 5/27/26, identified the following:R24 was frequently incontinent of urine. Staff were directed to document incontinent episodes. Bladder assessment at least quarterly. Monthly 24-hour (hr) bladder/bowel record. Provide with appropriate incontinence products. R24 required an extensive partial assistance of one (PAO1) using a gait belt (GB) and a wheeled walker to transfer, wipe, adjust clothing and manage incontinence. R24 was to receive peri cares twice daily and as needed after any incontinent episode. Protective ointment to skin as needed. Observe for signs/symptoms of urinary tract infection (UTI): pain or burning with urination, fever, increased incontinence, cloudy/odorous urine in small amounts, increased confusion/lethargy. Encourage adequate fluids.R24 had self-deficit with the following activities of daily living: bathing, personal hygiene, ambulation, transferring, toileting, dressing, bed mobility, eating, ambulating and medication administration. Staff were directed R24 required assist of two (AO2) assistance with all transfers to and from bed, wheelchair and toilet. R24 used a full body mechanical lift.R24 could verbally ask for assistance with toileting. R24 required assistance from two to get R24's toileting needs addressed. R24 used the toilet for my current toileting needs and was both continent/incontinent. R24 was to be offered toileting every 3 hours to help R24 to remain free of skin breakdown and respect R24's dignity. During an observation on 6/7/26 at 11:30 a.m., R24 was lying in bed with her head of bed (HOB) at 30 degrees. R24 was wearing a dusky purple sweatshirt and no pants. There was a fleece blanket across the foot of R24's bed but it was not covering R24. R24 was wearing an incontinent brief with no pants and had her knees bent with her feet resting on the bed. R24 was crying and stated staff told R24 she had to stay in bed and couldn't get up. I don't know why. R24 then stated, they told me to pee my pants, and they'd clean me up here. R24 stated this happened all the time. At that time, nursing assistant (NA)-B stepped into the room and told R24 NA-B needed to help another resident and would be back. NA-B turned off R24's call light and left the room. R24 continued to cry and stated nursing assistants said that and shut off R24's call light just about every day and they say they're short. R24 sobbed and stated I hate it here. It's awful. I hate peeing in my pants.At 12:10 p.m., NA-B entered R24's room and told R24 she was wet and needed to be cleaned up. While putting on gloves, NA-B told (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R24 she didn't need to cry because NA-B was there. NA-B proceeded to provide incontinent care. Afterwards, NA-A and NA-B transferred R24 into her wheelchair using the full body mechanical lift. During an interview on 6/7/26 at 12:28 p.m., NA-B stated the facility was working short that day. You just do the best you can. NA-B stated R24 did get up into her chair for breakfast that morning, but staff laid R24 down to do incontinent care after breakfast. NA-B stated R24 was encouraged to stay in bed because NA-B had other residents to care for. R24 did turn on her call light and asked to get up, but R24 was assistance of 2 and NA-B was providing care to another resident. During an interview on 6/9/26 at 11:29 a.m., trained medication aide (TMA)-A stated R24 should never wait when she had to go to the bathroom because R24 would then be incontinent. R24 should never be encouraged to go to the bathroom in her pants because that's not what R24 or any resident deserved. Staff are expected to either request help from another staff member or to prioritize work to the best of their ability.During an interview on 6/9/26 at 11:42 a.m., NA-C stated R24 cannot wait when R24 asked to use the bathroom. When R24 turned on her call light, NA-C tried to get her to the bathroom right away because R24 would have an accident. R24 or any other resident should never be told to go in their pants because of dignity.During an interview on 6/9/26 at 1:36 p.m., licensed practical nurse (LPN)-A stated a resident should never be told to just go in their pants because the residents have the right to receive their care.During an interview on 6/9/26 at 2:06 p.m., registered nurse (RN)-A stated a resident should never be told to be incontinent. It was a dignity issue as well as an ADL issue. It's just wrong.During an interview on 6/9/26 at 2:49 p.m., the director of nursing (DON) stated staff were expected to provide care when requested and to ensure all residents are safe. Staff were also expected to never tell a resident to be incontinent because it was a dignity issue for the residents.The facility policy Activities of Daily Living (ADL) dated 2021, identified staff were directed to provide residents with care, treatment and services appropriate to maintain or improve their ability to carry out activities of daily living (ADLs).

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. Based on interview and document review, the facility failed to ensure a resident grievance regarding a missing hearing aid was fully investigated, documented, resolved, and communicated to the resident representative in accordance with facility policy for 1 of 1 resident (R5) reviewed for grievances. Findings include: R5's Customer Concern/Grievance dated 5/20/26, identified family member (FM)-A reported R5's hearing aid was missing. The facility documented an initial search of the room, bedding, and laundry; however, no further investigation, follow-up, or resolution was documented. R5's progress notes from 5/20/26 through 6/6/26 contained no documentation regarding the missing hearing aid or grievance follow-up. During an interview on 6/9/26 at 2:33 p.m., the social services designee (SSD) acknowledged receiving the grievance but stated it had been assigned to another person and no outcome had been communicated. During an interview on 6/9/26 at 3:48 p.m., FM-A reported she had not received any updates or information regarding the grievance after filing the concern. During an interview on 6/9/26 at 4:43 p.m., the director of nursing (DON) confirmed there was no documented follow-up and stated the expectation was that grievances would be resolved within five days and the complainant updated on progress and outcome. The facility's Concerns and Grievances policy required investigation, resolution, communication with the complainant within five business days, ongoing updates when resolution was delayed, and documentation of actions taken.

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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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to review and justify continued use of an as needed (PRN) psychotropic medication for 1 of 5 residents (R8) who were reviewed for unnecessary medications. Findings include: R8's quarterly Minimum Data Set, dated [DATE], identified R8 had moderate cognitive deficit and required moderate assistance with most activities of daily living (ADLs). R8 had not exhibited any behavior during the observation period and did not have hallucinations or delusions. R8 received antianxiety and antidepressant medications during the observation period. Diagnoses included congestive heart failure, dementia, diabetes, and depression. R8's undated Active Physician Orders, identified numerous medication orders for R8, which included haloperidol (antipsychotic) 1 milligram (MG) for agitation and restlessness every four hours PRN with start date 3/1/26 and end date was listed as open ended. R8's care plan dated 3/23/26, identified R8 was under hospice care for end-of-life status due to heart failure. Approaches included to follow the hospice plan of care, communicate with hospice physician and nurses to discuss medication concerns and what was effective. Hospice services with standing orders, scheduled and as needed (PRN) medications for pain, shortness of breath, restlessness and secretions. The care plan identified R8 received psychotropic medications for depression and anxiety with a goal to not experience any adverse reactions. Approaches listed included to administer medications as ordered. Administer the antianxiety medication for increased anxiety and restless. Staff were to document three interventions trialed before administering the PRN medication. MD review per guidelines for a gradual dose reduction and monthly pharmacist review. R8's Consultant Pharmacist Recommendation to Physician reports identified the following:3/9/26, identified the pharmacist recommended to discontinue the PRN use of Haldol 1 mg every four hours PRN for anxiety/agitation on or before 3/14/26, following federal guidelines that PNR orders for anti-psychotic drugs were limited to fourteen days and could not be renewed unless the attending physician evaluated the resident for the appropriateness of the renewal. R8's physician commented that R8 was a hospice patient and signed the recommendation with no further response or action on 3/24/26. 4/3/26, identified the pharmacist recommended to discontinue the PRN use of Haldol 1 mg every four hours PRN for anxiety/agitation on or before 3/14/26, following federal guidelines that PNR orders for anti-psychotic drugs were limited to fourteen days and could not be renewed unless the attending physician evaluated the resident for the appropriateness of the renewal. No physician response was documented. R8's PRN Medication Administration Record (MAR) dated 5/1/26 to 5/31/26, identified an order for Haldol 1 mg every four hours PRN for agitation and restless. start date of 3/1/26 and open-ended end date. The MAR documented the medication had been administered to R8 on 5/19/26 and 5/26/26. R8's medical record lacked evidence a face-to-face visit was performed by a medical provider and identified the justification for continued used of the antipsychotic. During observation on 6/7/26, R8 was noted be hollering she had to use the bathroom from her room. An unidentified nursing assistant (NA) assisted the resident to use the bathroom and then assisted her into a recliner in the facility's commons area. R8 closed her eyes and went to sleep. The NA stated R8 was tired as she had been up till 3:00 a.m. the night before. During interview on 6/8/26, at 1:23 p.m. licensed practical nurse (LPN)-A stated R8 had a PRN Haldol ordered that was used once in a while. The medication made R8 sleepy, so LPN-A did not typically give her the medication during the day. R8 was diabetic and LPN-A wanted to be sure R8 was alert enough to eat her meals. If R8 was sleepy she would not eat. The PRN Haldol order came from hospice, so hospice would be the ones to review the order. LPN-A knew a pharmacist also came once in a while and reviewed resident medications. LPN-A did know PRN anti-psychotic medications were limited to a specific time, and she had asked the hospice nurse about that, however, she did not get any results. During interview on 6/9/26, at 10:27 a.m. the director of nursing (DON) stated all PRN (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	psychotropic medications should have a fourteen-day review. She had thought the regulation had changed for hospice patients, and it could go longer than fourteen days, but she always had them reviewed every fourteen days. The facility's process was to have hospice follow their patient's medications and notify the facility if there was any need for review or update. The facility's consultant's pharmacist was telephoned on 6/9/26, at 5:56 p.m. and message left to return call. During telephone interview on 6/10/26, at 9:29 a.m. the facility's consultant pharmacist (CP)-G stated he only reviewed medications for the facility for new admissions or hospital returns and was not the pharmacist that had done the monthly medication reviews for R8. CP-G stated it was his understanding the Center for Medicaid and Medicare (CMS) guidelines were that any PRN antipsychotic medication needed to be addressed by the physician The medication needed to be limited to fourteen days and re-evaluated by the provider. If the provider chose to continue the PRN antipsychotic medication, it would need to be evaluated with a face-to-face visit from the provider. CP-G stated hospice was not an exception. The facility's policy Psychotropic Medication Use with review date 9/7/23, identified PRN orders for psychotropic drugs were limited to fourteen days and could not be renewed unless the attending provider evaluated the resident for the appropriateness of the medication.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to provide activities of daily living (ADL) care and services necessary to maintain residents' abilities by failing to provide timely toileting assistance for 1 of 6 residents (R24) reviewed who required staff assistance with toileting and transfers; and failed to provide timely supervision and assistance with eating for 1 of 6 residents (R23) reviewed who required staff assistance during meals. Findings include: R24: R24's admission Minimum Data Set (MDS) dated [DATE], identified R24 had mild cognitive impairment and was dependent on staff for toileting and transfers and was frequently incontinent with bowel and bladder. Diagnoses included non-traumatic spinal cord dysfunction, diabetes, and dementia. R24's Activities of Daily Living (ADLs) Functional/Rehabilitation Potential Care Area Assessment (CAA) dated 5/11/26, identified R24 was a recent admit from another care center and had diagnoses of dementia, depression, heart failure and asthma. R24 had clear speech and was understood and usually understood. R24 denied shortness of breath. R24 stated she had pain per medication administration record (MAR) review. R24 had a history of refusing medications per staff. R24 was frequently incontinent of bowel and bladder and had some moisture-associated skin damage (MASD) noted with ointment/cream to apply. R24 required assistance for transfers. Care area was triggered due to ADL review. R24 would be assisted per need and per request. R24 was to be encouraged to be as independent as able and observed for changes in her abilities. Peri care completed with incontinence episodes. R24's Urinary Incontinence and Indwelling Catheter Care Area assessment dated [DATE], identified R24 required assistance for transfers. Care area was triggered due to prescribed medication, impaired mobility, health history and ADL review. She was to be observed for changes in her elimination pattern and peri care to be completed with incontinent episodes. R24's care plan revised 5/27/26, identified the following: R24 was frequently incontinent of urine. Staff were directed to document incontinent episodes. Bladder assessment at least quarterly. Monthly 24-hour (hr) bladder/bowel record. Provide with appropriate incontinence products. R24 required an extensive partial assistance of one (PAO1) using a gait belt (GB) and a wheeled walker to transfer, wipe, adjust clothing and manage incontinence. R24 was to receive peri cares twice daily and as needed after any incontinent episode. Protective ointment to skin as needed. Observe for signs/symptoms of urinary tract infection (UTI): pain or burning with urination, fever, increased incontinence, cloudy/odorous urine in small amounts, increased confusion/lethargy. Encourage adequate fluids. R24 had self-deficit with the following activities of daily living: bathing, personal hygiene, ambulation, transferring, toileting, dressing, bed mobility, eating, ambulating and medication administration. Staff were directed R24 required assist of two (AO2) assistance with all transfers to and from bed, wheelchair and toilet. R24 used a full body mechanical lift. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R24 could verbally ask for assistance with toileting. R24 required assistance from two to get R24's toileting needs addressed. R24 used the toilet for my current toileting needs and was both continent/incontinent. R24 was to be offered toileting every three hours to help R24 to remain free of skin breakdown and respect R24's dignity. During an observation on 6/7/26 at 11:30 a.m., R24 was lying in bed with her head of bed (HOB) at 30 degrees. R24 was wearing a dusky purple sweatshirt and no pants. There was a fleece blanket across the foot of R24's bed but it was not covering R24. R24 was wearing an incontinent brief with no pants and had her knees bent with her feet resting on the bed. R24 was crying and stated staff told R24 she had to stay in bed and couldn't get up. I don't know why. R24 then stated, they told me to pee my pants, and they'd clean me up here. R24 stated this happened all the time. At that time, nursing assistant (NA)-B stepped into the room and told R24 NA-B needed to help another resident and would be back. NA-B turned off R24's call light and left the room. R24 continued to cry and stated nursing assistants said that and shut off R24's call light just about every day and they say they're short. R24 sobbed and stated I hate it here. It's awful. I hate peeing in my pants. At 12:10 p.m., NA-B entered R24's room and told R24 she was wet, so she needed to be cleaned up. NA-B put on gloves then told R24 she didn't need to cry because she was there. R24 stated I want to get up. At 12:11 p.m. NA-B unfastened R24's incontinent brief and used disposable wipes to clean R24's skin of feces and urine. R24 stated that her skin was itchy, NA-B told R24 that R24 had pooped and NA-B would clean R24's skin well. At 12:13 p.m., NA-B rolled R24 to the right and R24 began crying and stated, I can't do this. NA-B told R24 that they were almost done. R24's skin on her upper thighs and buttocks was reddened but had no open areas. NA-B applied barrier cream then a clean brief. At 12:16 p.m., NA-B put on R24's pants. NA-B then removed her gloves and removed the trash from the trash containers and asked for assistance with R24's transfer over the walkie. NA-B exited the room. At 12:19 p.m., NA-B returned with a full body mechanical lift sling and placed it under R24. NA-B told R24 that she needed another staff person to assist with the transfer and left the room. At 12:22 p.m., NA-A and NA-B entered the room and used the ceiling lift to transfer R24 from her bed to her wheelchair. NA-B then brought R24 to the dining room for her noon meal. During an interview on 6/7/26 at 12:28 p.m., NA-B stated the facility was working short that day. You just do the best you can. NA-B stated R24 did get up into her chair for breakfast that morning, but staff laid R24 down to do incontinent care after breakfast. NA-B stated R24 was encouraged to stay in bed because NA-B had other residents to care for. R24 did turn on her call light and asked to get up, but R24 was assistance of 2 and NA-B was providing care to another resident. During an interview on 6/9/26 at 11:29 a.m., trained medication aide (TMA)-A stated R24 should never wait when she had to go to the bathroom because R24 would then be incontinent and R24 deserved to receive the care she needed. Staff were expected to either request help from another staff member or to prioritize work to the best of their ability. During an interview on 6/9/26 at 11:42 a.m., NA-C stated R24 cannot wait when R24 asked to use the (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	bathroom. When R24 turned on her call light, NA-C tried to get her to the bathroom right away because R24 would have an accident. During an interview on 6/9/26 at 1:36 p.m., licensed practical nurse (LPN)-A stated staff were expected to provide timely toileting assistance to prevent incontinence and skin breakdown. During an interview on 6/9/26 at 2:06 p.m., registered nurse (RN)-A stated a resident should be provided with timely toileting assistance to prevent incontinence and skin breakdown. During an interview on 6/9/26 at 2:49 p.m., the director of nursing (DON) stated staff were expected to provide care when requested and to ensure all residents were safe. R23: R23's quarterly MDS dated [DATE], identified R23 was cognitively intact and independent with eating. R23 had diagnoses of obesity and mass/lump on abdomen. The MDS did not identify any a significant weight loss or gain. R23's mini nutritional assessment dated [DATE], identified R23 normally ate 51-75% of most meals. R23 was assisted with meals for optimal intake. R23's care plan dated 5/26/26 identified R23 was independent with eating. During observations on 6/7/26 at 1:04 p.m., there was not enough staff in the dining room to assist residents with eating. A t 1:05 p.m., there were at least 2 residents who were sitting there with food in front of them and were not eating nor was staff helping them. A t 1:09 p.m., R23 was identified as one of the residents sitting at the table where staff are supposed to assist residents with eating. At 1:12 p.m., R23 still had her plate of food in front of her, and she had not attempted to eat. R23's potatoes and meat had formed a crust on them. R23 waited 45 minutes before staff assisted her to eat. At 1:15 p.m., R23 ate well with staff assistance. During an interview on 6/9/26 at 7:36 a.m., nursing assistant (NA)-D stated R23 needed to be supervised while eating. R23 ate slowly and it would take her a while to eat, and we encourage her at that time. When R23 stopped using the silverware while eating, staff assisted R23. During an interview on 6/9/26 at 2:02 p.m., NA-A stated R23 had changed over the weekend, previously she just required supervision with eating. R23 had seemed to decline and had started to pocket food and had moved to a different table to assist with eating because R23 needed more help with meals. During lunch on Sunday 6/7/26, the facility was short staffed and the residents in the dining room had to wait for assistance to eat and some had to wait an extended period of time before they received help. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/9/26 at 4:43 p.m., the director of nursing (DON) stated residents who required supervision with eating would be watched and if the residents had stopped eating or had not started for about five minutes staff are expected to cue residents to continue to eat. If after ten minutes staff should approach resident and assist with eating. I would be expected if R23 was not eating it would be realized quickly and assisted in a timely fashion. It is not dignified to sit there with a plate of food in front of you and not being able to eat it. Staff should wait until someone is available to assist with eating before bringing out the plate. The facility policy Activities of Daily Living (ADL) dated 2021, identified staff were directed to provide residents with care, treatment and services appropriate to maintain or improve their ability to carry out activities of daily living (ADLs).

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** During observation, interview, and document review, the facility failed to perform hand hygiene between glove changes during pressure ulcer wound care for 1 of 2 residents (R5) reviewed for pressure ulcers, creating the potential for contamination of pressure ulcer wounds and development of infection. Findings include:R5's admission Minimum Data Set (MDS) dated [DATE], identified R5 was cognitively intact. R5 was substantial/maximal assist with transfers, and supervision with bed mobility. R5's diagnosis includes fracture of thoracic (mid back) vertebrae, muscle weakness, and amputation of right lower leg. It identified the resident was at risk for pressure ulcers but did not have one. R5's pressure ulcer/injury Care Area Assessment (CAA) dated 5/8/26, identified R5 was at risk for pressure ulcers due to recent injury with a fracture of thoracic vertebra. Plan of care updated for prevention of pressure related skin impairments. R5's provider's orders identified the following:6/1/26, identified for left heel, cleanse heel gently with saline wipe. Pat dry. place a Mepilex (a specialized silicone foam dressing). over the area. 6/8/26, identified to cleanse the right buttock with saline wipes and pat dry, then pack with Aquacel AG (an advanced antimicrobial primary wound dressing) and cover with a sacral Mepilex. In gluteal crease (between the buttocks) cleanse wound with saline wipes and cover with a 4-inch by 4-inch Mepilex.R5's wound assessment dated [DATE], identified they had a pressure ulcer on right upper buttock. The wound measured 5 centimeters (cm) wide x 6.5 cm long x 2 cm deep. The wound was odorous, and heavy drainage of purulent dark brown drainage which saturated the dressings. R5 also had an unstageable pressure ulcer on their coccyx measuring 2.2 cm x 2.8 and identified scab was completely attached. R5 also had a deep tissue injury on his left heel with drained blister and intact epidermal (skin) layer in place which measured 4 cm x 5 cm. The resident was seen the previous week and had wound debrided and had not much change and ordered a follow up appt for wound debridement. During observation on 6/9/26 at 8:08 a.m., licensed practical nurse (LPN)-A gathered the supplies she would need and asked nursing assistant (NA)-A to help position R5. LPN-A and NA-A both sanitized hands and then put on personal protective equipment (PPE) for wound dressing change. Once in the room they positioned R5, and NA-A helped to stabilize him. LPN-A placed a barrier down and then proceeded to remove the old dressing. The dressing was saturated with purulent dark brown drainage and was very odorous. The wound bed was full of slough (dead, non-viable tissue that accumulated on the surface of the wound bed). The gluteal fold dressing was also removed due to starting to come off. Once the dressings were removed, LPN-A removed the dirty gloves and did not do hand hygiene and then placed another pair of gloves on. LPN-A then proceeded to clean both wounds using saline spray and wipes. LPN-A then removed her dirty gloves and did not perform hand hygiene before putting a pair of new gloves on. LPN-A opened the Aquacel AG and placed it in the wound bed then opened the sacral Mepilex on the wound on the right buttock and then placed a 4-inch x 4-inch Mepilex in gluteal crease. LPN-A then started to clean up and when completed she removed her gloves then seen the left heel dressing was coming off. Without doing hand hygiene LPN-A placed a pair of gloves on and then removed the old dressing. There was no drainage or odor coming from wound and it was covered with a layer of old skin. LPN-A removed gloves and put a different pair on without doing hand hygiene and then, then proceeded to clean the heel with saline wipes. Then changed gloves again without doing hand hygiene and placed the 4-inch x 4-inch Mepilex dressing on R5's heel. Upon completing the dressing changes, she washed her hands with soap and water and then removed her gown and sanitized her hands on exiting the room. During an interview on 6/9/26 at 8:51 a.m., LPN-A stated she washed her hands prior to starting and once the dressing change was done. She did not think to do hand hygiene when changing gloves. During an interview on 6/9/26 at 8:51 a.m., the director of nursing (DON) stated nurses were to follow wound procedures when doing dressing changes. That would include hand hygiene each time gloves were changed. Hand hygiene was done to ensure the (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	wound does not become decontaminated when placing clean dressings. The facility's Contact Precautions policy dated 9/2023, identified hand hygiene is performed between glove changes and when removing gloves. A policy regarding pressure ulcers was requested, but one was not received.

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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 interview and document review, the facility failed to ensure transfers were performed in accordance with assessed needs, care plan interventions, and facility policy for 1 of 3 residents (R24) reviewed for accidents. Staff performed transfers using a full-body mechanical lift with one staff member rather than the required two staff members, creating the potential for falls, entrapment, and transfer-related injury. Findings include:R24's admission Minimum Data Set (MDS) dated [DATE], identified R24 had a mild cognitive impairment and had diagnoses that included non-traumatic spinal cord dysfunction, diabetes, and dementia. R24 was dependent on staff for toileting and transfers and was frequently incontinent with bowel and bladder.R24's Activities of Daily Living (ADLs) Functional/Rehabilitation Potential Care Area Assessment (CAA) dated 5/11/26, identified R24 was a recent admit from another care center and had diagnoses of dementia, depression, heart failure and asthma. R24 had clear speech and was understood and usually understood. R24 denied shortness of breath. R24 stated she had pain per medication administration record (MAR) review. R24 had a history of refusing medications per staff. R24 was frequently incontinent of bowel and bladder and had some moisture-associated skin damage (MASD) noted with ointment/cream to apply. R24 required assistance for transfers. Care area was triggered due to ADL review. R24 would be assisted per need and per request. R24 was to be encouraged to be as independent as able and observed for changes in her abilities. Peri care completed with incontinence episodes.R24's Urinary Incontinence and Indwelling Catheter Care Area assessment dated [DATE], identified R24 required assistance for transfers. Care area was triggered due to prescribed medication, impaired mobility, health history and ADL review. She was to be observed for changes in her elimination pattern and peri care to be completed with incontinent episodes.R24's care plan revised 5/27/26, identified R24 had self-deficit with transferring. Staff were directed to provide assistance with two staff with all transfers to and from bed, wheelchair and toilet. R24 used a full body mechanical lift. During an interview on 6/9/26 at 11:29 a.m., trained medication aide (TMA)-A stated staffing was awful. The facility used a lot of agency staff and the schedule frequently got messed up which added to the problem. Staff did the best they could with what they had. TMA-A tried her hardest when they had to work short to prioritize work and to help the nursing assistants as much as she was able. R24 could not wait when R24 asked to use the bathroom because she would be incontinent. TMA-A stated she wasn't going to lie and transferred R24 using the full body mechanical lift by herself. TMA-A did this because R24 had a right to get up and use the bathroom. It was also harmful to R24 skin to void in her pants. TMA-A stated she felt the transfer was safe doing that.During an interview on 6/9/26 at 11:42 a.m., NA-C stated she never transferred R24 with assistance of one and the full body mechanical lift. It was unsafe to do that. During an interview on 6/9/26 at 11:57 a.m., R24 stated sometimes there was not enough staff at the facility, and they transfer her with the lift with only one staff member. R24 stated they say there's not enough staff and it was against the rules, but they do it. R24 never felt unsafe but knew she was not supposed to tell anyone to get anybody in trouble. I'm just thankful to get to the toilet. During an interview on 6/9/26 at 1:36 p.m., licensed practical nurse (LPN)-A stated she had told the nursing assistants to not transfer any resident with the full body mechanical lift with assistance of one and had never witnessed any staff doing that. During an interview on 6/9/26 at 1:49 p.m., nursing assistant (NA)-A didn't know for sure if staff transferred R24 using the full body mechanical lift with only one staff member, but if they're unable to find help NA-A could see them doing it. NA-A stated she has seen staff come out of a room pushing a resident in a wheelchair and NA-A had questioned how the resident was transferred because NA-A had not helped. NA-A stated she had never asked, and the staff member had never said.During an interview on 6/9/26 at 2:06 p.m., registered nurse (RN)-A stated the staff should never be so short staffed they were transferring any resident using the (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	ceiling lift with assistance of one for the safety of the resident. During an interview on 6/9/26 at 2:49 p.m., the director of nursing (DON) stated no resident should be transferred with the full body mechanical lift using assistance of one because it was a safety issue as well as best practice. The facility policy Using a Mechanical Lift dated 2024, identified the purpose of this procedure is to establish the general principles of safe lifting using a mechanical lifting device. It is not a substitute for manufacturer's training or instructions. I. At least two (2) trained associates are needed to safely move a resident with a mechanical full body floor based mechanical lift or a ceiling/overhead full body lift.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 a reported medication error was investigated, documented, and addressed in accordance with facility policy for 1 of 5 residents (R37) reviewed for unnecessary medications. This deficient practice resulted in the facility's inability to determine the circumstances surrounding a reported Zepbound medication error, assess resident impact, and implement interventions to prevent recurrence.Findings include: R37's quarterly Minimum Data Set (MDS) dated [DATE], identified R37 had a moderate cognitive impairment and had diagnoses that included morbid obesity, cerebral palsy and obstructive sleep apnea. R37's Event Report dated 4/23/26 at 9:37 a.m., identified Zepbound (an FDA-approved, once-weekly injectable medication containing tripeptide. It is prescribed alongside a reduced-calorie diet and increased exercise for chronic weight management in adults with obesity or those who are overweight with weight-related conditions) wrong dose on 4/22/26. The report failed to identify any investigation into the event or actions taken to prevent further events. R37's medical record failed to identify any further information regarding the 4/22/26 Zepbound wrong dose. During an interview on 6/8/26 at 10:44 a.m., the director of nursing (DON) stated she had reviewed R37's medical record and R37's medication error investigation. The DON stated there was a lapse in the process and an investigation was not completed. The DON spoke with facility staff who explained the medication did not come from the pharmacy and R37 did not receive his dose of medication. However, the event report stated wrong dose. The DON stated investigation needed to be done to ensure what had occurred. The staff were expected to complete an event report, then complete an investigation into what had happened. This needed to be documented as well as interventions to prevent further medication errors. During an interview on 6/9/26 at 2:15 p.m., registered nurse (RN)-A stated she vaguely remembered the event and attempted to review R37's medical record for further information. RN-A stated there was no documentation to explain what had occurred or actions taken. RN-A stated there should be a progress note, an event report, and a documented investigation into what happened. Afterwards, it would be brought to IDT to discuss what had occurred and/or if further actions needed to be taken. An emailed response from the consultant pharmacist dated 6/10/26, identified the pharmacist expected facility staff to complete a thorough root cause investigation and analysis, appropriate follow-up, and detailed documentation for any medication error identified. This should include assessment of the resident, physician notification when indicated, monitoring for adverse effects, and implementation of measures to help prevent recurrence. In the case of a resident receiving a one-time higher dose of tirzepatide (Zepbound), potential adverse effects may include gastrointestinal intolerance such as nausea, vomiting, diarrhea, abdominal discomfort, and decreased appetite. Conversely, if a resident receives a lower-than-ordered dose, potential concerns may include less effective appetite suppression, and possible elevations in blood glucose for residents using the medication for glycemic control. The facility policy Medication Error/Occurrence dated 2021, identified When an error is made in the preparation or administration of a drug or biological, the licensed nurse provides any necessary immediate care and notifies the attending provider and resident or resident representative when nursing or medical intervention, observation or treatment is indicated. Medication errors are tracked and trended for quality improvement purposes.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to ensure consultant pharmacist recommendations regarding an irregularity in psychotropic medication use were addressed and resolved for 1 of 5 residents (R8) reviewed for unnecessary medications. The facility failed to ensure a required face-to-face practitioner evaluation occurred and allowed a PRN antipsychotic medication order to remain active and be administered despite repeated consultant pharmacist recommendations for review and discontinuation.Findings include: R8's quarterly Minimum Data Set, dated [DATE], identified R8 had moderate cognitive deficit and required moderate assistance with most activities of daily living (ADLs). R8 had not exhibited any behavior during the observation period and did not have hallucinations or delusions. R8 consumed antianxiety and antidepressant medications during the observation period. Diagnoses included congestive heart failure, dementia, diabetes, and depression. R8's care plan dated 3/23/26, identified R8 was under hospice care for end-of-life status due to heart failure. Approaches included to follow the hospice plan of care, communicate with hospice physician and nurses to discuss medication concerns and what was effective. Hospice services with standing orders, scheduled and as needed (PRN) medications for pain, shortness of breath, restlessness and secretions. The care plan identified R8 received psychotropic medications for depression and anxiety with a goal to not experience any adverse reactions. Approaches listed included to administer medications as ordered. Administer the antianxiety medication for increased anxiety and restless. Staff were to document three interventions trialed before administering the PRN medication. MD review per guidelines for a gradual dose reduction and monthly pharmacist review. R8's undated Active Physician Orders identified numerous medication orders for R8, which included haloperidol 1 milligram (MG) for agitation and restlessness every four hours PRN with start date 3/1/26 and end date was listed as open ended. R8's PRN Medication Administration Record (MAR) dated 5/1/26 to 5/31/26, identified an order for Haldol 1 mg every four hours PRN for agitation and restless. start date of 3/1/26 and open-ended end date. The MAR documented the medication had been administered to R8 on 5/19/26 and 5/26/26. Consultant Pharmacist Recommendation to Physician forms identified the following:3/9/26, identified the pharmacist recommended to discontinue the PRN use of Haldol 1 mg every four hours PRN for anxiety/agitation on or before 3/14/26, following federal guidelines that PNR orders for anti-psychotic drugs were limited to fourteen days and could not be renewed unless the attending physician evaluated the resident for the appropriateness of the renewal. R8's physician commented that R8 was a hospice patient and signed the recommendation with no further response or action on 3/24/26. 4/3/26, identified the pharmacist recommended to discontinue the PRN use of Haldol 1 mg every four hours PRN for anxiety/agitation on or before 3/14/26, following federal guidelines that PNR orders for anti-psychotic drugs were limited to fourteen days and could not be renewed unless the attending physician evaluated the resident for the appropriateness of the renewal. No physician response was documented. R8's medical record lacked a face-to-face assessment by the medical provider to justify continued use of the Haldol. During interview on 6/9/26, at 10:27 a.m. the director of nursing (DON) stated all PRN psychotropic medications should have a fourteen-day review. She had thought the regulation had changed for hospice patients, and it could go longer than fourteen days, but she always had them reviewed every fourteen days. The facility's process was to have hospice follow their patient's medications and notify the facility if there was any need for review or update. The facility's consultant's pharmacist was telephoned on 6/9/26, at 5:56 p.m. and message left to return call. During telephone interview on 6/10/26, at 9:29 a.m. the facility's consultant pharmacist (CP)-G stated he only reviewed medications for the facility for new admissions or hospital returns and was not the pharmacist that had done the monthly medication reviews for R8. CP-G stated it was his understanding the Center for Medicaid and Medicare (CMS) guidelines were that any (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PRN antipsychotic medication needed to be addressed by the physician The medication needed to be limited to fourteen days and re-evaluated by the provider. If the provider chose to continue the PRN antipsychotic medication, it would need to be evaluated with a face-to-face visit from the provider. CP-G stated hospice was not an exception. In an electronic mail (email) response received on 6/10/26, at 4:30 p.m. CP-H wrote she had made recommendations to R8's primary provider both in March and April of 2026. R8's physician had signed each recommendation, acknowledging he had reviewed them. In addition, CP-H had emailed the DON and the facility's medical director to reiterate that all PRN antipsychotic medications were subject to an initial 14 day stop date requirement unless a documented face to face evaluation was completed. The order for the PNR haloperidol was discontinued on 6/9/26, However, the discontinuation of the medication was after interviews were completed regarding the continued use of the PRN medication. The facility's policy Psychotropic Medication Use with review date 9/7/23, identified PRN orders for psychotropic drugs were limited to fourteen days and could not be renewed unless the attending provider evaluated the resident for the appropriateness of the medication.