STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245511	A. Building B. Wing	01/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cura of Monticello	1104 East River Street Monticello, MN 55362

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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 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 record review and interview, the facility failed to ensure residents' comprehensive care plans were updated to include Enhanced Barrier Precautions (EBP) interventions for 3 of 3 residents reviewed (R11, R14, and R28) who met criteria for EBP. Furthermore, based on observation, interview and document review, the facility failed to ensure resident care plans and TASK sheets contained information for 1 of 1 resident (R1) in the sample who received oxygen. Findings include: R11R11's quarterly Minimum Data Set (MDS) dated [DATE], identified R11 had intact cognition and required assistance with activities of daily living (ADLs). R11's diagnoses included chronic systolic congestive heart failure (a condition in which the heart has a reduced ability to pump blood effectively), hypertension (persistently elevated blood pressure), arthritis (inflammation of joints causing pain and stiffness), depression (a mood disorder causing persistent sadness and loss of interest), atrial fibrillation (an irregular and often rapid heart rhythm), pain in the right and left hands, bilateral blindness with category 3 severe visual impairment (profound vision loss), a stage 2 pressure ulcer (partial-thickness skin loss), congenital glaucoma (elevated eye pressure present at birth), and Barrett's esophagus without dysplasia (abnormal esophageal lining without precancerous changes). The MDS also identified R11 was blind, at risk for falls, and had one stage 2 pressure ulcer. R11's electronic medical record (EMR), reviewed on 1/14/26, identified R11 required Enhanced Barrier Precautions due to wounds on the coccyx and back of the thigh. Review of R11's comprehensive care plan revealed no interventions addressing Enhanced Barrier Precautions, including the use of gowns and gloves during high-contact resident care activities, staff instructions, or infection control measures. There was no evidence the care plan had been revised to reflect R11's infection prevention needs. R14R14's annual MDS dated [DATE], identified R14 had intact cognition and required assistance with ADLs. R14's diagnoses included arthritis (joint inflammation causing pain and stiffness), osteoporosis (decreased bone density increasing fracture risk), anxiety disorder (persistent excessive worry and fear), depression (mood disorder causing persistent sadness and loss of interest), chronic obstructive pulmonary disease (COPD) (a chronic lung disease causing airflow limitation), respiratory failure (inability of the lungs to adequately exchange oxygen and carbon dioxide), displaced bimalleolar fracture of the right lower leg (fracture involving both ankle bones with bone displacement), complex regional pain syndrome (a chronic pain condition affecting a limb), neuralgia and neuritis (nerve pain and nerve inflammation), dysphasia (difficulty swallowing), lymphedema (swelling due to lymphatic fluid buildup), and chronic respiratory failure with hypoxia (long-term inadequate oxygen levels in the blood). The MDS indicated R14 received oxygen therapy and had no pressure ulcers or wounds. R14's EMR, reviewed on 1/14/26, identified R14 required Enhanced Barrier Precautions due to a (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	pressure ulcer on the right medial ankle. Review of R14's comprehensive care plan revealed no interventions addressing Enhanced Barrier Precautions, including the use of gowns and gloves during high-contact resident care activities, staff instructions, or infection control measures. There was no evidence that the care plan had been revised to reflect R14's infection prevention needs. R28R28's quarterly MDS dated [DATE], identified cognition was coded as not assessed, and the resident required assistance with ADLs. R28's diagnoses included progressive neurological conditions (disorders affecting the brain and nervous system that worsen over time), Parkinson's disease with dyskinesia with fluctuations (a movement disorder causing tremors, rigidity, and involuntary movements that vary in severity), hypertension (chronically elevated blood pressure), non-Alzheimer's dementia (decline in memory, thinking, and reasoning not caused by Alzheimer's disease), anxiety disorder (persistent excessive fear or worry), psychotic disorder (loss of contact with reality, including delusions or hallucinations), hallucinations (perceiving sights, sounds, or sensations that are not present), obstructive sleep apnea (repeated airway obstruction during sleep causing breathing pauses), and adjustment disorder with anxiety (an emotional or behavioral response to stress causing anxiety symptoms). R28's EMR, reviewed on 1/14/26, identified R28 required Enhanced Barrier Precautions due to wounds on the right and left buttocks. Review of R28's comprehensive care plan revealed no interventions addressing Enhanced Barrier Precautions, including the use of gowns and gloves during high-contact resident care activities, staff instructions, or infection control measures. There was no evidence the care plan had been revised to reflect R28's infection prevention needs. During an interview on 1/15/26 at 10:10 a.m., nursing assistant (NA)-D confirmed staff relied on posted signage to determine which precautions residents were on. NA-D confirmed R11, R14, and R28 were on EBP precautions but was unsure of the reason and stated the residents had been on precautions for a long time. NA-D stated staff were to don gloves, a gown, and a face mask when assisting residents with high-contact ADLs. During an interview on 1/15/26 at 10:24 a.m., NA-E confirmed R11, R14, and R28 were on EBP precautions and had been on them for some time. NA-E confirmed staff relied on isolation signage and did not reference the care plan for EBP guidance. NA-E stated staff were to don gloves, a face mask, and a gown when assisting residents with high-contact cares. During an interview on 1/15/26 at 1:02 p.m., the registered nurse clinical coordinator (RN)-C and assistant director of nursing (ADON)-B confirmed R11, R14, and R28 required EBP and that EBP were not addressed in the residents' care plans. RN-C and ADON-B stated EBP should be included in the care plan, so staff are aware of how to care for each resident and understand the reason for the precautions. R1 R1's admission record documented the diagnoses of essential hypertension, paroxysmal atrial fibrillation and asthma. R1 was admitted to the facility after a hospital stay for pneumonia. R1's admission Minimum Data Set (MDS) dated [DATE], indicated R1 required assistance with activities of daily living (ADLs), received oxygen and was moderately cognitively impaired. During observation and interview on 1/12/26 at 10:47 a.m., R1 stated she was admitted to the facility (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	from a hospital after she fell due to pneumonia at home. R1 was wearing a nasal cannula for oxygen, no date was found to indicate when the tubing was last changed. Noted the cannula prongs (the parts placed in the nares of the nose) had a slight tan color (normally clear in color). R1 was unable to remember when her oxygen tubing was last changed. In review of R1's care plan, initiated 11/18/25, did not document the use of oxygen, only [Self-Care] deficit related to pneumonia, acute respiratory failure, neither the goal nor the approach sections documented the use of oxygen. A review of the Task section in Point Click Care (PCC – electronic medical record) for R1, also lacked documentation R1 was receiving oxygen therapy. In an interview on 1/15/26 at 1:41 pm, nursing care manager (RN)-B and assistant director or nursing (ADON)-A, after review of the R1's care plan and TASK section of the PCC, RN-B verified the documents lack the documentation R1 utilized oxygen (RN-B updated the TASK sheet before providing a copy to surveyor). The facility policy, entitled: Care Plans, Comprehensive Person – Centered (effective date: 02/2025) indicated the following: 10. Identifying problem areas and their causes, and developing interventions that are targeted and meaningful to the resident, are the endpoint of an interdisciplinary process. a. No single discipline can manage an approach in isolation. b. The resident's physician (or primary healthcare provider) is integral to this process.

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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 residents were provided care in a manner that promoted dignity and respect by failing to offer and perform routine grooming services, specifically shaving, for 2 of 2 residents (R14 and R28) reviewed for personal hygiene. In addition, the facility failed to ensure a catheter bag containing urine was concealed from public view for 1 of 1 residents (R20) reviewed with a catheter.Findings included: R14 R14's annual Minimum Data Set (MDS) dated [DATE], identified R14 had intact cognition and required assistance with activities of daily living (ADLs). R14's diagnoses included arthritis (joint inflammation causing pain and stiffness), osteoporosis (decreased bone density increasing fracture risk), anxiety disorder (persistent excessive worry and fear), depression (mood disorder causing persistent sadness and loss of interest), chronic obstructive pulmonary disease (COPD) (chronic lung disease causing airflow limitation), respiratory failure (inability of the lungs to adequately exchange oxygen and carbon dioxide), displaced bimalleolar fracture of the right lower leg (fracture involving both ankle bones with bone displacement), complex regional pain syndrome (chronic pain condition affecting a limb), neuralgia and neuritis (nerve pain and nerve inflammation), dysphasia (difficulty swallowing), lymphedema (swelling due to lymphatic fluid buildup), and chronic respiratory failure with hypoxia (long-term inadequate oxygen levels in the blood). During observation on 1/12/26 at 12:02 p.m., R14 was observed in the dining room with several long white hairs along the right side of her jawline and chin measuring approximately one inch in length. During observation on 1/13/26 at 1:04 p.m., the white chin hair remained present along the right side of R14's jawline and chin. During observation and interview on 1/14/26 at 9:14 a.m., R14 continued to have chin hairs present and stated she did not like having them and stated staff needed to assist her with shaving. During observation on 1/15/26 at 10:18 a.m., R14 exited the tub room with facial hair still present. Staff assisted R14 to activities and did not offer to assist R14 with shaving. R14's electronic medical record (EMR), reviewed 4/20/25 to 1/15/26, revealed the following: R14's care plan, dated 1/5/26, revealed R14 required staff assistance with personal hygiene and grooming. EMR lacked documentation indicating staff offered shaving assistance or that R14 refused shaving. R28 R28's quarterly MDS dated [DATE], identified R28's cognition was not assessed and indicated R28 required assistance with ADLs. R28's diagnoses included progressive neurological conditions (disorders causing gradual decline in nervous system function), Parkinson's disease with dyskinesia with fluctuations (neurodegenerative disorder causing tremors, rigidity, and involuntary movements (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	with symptom variability), hypertension (high blood pressure), non-Alzheimer's dementia (cognitive decline not caused by Alzheimer's disease), anxiety disorder (persistent excessive worry and fear), psychotic disorder (condition involving impaired reality perception), hallucinations (seeing or hearing things not present), obstructive sleep apnea (repeated breathing interruptions during sleep), and adjustment disorder with anxiety (emotional response to stress causing anxiety). R28's annual MDS dated [DATE], identified R28 had intact cognition and required assistance with ADLs. During observation and interview on 1/12/26 at 1:04 p.m., R28 was observed with long facial hair extending beyond the chin and upper lip, with uneven growth. R28 stated he preferred to be clean shaven and stated he needed staff assistance with shaving. During observation on 1/13/26 at 1:46 p.m., R28's facial hair remained present. During observation on 1/14/26 at 9:11 a.m., R28 was observed exiting the tub room following his bath, and facial hair remained present. During observation and interview on 1/14/26 at 2:21 p.m., R28's facial hair remained present. R28 stated he had received a bath that morning, but staff had not assisted him with shaving and stated staff still have to do that. During observation on 1/15/26 at 7:27 a.m., R28's facial hair remained present. R28's EMR, reviewed 4/20/25 to 1/15/26, revealed the following: R28's care plan, dated 10/22/25, indicated R28 required staff assistance with personal hygiene and grooming. EMR lacked documentation indicating staff offered shaving assistance or that R28 refused shaving. EMR also identified a task for staff to assist R28 with shaving every morning; however, the task was documented as completed (yes) on 1/13/26 and 1/14/26 despite observations and interview with R28 to indicate shaving was not performed. During interview on 1/15/26 at 10:10 a.m., nursing assistant (NA)-D stated NAs assisted residents with shaving. NA-D stated when chin hair was observed, staff could assist the resident with shaving at that time, otherwise it would be completed on bath days. NA-D stated both R14 and R28 required staff assistance with shaving and preferred to be clean shaven. During interview on 1/15/26 at 10:24 a.m., NA-E stated whichever staff member noticed facial hair on a resident should immediately assist the resident with shaving or ensure it was addressed on bath days. During interview on 1/15/26 at 1:02 p.m., the registered nurse care manager (RN)-C and assistant director of nursing (ADON)-B stated they expected staff to assist residents with shaving on bath days or whenever facial hair was observed. RN-C and ADON-B stated R28 was very particular about shaving and that being clean shaven was very important to him. RN-C and ADON-B confirmed both R14 and R28 should have been assisted with shaving by staff. ADON-B stated assisting residents (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	with shaving was important for the resident's dignity. R20 R20's admission MDS dated [DATE], identified R20 was dependent on staff for activities of daily living (ADLs). Diagnoses included Hypertensive heart and chronic kidney disease with heart failure, hyperlipidemia, benign prostatic hyperplasia (enlarged prostate causing urinary issues by pressing on the urethra), and retention of urine. R20 had an indwelling catheter. During observation on 1/12/26 at 10:17 a.m., R20 was seated in common area watching television (TV) with urine catheter bag hung from leg rest on wheelchair, no cover was in place. Yellow colored urine was observed in the bag. On 1/13/26 at 3:37 p.m., observed R20 seated in his room, door open, observed from the hallway R20's catheter bag was uncovered with yellow urine observed in the bag. On 1/13/26 at 5:55 p.m., R20 was observed in the main dining room, catheter bag was hung, uncovered, on R20's wheelchair, with yellow urine visible. On 1/14/26 at 9:44 a.m., R20 was seated in his room, catheter bag uncovered with yellow urine visible. On 1/15/26 9:57 a.m., R20 observed seated in his room, uncovered catheter bag was hung on side of leg rest on wheelchair with yellow urine visible from the hallway. When interviewed on 1/15/26 at 11:00 a.m., nursing assistant (NA)-A stated R20 did not use a leg bag for his catheter. NA-A stated catheter bags had a blue privacy flap attached to the bag to protect dignity of residents with catheters. NA-A and surveyor observed R20's catheter bag, NA-A stated, Oh he doesn't have a flap, NA-A further stated since the bag did not have a flap it should have been placed in a privacy bag. When interviewed on 1/15/26 at 11:48 a.m., licensed practical nurse (LPN)-A stated privacy bags were available and should be in place when a resident has left their room. LPN-A stated the catheter bags usually had a privacy flap which protected residents' dignity especially in the dining room, LPN-A stated, I know I don't want to look at someone's urine. When interviewed on 1/15/26 at 1:41 p.m., assistant director of nursing (ADON)-A stated the expectation was for the privacy and dignity of residents, catheter bags were to be placed in a privacy bag or a bag with a privacy flap was to be used. Facility Quality of Life-Dignity policy dated 10/2025, indicated demeaning practices and standards of care that compromise dignity are prohibited, staff shall promote dignity and assist residents as needed by helping the resident to keep urinary catheter bags covered.

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure a resident was assessed, as scheduled, for the ability to safely self-administer a prescribed nebulizer treatment for 1 of 1 resident reviewed (R14). Specifically, the facility failed to complete required assessments to determine the resident's continued ability to self-administer nebulizer treatments in accordance with facility policy and professional standards of practice. This deficient practice resulted in the potential for improper medication administration, missed or ineffective treatments, and respiratory compromise.Findings included:R14's annual Minimum Data Set (MDS) dated [DATE] identified R14 had intact cognition and required assistance with activities of daily living (ADLs). R14's diagnoses included chronic obstructive pulmonary disease [COPD] (chronic lung disease causing airflow limitation), respiratory failure (inability of the lungs to adequately exchange oxygen and carbon dioxide), dysphasia (difficulty with swallowing and/or speech related to neurological impairment), and chronic respiratory failure with hypoxia (long-term inability to maintain adequate blood oxygen levels). The MDS indicated R14 received oxygen therapy.During observation on 1/15/26 at 9:14 a.m., R14 was observed sitting in her wheelchair in her room with her eyes closed and her head hanging forward. The nebulizer mask was not fully sealed around R14's mouth and nose, and the medication canister was empty while the machine continued to run.Physician's order dated 11/5/25, included scheduled nebulizer treatments of Ipratropium-Albuterol inhalation solution 3 mg (milligrams)/3 mL(milliliters) three times daily related to chronic obstructive pulmonary disease.Physician's order dated 1/13/23, approved R14 to self-administer the treatment after nursing setup and assessment.Review of R14's clinical record revealed the last documented self-administration assessment was completed on 3/24/25. This assessment indicated R11 was able to self-administer nebulizer treatments after medication was set up. The record indicated further assessments were required to be completed quarterly (6/25, 9/25, and 12/25) to evaluate R14's ongoing ability to safely and effectively self-administer nebulizer treatments, including proper equipment setup, medication preparation, administration technique, and recognition of adverse effects. Further record review for dates 4/2025 through 1/14/2026, revealed no evidence nursing staff reassessed R14's competency for self-administration at the facility-defined reassessment intervals. During interview on 1/15/26 at 10:24 a.m., trained medication aide (TMA)-E stated she was not sure which residents had self-administration orders and was not aware where to locate that information. TMA-E stated she set up R14's nebulizer solution at 9:00 a.m., assisted R14 with applying the nebulizer mask, turned the nebulizer machine on, and then left the room. TMA-E stated R14 usually turned the nebulizer machine off once the treatment was completed. During interview on 1/15/26 at 1:02 p.m., the registered nurse care manager (RN)-C and assistant director of nursing (ADON)-B stated self-administration assessments were required to be completed quarterly and confirmed R14's last assessment was completed on 3/24/25. RN-C and ADON-B stated R14 should have had three assessments completed since that date to ensure she remained able to safely self-administer nebulizer treatments. RN-C and ADON-B confirmed observation of R14's nebulizer running without staff supervision would be considered self-administration of medications. The facility's Medication Self-Administration by Residents policy, dated 2/24, indicated residents were permitted to self-administer medications only in accordance with specified procedures. The policy required interdisciplinary team review and a competency assessment addressing medication safety, physical and cognitive ability, understanding of medication purpose and side effects, ability to follow instructions and timing, knowledge of refusal rights, and safe storage practices. The policy further required residents to demonstrate competency through return demonstration, with continued approval dependent on quarterly interdisciplinary review and compliance with physician orders and facility procedures.

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure a resident was informed of the medications being administered at the time of administration in accordance with the resident's expressed preferences and right to make informed choices for 1 of 1 resident (R11) reviewed. Specifically, the facility failed to verbally identify medications prior to administration for a resident who was blind and had requested to be informed of all medications received. Findings include:R11's quarterly Minimum Data Set (MDS) dated [DATE], identified R11 had intact cognition and required assistance with activities of daily living (ADLs). R11's diagnoses included chronic systolic (congestive) heart failure (reduced heart pumping ability), hypertension (high blood pressure), arthritis (joint inflammation and pain), depression (mood disorder), atrial fibrillation (irregular heart rhythm), pain in the right and left hands, blindness in the right and left eyes, category 3 (severe visual impairment), pressure ulcer, stage 2 (partial-thickness skin loss), congenital glaucoma (increased eye pressure from birth), and Barrett's esophagus without dysplasia (abnormal esophageal lining without precancerous changes). The MDS also identified R11 was blind and required assistance with medication administration.During an interview on [DATE] at 6:39 p.m., family member (FM)-A stated R11 and the family had repeatedly requested staff inform R11 of what medications she was receiving prior to each medication administration due to her blindness. FM-A stated this concern had remained unresolved, as staff continued to administer medications without consistently informing R11 of what medications she was receiving.During observation on [DATE] at 7:29 a.m., trained medication aide (TMA)-E prepared R11's medications and placed them in applesauce. TMA-E entered R11's room and administered the medications using a spoon. TMA-E did not inform R11 what medications were being administered.During an interview on [DATE] at 7:31 a.m., TMA-E stated she did not tell R11 what medications she was receiving and stated that if R11 questioned what she was receiving, she would then tell her.During an interview on [DATE] at 7:38 a.m., R11 stated she was unable to see medications and relied on staff to tell her what medications she was receiving. R11 stated staff often administered medications without explaining what they were or why they were given. R11 has requested staff inform her of each medication prior to administration, but staff had not done so. R11 stated when she asked, staff were short with her, so she stopped asking. When asked how she felt about not being informed of her medications, R11 stated, It is what it is. I guess I haven't died or gotten sick yet.Record review revealed special instructions on R11's profile and banner in the electronic medical record (EMR) indicated R11 requested to receive medications in private and requested to be informed of all medications at every medication pass.R11's care plan, reviewed date of [DATE], indicated R11 would receive medications based on preferences listed in Special Instructions, with review by the RN clinical coordinator annually and as needed.During an interview on [DATE] at 1:02 p.m., the registered nurse clinical coordinator (RN)-C and assistant director of nursing (ADON)-B confirmed R11 was blind and stated staff were expected to explain medications when administering them. RN-C and ADON-B stated it was important because R11 could not see and had the right to know what medications she was receiving.The facility Quality of Life policy, dated 10/25, indicated residents would be assisted in maintaining and enhancing self-esteem and self-worth. The policy stated staff shall keep residents informed and oriented to their environment, explain procedures before they were performed, and inform residents in advance of changes to usual routines or surroundings.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure the resident's representative was notified after a fall for 1 of 1 resident (R11) reviewed for notification of change. Findings include:R11's quarterly Minimum Data Set (MDS) dated [DATE], identified R11 had intact cognition and required assistance with activities of daily living (ADLs). R11's diagnoses included chronic systolic (congestive) heart failure (reduced heart pumping ability), hypertension (high blood pressure), arthritis (joint inflammation and pain), depression (mood disorder), atrial fibrillation (irregular heart rhythm), pain in the right and left hands, blindness in the right and left eyes, category 3 (severe visual impairment), pressure ulcer, stage 2 (partial-thickness skin loss), congenital glaucoma (increased eye pressure from birth), and Barrett's esophagus without dysplasia (abnormal esophageal lining without precancerous changes). The MDS also identified R11 was blind and at risk for falls.R11's electronic medical record (EMR) reviewed 4/20/25 to 1/15/26 indicated an incident report dated 4/29/25, documented R11 was found on the floor in her room after attempting to transfer from bed to wheelchair. Nursing staff assisted R11 back into the wheelchair. Record failed to include documentation the resident's family or legal representative was notified of the fall or informed of the post-fall assessment findings. During an interview on 1/13/26 at 6:39 p.m., R11's family member (FM)-A stated she had not been notified by the facility of the fall that occurred on 4/29/25. FM-A stated she became aware of the fall only after viewing video footage from the camera in R11's room. FM-A stated she contacted the facility to discuss the incident and stated she would not have known the fall had occurred if she had not seen the video.During an interview on 1/15/26 at 2:06 p.m., the assistant director of nursing (ADON)-A confirmed the resident's family should have been notified after the fall and acknowledged there was no documentation of notification in the medical record.The facility Falls policy, dated 6/25, indicated staff would notify the resident's representative after completing the Post-Fall Investigation.

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	245511	A. Building B. Wing	01/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cura of Monticello	1104 East River Street Monticello, MN 55362

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure accurate reporting of an alleged violation involving resident neglect for 1 of 1 incident reviewed involving (R11). Specifically, the facility reported inaccurate information related to a resident fall with injury, which did not accurately reflect the circumstances and outcome of the accident. This deficient practice resulted in the potential for delayed or inappropriate oversight, failure to ensure resident protection, and noncompliance with federal reporting requirements.Findings include:R11's annual Minimum Data Set (MDS) dated [DATE], identified R11 had intact cognition, was blind, and required assistance with activities of daily living (ADLs). R11's diagnoses included chronic systolic (congestive) heart failure (reduced heart pumping ability), hypertension (high blood pressure), arthritis (joint inflammation and pain), depression (mood disorder), atrial fibrillation (irregular heart rhythm), pain in the right and left hands, blindness in the right and left eyes, category 3 (severe visual impairment), a stage 2 pressure ulcer (partial-thickness skin loss), congenital glaucoma (increased eye pressure from birth), and Barrett's esophagus without dysplasia (abnormal esophageal lining without precancerous changes). The MDS further identified R11 utilized a wheelchair for mobility and was at risk for falls.R11's quarterly MDS dated [DATE], identified R11 had intact cognition, was blind, and required assistance with ADLs. R11's diagnoses included chronic systolic (congestive) heart failure, hypertension, arthritis, depression, atrial fibrillation, pain in the right and left hands, blindness in the right and left eyes, category, a stage 2 pressure ulcer, congenital glaucoma, and Barrett's esophagus without dysplasia. The MDS further identified R11 utilized a wheelchair for mobility and was at risk for falls.R11's electronic medical record (EMR) reviewed 4/20/25 through 1/15/26 revealed R11 experienced a fall on 4/29/25 that resulted in injury. Review of the EMR, incident report, and nursing documentation indicated the resident sustained injuries requiring assessment and intervention.R11's progress note dated 4/29/25 at 6:57 a.m., indicated, Witnessed fall in the resident's room because the resident leaned over to the table for support during transfer. The table slid over and the resident fell. The resident had a new bruise to her left elbow. No bleeding. No deep skin tear.Further record review revealed R11 underwent an x-ray of her foot on 5/3/25, after family member (FM)-A requested further evaluation. Review of the x-ray results indicated R11 sustained fractures to multiple toes as a result of the fall. Post-fall documentation confirmed the injuries required medical evaluation and treatment. Review of the EMR and facility investigation revealed the facility did not submit a corrected or amended report after identifying discrepancies in the reported information. An untitled word document located in the facility investigation folder indicated, On 5/1/2025 at around 4:00 p.m., the administrator and RN went to visit with the resident and family to address their concerns, including:There was no communication to them about the fall.On camera footage, no one asked if the resident was okay.Prior to the fall, a staff member did not lock the brakes on her chair, and the daughter stated the chair should always be locked as a standard for the resident.The daughter stated the aide said, I'm too busy, to help the resident.The daughter believed the aide stood outside/on the edge of the room and observed the resident attempting to be independent rather than helping her because the aide was quickly present after the fall to assist.There was no vital signs machine available immediately after the fall.The incident occurred around 4:50 a.m. on the NOC shift.Review of the facility document, Vulnerable Adult Reporting checklist dated 5/3/25, indicated no staff re-education was completed, as the facility documented the resident self-transferred, which the document indicated led to the fall.Review of the facility's report submitted to the State Agency (SA) on 5/3/25, indicated notification was received to facility that a fracture was found upon x-ray of R11's left foot. R11 had been experiencing pain in her left foot after a self transfer that resulted in a fall. R11 was transferred herself to wheelchair and slid out on to the ground on left side. Fracture may have occurred due to that fall on 4/29. The fall was (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	investigated on 5/1 and interviews with resident were completed, as well as with the staff who were working at the time of the fall. R11's progress note dated 5/9/25 at 10:52 a.m., indicated, After interviews completed by multiple staff members and the resident regarding the resident's fall, it was not witnessed based on the communication reported to the facility administrator. RN [registered nurse] updated by clinical leadership regarding this note.Review of the facility's 5-day report submitted to the SA on 5/9/25, indicated the facility's summary revealed R11 liked to get up at an earlier time in the morning and did not think the staff were coming to help her fast enough. R11 pushed her table back and tried sitting on her wheelchair but there was no breaks on the wheelchair so she slipped onto her left side onto the floor. Later a fracture was discovered and initial report submitted. Two of the staff members who were working at the time reported that a fall occurred when they were doing rounds. One staff member went into R11's first, and than another came in and assisted with care due to the fall. Verified a fracture took place probable due to Fall occurred on 4/29/25 when R11 self-transferred. Facility indicated there was no perpetrator in this incident. Review of the facility's report submitted to the required reporting entity indicated the fall was reported inaccurately, including incorrect or incomplete information regarding the circumstances surrounding the fall. The information reported was inconsistent with the facility's internal documentation and R11's medical record. Multiple interviews were attempted with facility nursing leadership; however, leadership employed at the time of the incident was either unavailable or no longer employed by the facility. Current facility leadership reported they were unaware of the fall and the related investigation.According to the facility's investigation, the following interviews were conducted by facility leadership following R11's fall:Nursing assistant (NA)-G Statement: 5/1/2025 Employee was working with another resident and the RN said that there was a fall with R11. The other co-worker NA-H was working with another resident and saw R11's call light and said that she was working with another resident, and she would come back. R11 maybe got impatient and when NA-H got back she heard screaming and R11 was on the floor and a couple minutes later NA-G came in. There was just the two of them and the RN asked if there were any injuries and there was small cut on elbow, a bruise on her shoulder and something red on her right leg but was unsure if it was from the fall. A couple of minutes later the RN came in to do a skin check. Employee took vitals after the resident was put in her chair.NA-H Statement: 5/3/2025 NA-H was working at 4:30 AM doing rounds and working with a resident, and saw that R11's call light was on. She went in and said, can I help you? R11 said you know, I would like to get dressed and then NA-H told the resident that she would be back because she was in the middle of rounds and that she would back as she was in the middle of cares so she would be back. NA-H went to the other residents room and then after she was done with the other resident she heard screaming, and searched to see who it was and found that it was R11, as she checked two rooms close by hearing the screaming. When she went in R11 was already on the floor so she went and stood by her and asked if she was okay, R11 said that someone put something in her way and NA-H thought R11 had moved the table, and told R11 that no one had put anything in her way. NA-H called the nurse to come and do vitals and her co-worker came in, and helped put R11 in her chair. After this NA-H left the residents room.During interview on 1/14/26 at 1:51 p.m., NA-G stated she was working down another hall when NA-H informed her R11 had fallen. NA-G stated when she entered R11's room, R11 had already been assisted up and was seated in her wheelchair. NA-G stated NA-H told her R11 attempted to get up independently and pushed the bedside table, which led to the fall. NA-G stated facility policy required nursing assistants to wait to move a resident after a fall until a nurse completed an assessment. NA-G further stated that despite the policy, residents were often assisted off the floor based on how they normally transferred. NA-G stated nursing administration later questioned her regarding the fall, and she reported a concern that the registered nurse (RN)-D did not enter R11's room to complete a post-fall assessment. NA-G was not able to recall why their interview was different with the surveyor than it was with the facility.During interview on 1/14/26 at 1:58 p.m., RN-D stated R11 activated the call light and NA-H (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	entered the room to respond. NA-H then notified her of fall while she was administering medication at the medication cart. RN-D stated she called NA-G to get the mechanical lift and instructed staff to, get her up, while she continued passing medications. RN-D stated when she entered the room, R11 had already been lifted using the mechanical lift and was seated on the toilet. She observed R11's left ankle was swollen and R11 reported pain. RN-D stated she asked R11 if she wanted to go to the hospital, and R11 declined. RN-D stated if a resident fell, a post-fall risk assessment should be completed, vital signs obtained, neurological checks initiated due to the fall being unwitnessed, and the resident's family and provider notified, with all findings documented in the medical record. RN-D was not able to recall why their interview was different with the surveyor than it was with the facility.During interview on 1/14/26 at 2:53 p.m., NA-H stated she was completing rounds with a co-worker when she entered R11's room and observed R11 on the floor. NA-H stated she called for the nurse, who was passing medications at the time. NA-H stated the co-worker, NA-G, and the nurse, RN-D, entered the room and assisted R11 off the floor while she continued completing rounds. NA-H was not able to recall why their interview was different with the surveyor than it was with the facility.During interview on 1/14/26 at 2:41 p.m., the assistant director of nursing (ADON)-A stated she began employment at the facility in June 2025. ADON-A reviewed the investigation and confirmed the fall was reported with inaccurate details and acknowledged the report did not fully or accurately reflect the incident as it occurred. ADON-A stated she did not recall additional details related to the incident.The facility's Vulnerable Adult Policy, dated 11/2025, indicated it was the responsibility of the facility to ensure all alleged violations involving abuse, neglect, injuries of unknown source, and misappropriation of resident property were reported immediately, but not later than two (2) hours after the allegation was made if the events causing the allegation involved abuse or resulted in serious bodily injury, or not later than twenty-four (24) hours if the events did not involve abuse and did not result in serious bodily injury. Reports were required to be made to the facility administrator and other required officials, including the State Survey Agency and Adult Protective Services, where state law provided jurisdiction in long-term care facilities, in accordance with state law and established procedures. The policy further required all personnel to comply with applicable state and local laws regarding incidents of actual or suspected maltreatment, pursuant to 42 CFR S483.12(c)(1).The policy defined neglect as:Neglect is the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress.A failure or omission by a caregiver to supply a vulnerable adult with care or services, including but not limited to food, clothing, shelter, health care, or supervision, that were reasonable and necessary to obtain or maintain the vulnerable adult's physical or mental health or safety, considering the physical or mental capacity or dysfunction of the vulnerable adult, and which was not an accident or therapeutic conduct.The absence or likelihood of absence of care or services, including but not limited to food, clothing, shelter, health care, or supervision, necessary to maintain the physical or mental health of the vulnerable adult, which a reasonable person would deem essential to obtain or maintain the vulnerable adult's health, safety, or comfort.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure the Office of the Ombudsman for Long-Term Care was notified of a resident's transfer to the hospital and subsequent discharge from the facility for 2 of 2 residents (R70 and R72) reviewed as a closed record.Findings include: R70 R70's admission Minimum Data Set (MDS) dated [DATE], identified R70's cognition was not assessed and R70 required assistance with activities of daily living (ADLs). R70's diagnoses included traumatic subdural hemorrhage with loss of consciousness, status unknown (bleeding between the brain and skull caused by trauma, potentially affecting neurological function), hypertension (chronic elevated blood pressure increasing cardiovascular risk), and heart failure (a condition in which the heart is unable to pump blood effectively to meet the body's needs). Record review revealed R70 was transferred to the hospital on [DATE], and was later discharged from the facility on 11/24/25. Review R70's complete medical record, facility transfer documentation, R70's discharge paperwork, and Ombudsman notification logs revealed no evidence or documentation indicating the Office of the Ombudsman for Long-Term Care was notified of R70's hospital transfer or discharge from the facility. R72 R72's admission Minimum Data Set (MDS) dated [DATE], identified R72 was cognitively intact and required assistance with activities of daily living (ADLs). R72's diagnoses included traumatic congestive heart failure (chronic condition where the heart muscle weakens and can't pump enough oxygen-rich blood), atherosclerotic heart disease (heart disease caused by plaque buildup in artery walls), diabetes, chronic kidney disease stage 3, peripheral vascular disease (narrowing and blockage, or spasm of blood vessels), hypertension (chronic elevated blood pressure increasing cardiovascular risk) and osteoarthritis (chronic generative joint disease where protective cartilage breaks down). Record review revealed R72 discharged home on [DATE]. Review of the R72's complete medical record, facility transfer documentation, R72's discharge paperwork, and Ombudsman notification logs revealed no evidence or documentation indicating the Office of the Ombudsman for Long-Term Care was notified of R72's discharge from the facility. During an interview on 1/15/26 at 12:17 p.m., the social services designee (SSD) stated she attempted to fax the Ombudsman weekly on Fridays all transfers and discharges that had occurred during the week. The SSD stated she used the same fax cover sheet, which did not indicate the date or time, and she did not receive confirmation that the fax was successfully sent. The SSD confirmed the facility did not have documentation verifying the Ombudsman was notified of R 70's transfer/discharge or R72's discharge and confirmed the facility could not provide evidence such notification occurred. (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's Discharge Policy, dated 2/25, revealed the policy required notification to the Ombudsman for resident transfers and discharges.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure the Brief Interview for Mental Status (BIMS) assessment was completed and accurately coded for a quarterly and/or admission Minimum Data Set (MDS) assessment for 2 of 2 residents reviewed (R28 and R20). In addition, the facility failed to ensure a physical restraint assessment was completed for 1 of 1 resident reviewed (R8) for accuracy of assessment. R28 R28's quarterly MDS dated [DATE], identified cognition was coded as not assessed. R28 required assistance with activities of daily living (ADLs). R28's diagnoses included progressive neurological conditions (disorders affecting the brain and nervous system that worsen over time), Parkinson's disease with dyskinesia with fluctuations (a movement disorder causing tremors, rigidity, and involuntary movements that vary in severity), hypertension (chronically elevated blood pressure), non-Alzheimer's dementia (decline in memory, thinking, and reasoning not caused by Alzheimer's disease), anxiety disorder (persistent excessive fear or worry), psychotic disorder (loss of contact with reality, including delusions or hallucinations), hallucinations (perceiving sights, sounds, or sensations that are not present), obstructive sleep apnea (repeated airway obstruction during sleep causing breathing pauses), and adjustment disorder with anxiety (emotional or behavioral response to stress causing anxiety symptoms). R28's annual MDS dated [DATE], identified the resident had intact cognition, was alert, able to communicate, and capable of responding to questions during routine care and nursing assessments during the same assessment reference period. During an interview on 1/15/26 at 12:06 p.m., the corporate MDS nurse (MDS-C) confirmed the BIMS assessment was not completed for the quarterly MDS and was coded as not assessed when the MDS was submitted. MDS-C stated no clinical justification or documentation existed to support the decision to code the BIMS as not assessed. Review of federal MDS guidelines required facilities to attempt and accurately code the BIMS for residents able to participate to ensure accurate assessment of cognitive status. Review of the facility policy titled Minimum Data Set, Management of, Long Term Care, dated 1/26, indicated the facility was responsible for ensuring the MDS was accurately and comprehensively completed. The policy further stated all MDS assessments and records would be completed and electronically encoded into the facility's electronic medical record and transmitted to the state database in accordance with current regulations. R20 R20's admission Minimum Data Set (MDS) dated [DATE], identified R20's cognition was coded as not assessed. R20 was dependent on staff assistance with activities of daily living (ADL's). R20's diagnoses included hypertensive heart and chronic kidney disease with heart failure (chronic high blood pressure leading to heart failure and reduced kidney function), hyperlipidemia, benign prostatic hyperplasia (enlarged prostate causing urinary symptoms), history of transient ischemic attack (brief episode of neurological dysfunction), retention of urine, repeated falls, and anemia. Review of R20's electronic medical record (EMR) admission through 1/15/26, failed to indicate there (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was a brief interview for mental status (BIMS) completed for R20. R20's care plan reviewed 1/14/26 failed to address R20's cognitive status. When interviewed on 1/15/26 at 12:06 p.m., the corporate MDS nurse (MDs)-C stated BIMS assessment was expected to be completed at admission, quarterly and when there was a significant change. MDS-C reviewed R20's assessments, stated she was unable to locate a BIMS assessment in R20s EMR and should have been completed. Review of federal MDS guidelines required facilities to attempt and accurately code the BIMS for residents able to participate to ensure accurate assessment of cognitive status. Review of the facility policy titled Minimum Data Set, Management of, Long Term Care, dated 1/26, indicated the facility was responsible for ensuring the MDS was accurately and comprehensively completed. The policy further stated all MDS assessments and records would be completed and electronically encoded into the facility's electronic medical record and transmitted to the state database in accordance with current regulations. R8 R8's quarterly MDS dated [DATE], indicated R8 was cognitively intact and was dependent on staff for ADLs. R8's diagnoses included quadriplegia (paralysis that affects all limbs), dysphagia, autonomic dysreflexia (overreaction of nervous system), cramp and spasm. R8's care plan dated 11/3/25, indicated R8 utilized a seat belt in the wheelchair due to quadriplegia with core instability. R8 was able to stated when he wanted the seat belt on and off. On 1/12/26 at 3:44 p.m., observed R8 in wheelchair with seatbelt buckled. On 1/13/26 at 1:03 p.m., R8 was observed in wheelchair with seatbelt buckled. On 1/14/26 at 2:28 p.m., R8 was observed seated in wheelchair with seatbelt buckled. R8 stated he was unable to buckle and/or unbuckle the belt himself, had staff apply the seatbelt when placed in the wheelchair. R8 only unbuckled when going back into bed. R8 stated he preferred to have the seatbelt in place for safety and had never had skin concerns related to the seatbelt. Review of R8's EMR on 1/14/26 at 9:21 a.m., failed to indicate there was a physical device assessment completed regarding the use of a seatbelt for R8. When interviewed on 1/15/26 at 1:41p.m., assistant director of nursing (ADON)-A stated physical device assessments were expected to be completed on admission, quarterly and any significant change. ADON-A reviewed R8's EMR, ADON located a physical device assessment completed on 1/8/26, however the assessment did not address R8 utilizing a seatbelt in the wheelchair, further stating that was odd since R8 has utilized the seatbelt for as long as she could remember. ADON-A stated the assessment was important to ensure safe use of the seatbelt and whether it would be considered a restraint. Facility Physical Device Assessment – Long Term Care policy dated 4/2023, indicated a physical device assessment would be completed to determine the potential for use of restraints based on the residents' condition and medical symptoms. The policy further indicated ongoing (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	re-assessment of the effectiveness and continued need would be completed through the duration of use.

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure weekly skin assessments were completed as scheduled for 1 of 1 residents (R14) reviewed for completion of skin assessments. Furthermore, based on observation, interview and document review, the facility failed to ensure residents care plans were implemented for 1 of 1 resident (R41) in the sample who received occupational therapy orders for positioning. Findings included: R14 R14's annual Minimum Data Set (MDS) dated [DATE], identified R14 had intact cognition and required assistance with activities of daily living (ADLs). R14's diagnoses included arthritis (joint inflammation resulting in pain and stiffness), osteoporosis (decreased bone density with increased fracture risk), anxiety disorder (persistent excessive worry and fear), depression (mood disorder characterized by persistent sadness and loss of interest), displaced bimalleolar fracture of the right lower leg (fractures involving both ankle bones with displacement), complex regional pain syndrome (chronic pain condition associated with abnormal nerve response following injury), neuralgia and neuritis (nerve pain and nerve inflammation), dysphasia (difficulty with swallowing and/or speech related to neurological impairment), and lymphedema (swelling due to impaired lymphatic drainage). R14's care plan dated 1/5/26. identified R14 was at risk for impaired skin integrity and required weekly head-to-toe skin assessments. Record review on 1/15/26. revealed weekly skin assessment documentation was missing for the weeks of 1/8/26 and 1/15/26. No nursing notes, skin assessment forms, or wound monitoring records included the required assessments were completed. During an interview on 1/15/26 at 10:10 a.m., nursing assistant (NA)-D stated nurses completed the skin assessments weekly on residents' bath days. NA-D stated when nursing assistants assisted residents in the shower or tub room, they contacted the nurse by walkie-talkie, who either came to complete the skin assessment or completed it later in the resident's room. During an interview on 1/15/26 at 10:24 a.m., trained medication aide (TMA)-E stated nurses completed weekly skin assessments on residents' bath days. During an interview on 1/15/26 at 1:02 p.m., the registered nurse clinical coordinator (RN)-C and assistant director of nursing (ADON)-B stated weekly skin assessments were required for residents at risk for skin breakdown and confirmed staff were responsible for completing and documenting the assessments each week. RN-C and ADON-B stated R14's weekly skin assessments were not completed as scheduled and could not provide documentation showing the assessments were performed. RN-C and ADON-B confirmed the last documented skin assessment was completed on 1/1/25. ADON-B stated skin assessments were important for R14 due to a history of wounds, incontinence, limited mobility requiring chair use, and fragile skin. Review of the facility policy titled Skin Integrity Maintenance and Pressure Injury Prevention, dated 9/25, indicated residents were assessed for potential risk for skin breakdown and interventions were (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cura of Monticello	1104 East River Street Monticello, MN 55362

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	initiated to prevent skin alterations. The policy required staff to observe resident skin condition by completing a weekly skin audit upon admission, readmission, weekly, and as needed. R41 R41 admission record and Diagnosis Listing documented the diagnoses of Parkinson's disease, and major depression episode. R41 quarterly Minimum Data Set (MDS), dated [DATE], with a correction assessment completed on 1/6/26, indicated R41 required substantial/maximal assistance with most activities of daily living (ADLs), received substantial/maximal assistance with transferring and positioning and was moderately cognitively impaired. A review of R41's electronic medical records (EMR), MISC section (miscellaneous section of EMR for scanned documentation), an occupational therapy assessment (dated 4/7/25), the occupational therapist provided the following information and orders for R41: Positioning: keep custom WC reclined back at least 10 + degrees for optimal midline positioning. In review of R41's care plan printed 1/15/26, and nursing assistant Kardex printed 1/15/25, documented and directed nursing staff to recline R41's adaptive WC to assist in sitting more upright and prevent leaning. On 1/12/26 at 12:17 p.m., R41 was observed in his room, partially seated in adaptive wheelchair (WC). R41's upper body was leaning over the grab bar attached to his bed, attempting to get into bed. Staff were alerted. On 1/13/26 at 1:43 p.m., R41 was in his room leaning to the right over right side of WC. Nursing assistant (NA)-F just entered the room to make his bed. NA-F told R41 she would be laying him down once his bed was made. On 1/14/26 at 9:14 a.m., R41 had wheeled self into the bathroom and was attempting to self-transfer on to the toilet. Staff were alerted. On 1/14/2026 at 10:05 a.m., R41 was wheeling around his room in his WC leaning to the right and reaching down to his feet and front wheels on the WC. On 1/15/26 at 7:36 a.m., R41 was in room in WC, leaning forward in WC, playing with front WC wheels and talking to self. During all general observations from 1/12/26 through the morning of 1/15/26, R41's WC and WC back were always observed in a 90-degree position compared to the WC seat. During interview on 1/15/26 7:57 a.m., nursing assistant (NA)-A stated R41 is always leaning in the WC, but there are times he sits more upright on his own. NA-A could not remember if R41 was in a standard or adaptive WC. At 8:04 a.m., NA-A turned to NA-B and asked NA-B what type of WC R41 had. NA-B stated R41 had a standard WC. In an interview on 1/15/26 at 9:28 a.m., nursing care manager (RN)-A and assistant director of nursing (ADON)-A stated the facility had requested and ordered a new WC, with the medical supply company (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	adapted for R41. Occupational therapy worked with R41 and the staff after it was delivered. During an interview on 1/15/26 10:21 a.m., occupational therapist (OTR)-A stated upon entering R41's room he was currently sitting at a 90/90 (defined as: resident's WC back was completely upright, to the seat - not reclined) showing how the adaptive WC tilts in place. OTR-A stated the purpose of the 10+ degree reclining was to allow R41 to sit up more straight by using his own body's gravity. OTR cued R41 to sit up straight, which he did, but then returned to the leaning to the right over the WC arm rest. OTR-A stated she was unaware of R41's leaning issues, and stated she would have to have nursing obtain orders for her to evaluate. OTR-A stated nursing should be letting therapy know when a resident might need to be seen and re-evaluated. A policy was requested, but was informed the facility did not have a policy specific to therapy orders for positioning.

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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 observation, interview, and record review, the facility failed to ensure the resident was provided adequate supervision and assistive devices to prevent avoidable accidents for 1 of 4 residents reviewed (R11) for accidents. Findings include:R11's annual Minimum Data Set (MDS) dated [DATE], identified R11 had intact cognition, was blind, and required assistance with activities of daily living (ADLs). R11's diagnoses included chronic systolic (congestive) heart failure (reduced heart pumping ability), hypertension (high blood pressure), arthritis (joint inflammation and pain), depression (mood disorder), atrial fibrillation (irregular heart rhythm), pain in the right and left hands, blindness in the right and left eyes, category 3 (severe visual impairment), a stage 2 pressure ulcer (partial-thickness skin loss), congenital glaucoma (increased eye pressure from birth), and Barrett's esophagus without dysplasia (abnormal esophageal lining without precancerous changes). The MDS further identified R11 utilized a wheelchair for mobility and was at risk for falls.R11's quarterly MDS dated [DATE], identified R11 had intact cognition, was blind, and required assistance with ADLs. R11's diagnoses included chronic systolic (congestive) heart failure, hypertension, arthritis, depression, atrial fibrillation, pain in the right and left hands, blindness in the right and left eyes, category, a stage 2 pressure ulcer, congenital glaucoma, and Barrett's esophagus without dysplasia. The MDS further identified R11 utilized a wheelchair for mobility and was at risk for falls.Video footage (VF) dated 4/29/25, on family member (FM)-A phone was provided and was reviewed with FM-A on 1/13/26 at 6:39 p.m. The VF showed nursing assistant (NA)-H entered R11's room and asked how she could help R11, to which R11 responded, you know. NA-H stated, I don't know. R11 asked NA-H to take the call light and place it on the table. NA-H took the call light from R11, placed it on the corner of the nightstand, and deactivated the call light by pressing the button on the wall. NA-H stated, we are doing rounds now, how can I help you? R11 then handed NA-H her water pitcher and asked her to move it to the table, which NA-H did. R11 next asked NA-H to move her Bible from the bedside table to the table, which NA-H also did. R11 then asked NA-H to move the bedside table, and NA-H moved the bedside table to an area in front of the nightstand. R11 asked NA-H to get her wheelchair while R11 was removing her blanket and moving her feet closer to the edge of the bed. NA-H stated, I will be right back. It is not five yet. I am doing rounds, and I am not doing this, so I will be right back, okay. The VF showed R11 grasped the assist bar on the side of the bed and sat herself upright. NA-H stated, I am in the middle of rounds, retrieved R11's wheelchair from across the room, placed it next to the bed, and exited the room without applying the wheelchair brakes. R11 stood and stated, why did you move all that stuff on me, and this is not where I told you to put it either. R11 then took the call light from the corner of the nightstand and felt her way to the table to place the call light on the table. R11 then turned and attempted to move the bedside table closer to the table and reached for the arm of the wheelchair. The wheelchair rolled backward, causing R11 to fall forward, strike the bedside table, and land on her left side. The VF captured R11 stating, Ouch, good grief. You wouldn't be doing this stuff. I wouldn't be falling if you let me get up. Stupid people. Approximately 10-15 seconds later, NA-H reentered the room, observed R11 sitting on the floor, and R11 stated, Why do you always do this stuff to me? Why can't you just leave things alone and let me get up? NA-H then exited the room into the hallway and called out for assistance. R11 stated, You wouldn't have to have help if you left things alone and let me do it. Leave me alone and let me do what I have to do. No, you have to be moving things around differently. You want me to fall. NA-H then applied the wheelchair brakes and stood next to R11 while waiting for assistance. NA-G entered the room and positioned herself on R11's right side, while NA-H stood on R11's left side. NA-G and NA-H grasped under R11's arms and lifted her off the floor, R11 was not able to fully extend her legs, and placed her into the wheelchair. NA-H stated to NA-G, I think she slipped on the table, and then went to open the bathroom door. The (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	video footage then ended.R11's care plan initiated 1/17/25 indicated the following:Focus area: Vision: Has severely impaired vision - is legally bind since birth, initiated on 11/18/2016.Goal was for R11 to continue to be aware of her surroundings as evidenced by verbal reports through the next review date.Care plan directed staff to discuss with R11 prior to rearranging any items in her room so she would be aware of where items were located.Focus area: Falls: Potential for Falls and Significant Injury r/t severely impaired vision, bedbound experiences bladder and bowel incontinence; requires items in room to remain in same place/position, tends to prefer to keep door to room closed, has an electric lift recliner- however is not using; hx of refusing transfer belt to be used at times; can utilize her call light; able to direct staff where to place her call light per her preference and was initiated on 8/7/2017.Goal was for R11 to remain free from falls through next review with the following interventions in place:Do not rearrange room - Date Initiated: 08/07/2017Dycem UNDER w/c Cushion Date Initiated: 05/02/2022Encourage resident to use call light for assistance when needed. Encourage resident to elevate legs/feet daily. - Date Initiated: 04/10/2022Encourage resident to wear appropriate footwear/shoes PRN Date Initiated: 08/07/2017Hearing evaluations as requested PRN Date Initiated: 05/02/2021R11 has an electric lift recliner in room. She is not using at this time. Family will use while visiting. Date Initiated: 04/23/2021Journs bed in wide position to reduce risk of falls with injury. Date Initiated: 10/07/2022Keep call light within reach in bedroom and encourage to utilize it. Verbalize placement PRN. Date Initiated: 10/07/2022R11's electronic medical record (EMR) reviewed 4/20/25 through 5/31/25 completed. Facility document, Post-Fall Investigation, was initiated on 4/29/25, but failed to indicate if the fall was reviewed at the interdisciplinary team meeting and did not include new or updated fall interventions. R11's progress notes failed to include if a nursing assessment, including vital signs and assessment for pain or injury, was completed prior to staff assisting R11 from the floor. R11's progress note dated 4/29/25 at 6:57 a.m., indicated, Witnessed fall in the resident's room because the resident leaned over to the table for support during transfer. The table slid over and the resident fell. The resident had a new bruise to her left elbow. No bleeding. No deep skin tear.Document provided by facility of R11's x-ray of Left foot dated 5/3/25, included the following information:Indication: Fall. Unable to bear weight.Findings/impression: Degenerative (gradual deterioration of tissues in the body, often associated with aging) changes are present at the interphalangeal joints (hinge joints allowing for flexion and extension of toes), first metatarsophalangeal joint (located at the base of each toe) and at the tarsometatarsal joints (located in the midfoot). There is diffuse osseous demineralization (bones have lost a significant amount of minerals, leading to weakened bone structure). There is a non displaced fracture (bone cracks or breaks but maintains proper alignment) at the third (middle) metatarsal neck (just below the head of the bone located below the toe) and questionably at the fourth metatarsal neck. R11's progress note dated 5/9/25 at 10:52 a.m., indicated, After interviews completed by multiple staff members and the resident regarding the resident's fall, it was not witnessed based on the communication reported to the facility administrator. RN [registered nurse] updated by clinical leadership regarding this note.During interview on 1/12/26 at 3:02 p.m., R11 stated she activated her call light for assistance with getting up and a nursing assistant entered the room and asked what she needed. R11 stated she requested help getting up. R11 stated the nursing assistant told her she was busy and left the room after moving her belongings. R11 stated she attempted to put items back where they belonged and fell. Staff then entered the room and picked me up by my arms and put me in my wheelchair and didn't check me out at all.During interview on 1/13/26 at 6:39 p.m., FM-A stated R11 activated the call light and a nursing assistant responded and informed R11 she did not have time to assist R11 out of bed and needed to complete rounds, stating she would return in approximately five minutes. R11 was left sitting on the edge of the bed. R11's personal items were not within reach, the call light was wrapped around the bedside table, and the wheelchair brakes were not locked. FM-A stated R11 attempted to reposition her items, unwrapped the call light, and felt for the wheelchair. When R11 attempted to stand, the unlocked wheelchair moved, causing R11 to fall onto her side. The nursing assistant (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	entered the room after the fall, did not ask if R11 was okay, repositioned the wheelchair, applied the brakes, and called for assistance. R11 was picked up from the floor, placed into a wheelchair, and taken to the bathroom without an assessment being completed at that time, with vital signs obtained later. FM-A stated the fall was documented inaccurately and noted the nursing assistant stated the fall was witnessed despite not being present in the room at the time of the fall. FM-A further stated management was notified and expressed concern R11 should not have been moved from the floor prior to nursing assessment and vital signs should have been obtained immediately. FM-A stated R11 later reported pain along her entire side and sustained fractures to two toes, and months later an X-ray revealed a torn rotator cuff which FM-A felt was related to the fall.During interview on 1/14/26 at 1:51 p.m., NA-G stated she was working down another hall when NA-H informed her R11 had fallen. NA-G stated when she entered R11's room, R11 had already been assisted up and was seated in her wheelchair. NA-G stated NA-H told her R11 attempted to get up independently and pushed the bedside table, which led to the fall. NA-G stated facility policy required nursing assistants to wait to move a resident after a fall until a nurse completed an assessment. NA-G further stated, despite the policy, residents were often assisted off the floor based on how they normally transferred. NA-G stated nursing administration later questioned her regarding the fall, and she reported a concern that the registered nurse (RN)-D did not enter R11's room to complete a post-fall assessment. NA-G was not able to recall why their interview was different with the surveyor than it was with the facility.During interview on 1/14/26 at 1:58 p.m., RN-D stated R11 activated the call light and NA-H entered the room to respond. RN-D stated NA-H then notified her of the fall while she was administering medication at the medication cart. RN-D stated she called NA-G to get the mechanical lift and instructed staff to get her up while she continued passing medications. RN-D stated when she entered the room, R11 had already been lifted using the mechanical lift and was seated on the toilet. RN-D stated she observed R11's ankle was swollen and R11 reported pain. RN-D stated she asked R11 if she wanted to go to the hospital, and R11 declined. RN-D stated if a resident fell, a post-fall risk assessment should be completed, vital signs obtained, neurological checks initiated due to the fall being unwitnessed, and the resident's family and provider notified, with all findings documented in the medical record. RN-D was not able to recall why their interview was different with the surveyor than it was with the facility.During interview on 1/14/26 at 2:53 p.m., NA-H stated she was completing rounds with a co-worker when she entered R11's room and observed R11 on the floor. NA-H stated she called for the nurse, who was passing medications at the time. NA-H stated the co-worker, NA-G, and the nurse, RN-D, entered the room and assisted R11 off the floor while she continued completing rounds. NA-H was not able to recall why their interview was different with the surveyor than it was with the facility.During interview on 1/14/26 at 2:35 p.m., registered nurse clinical coordinator (RN)-C stated she began working at the facility in June 2025 and was unfamiliar with this fall. RN-C stated if a resident fell, staff should utilize a falls checklist and ensure the resident was stable. RN-C stated nursing staff should be notified immediately to complete an assessment, obtain vital signs, and complete required documentation. RN-C stated the resident should then be assisted up using a mechanical lift. RN-C stated the nurse should complete an initial safety assessment and notify the resident's provider and family, with all information documented in the medical record.During interview on 1/14/26 at 2:41 p.m., assistant director of nursing (ADON)-A stated she began working at the facility in June 2025. ADON-A stated the facility had a policy in place and staff were instructed to review the policy and were walked through required procedures. ADON-A stated the policy was relatively new and initiated by corporate. ADON-A stated staff were instructed to call for the nurse using the walkie-talkie system, after which the nurse would assess the resident and obtain vital signs. ADON-A stated the policy required use of a mechanical lift (Hoyer) to assist residents off the floor following a fall. ADON-A stated she did not recall additional details related to the incident.Multiple interviews were attempted with facility nursing leadership; however, leadership working at the time of the incident was either not available or no longer employed at the facility and (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	current leadership reported they were unaware of the fall and related investigation.The Facility Fall Management policy dated 6/26 indicated nursing staff, in collaboration with members of the interdisciplinary team, would strive to identify residents' specific risk factors and respond to modifiable risk factors contributing to residents' fall history and implement interventions to reduce residents' risk of falling and minimize complications from falls.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure respiratory care and services were provided in accordance with professional standards of practice for 3 of 5 residents (R4, R14, and R1) reviewed for oxygen services. Findings include: R4 R4's quarterly Minimum Data Set (MDS) dated [DATE], identified R4 had intact cognition and required assistance with activities of daily living (ADLs). R4's diagnoses included hypertensive heart and chronic kidney disease with heart failure and stage 5 chronic kidney disease or end-stage renal disease (advanced kidney failure associated with heart disease requiring dialysis or transplant), hypertension (chronically elevated blood pressure), diabetes mellitus (a metabolic disorder causing elevated blood glucose levels), non-Alzheimer's dementia (progressive cognitive decline not related to Alzheimer's disease), hemiplegia (paralysis affecting one side of the body), depression (a mood disorder characterized by persistent sadness and loss of interest), chronic obstructive pulmonary disease or COPD (a chronic lung disease causing airflow limitation), dependence on renal dialysis (requirement for dialysis due to kidney failure), and dependence on supplemental oxygen (requirement for oxygen therapy to maintain adequate oxygenation). During observation and interview on 1/12/26 at 3:19 p.m., R4 had an oxygen concentrator behind the recliner with attached oxygen tubing and a humidifier (bubbler). The oxygen tubing and bubbler were not labeled or dated. The bubbler contained visible condensation. R4 stated she wore oxygen at night and required staff assistance to apply it. R4 further stated she was not aware of when staff last changed the tubing or humidifier, and neither item was labeled nor dated to reflect when it was last changed. R4's electronic medical record, reviewed on 1/14/26, revealed no documentation indicating the oxygen tubing or bubbler had been changed within the previous 23 days. Further record review revealed not applicable was documented on the assigned tubing and bubbler change dates of 12/30/25, 1/5/26, and 1/13/26. The record revealed the last documented tubing change occurred on 12/23/25. R14 R14's annual MDS dated [DATE], identified R14 had intact cognition and required assistance with ADLs. R14's diagnoses included anxiety disorder (persistent excessive worry and fear), depression (a mood disorder causing persistent sadness and loss of interest), chronic obstructive pulmonary disease or COPD (a chronic lung disease causing airflow limitation), respiratory failure (inability of the lungs to adequately exchange oxygen and carbon dioxide), and chronic respiratory failure with hypoxia (long-term inadequate oxygen levels in the blood). The MDS indicated R14 received oxygen therapy. During observation on 1/12/26 at 12:09 p.m., R14 received oxygen via nasal cannula with attached oxygen tubing. The oxygen tubing was not labeled or dated and had a brown-tinged appearance, tubing is usually clear. R4's electronic medical record, reviewed on 1/14/26, revealed no documentation indicating the oxygen tubing or bubbler had been changed within the previous 30 days. Further record review (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	revealed not applicable was documented on the assigned tubing change dates of 12/16/25, 12/23/25, and 1/6/26, and no was indicated on 1/14/26. The record revealed the last documented tubing change occurred on 12/3/25. During an interview on 1/15/26 at 10:10 a.m., nursing assistant (NA)-D stated it was the nurse's responsibility to change oxygen supplies. NA-D confirmed R4's and R14's oxygen tubing was not labeled or dated. During an interview on 1/15/26 at 10:24 a.m., trained medication aide (TMA)-E stated she changed a resident's oxygen supplies if it appeared in her charting tasks. TMA-E was not aware of how often oxygen supplies should be changed. TMA-E stated oxygen supplies should be labeled and dated when changed. TMA-E confirmed R4's and R14's oxygen tubing was not labeled or dated. During an interview on 1/15/26 at 1:02 p.m., the registered nurse clinical coordinator (RN)-C and assistant director of nursing (ADON)-B stated oxygen tubing and bubbler components should be changed weekly and were scheduled for overnight nursing staff to complete. RN-C and ADON-B stated supplies should be labeled and dated with the date changed. RN-C and ADON-B confirmed R4's tubing and bubbler had not been changed weekly and were last documented as changed on 12/23/25. RN-C and ADON-B further confirmed R14's tubing had not been changed weekly and there was no documentation indicating it had been changed within the past 30 days. ADON-B stated weekly replacement was important for infection control and respiratory care standards. R1 R1's admission record documented the diagnoses of essential hypertension, paroxysmal atrial fibrillation and asthma. R1 was admitted to the facility after a hospital stay for pneumonia. R1's admission Minimum Data Set (MDS), dated [DATE], indicated R1 required assistance with activities of daily living (ADLs), received oxygen and was moderately cognitively impaired. During observation and interview on 1/12/26 at 10:47 a.m., R1 stated she was admitted to the facility from a hospital after she fell due to pneumonia at home. R1 was wearing a nasal cannula for oxygen. Date of last time tubing and cannula was changed was not visualized, but noted the cannula prongs (the parts placed in the nares of the nose) had a slight tan color (normally clear in color). R1 was unable to remember when her oxygen tubing was last changed. Interview on 1/13/26 at 5:53 p.m., registered nurse (RN)-A stated the night shift was responsible for the changing of resident oxygen tubing. Further daily observations on 1/13/26 (at 1:06 p.m., 1:47 p.m. and 4:17 p.m.), 1/14/26 (at 9:20 a.m., 10:12 a.m. and 2:32 p.m.), and 1/15 26 at 7:53 a.m., continued to note the oxygen tubing was undated and appear not to have been changed. During observation on 1/14/26 at 9:20 a.m., R1 was observed to be lying in bed with only one of the two cannula prongs in her nose, with the other on her left cheek. The prong on her cheek was noted to have a slight tan color (prongs are normally clear plastic in color). During an interview on 1/15/26 at 1:41 p.m., nursing care manager (RN)-B and assistant director or nursing (ADON)-A stated it was the responsibility of the night shift nurse to change out all oxygen (continued on next page)

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	245511	A. Building B. Wing	01/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cura of Monticello	1104 East River Street Monticello, MN 55362

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	supplies, including nasal cannulas. ADON-A stated the night shift had a [Night] Shift Checklist which documented weekly/daily assignments the night shift staff were to complete. RN-B provided a copy of the checklist which indicated Tuesday night the staff were to Change [oxygen] tubing, [nebulizer] set ups (date and initial) and Reorder [oxygen supplies from [Northwestern] Respiratory. RN-B and ADON-A stated the staff should know which residents on their assignments receive oxygen but this information does show up in the TASK section of the resident's chart, and was not on the medication or treatment record. During observation and interview on 1/15/26 at 1:55 p.m., with RN-B in R1's room, R1's extension tubing was laying on the floor and no dating was noted. RN-B stated she would change out the tubing now and place a new cannula for when resident returned. The facility policy, entitled: Oxygen Administration – Log Term Care (effective date 02/2024) indicated in section J-1 the following: Nasal cannulas, mask, or mouth pieces are to be replaced weekly and as needed. All extension tubing is to be changed monthly and as needed.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review the facility failed to ensure the facility was monitoring dialysis access site for 1 of 2 residents (R40) reviewed for dialysis. R40's annual Minimum Data Set (MDS) dated [DATE], identified R40 was cognitively intact and was independent with activities of daily living (ADLs) with exception of needing assistance with toileting and showering needs. R40 had diagnoses which included end stage 4 renal disease (kidney failure), dependance on hemodialysis (artificial blood filtration to remove waste and excess fluids), chronic pain, osteoarthritis and hypertension. Review of R40's electronic medical record (EMR) failed to identify an order for facility staff to assess R40's central venous catheter (CVC, port inserted in chest used for dialysis) for bleeding, to ensure CVC is secure and for signs of infection including redness, swelling, drainage, tenderness, warmth. During interview on 1/15/26 at 11:48 a.m., licensed practical nurse (LPN)-A stated there is no order that she was aware of to assess the CVC but knew R40 received dialysis so did look at the CVC site. When interviewed on 1/15/26 at 1:41 p.m., assistant director of nursing (ADON)-A stated R40 previously had a arteriovenous (AV) fistula (surgical creation of artery connected to vein in arm for access point for dialysis) that had failed before getting the CVC. ADON-A reviewed R40's orders and was unable to locate an order to assess the CVC site. ADON-A stated an order to assess the CVC site was expected to be in place, assessment was important for the health and safety of a resident that received dialysis. Facility hemodialysis, Care of a Resident with policy dated 8/2025, indicated licensed staff will monitor for complications related to hemodialysis which may include but not limited to bleeding, leg cramps, seizures, headache, fatigue, chest pain, and signs/symptoms of infection.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure staff followed enhanced barrier precautions (EBP) during resident care for 1 of 1 resident (R14) observed. In addition, the facility failed to discontinue isolation precautions that were no longer clinically indicated for 2 of 3 residents (R11 and R14) reviewed for infection control. Findings include:R11R11's quarterly Minimum Data Set (MDS) dated [DATE] identified R11 had intact cognition and required assistance with activities of daily living (ADLs). R11's diagnoses included chronic systolic congestive heart failure (a condition in which the heart has reduced ability to pump blood effectively), hypertension (persistently elevated blood pressure), arthritis (inflammation of joints causing pain and stiffness), depression (a mood disorder causing persistent sadness and loss of interest), atrial fibrillation (an irregular and often rapid heart rhythm), pain in the right and left hands, bilateral blindness with category 3 severe visual impairment (profound vision loss), a stage 2 pressure ulcer (partial-thickness skin loss), congenital glaucoma (elevated eye pressure present at birth), and Barrett's esophagus without dysplasia (abnormal esophageal lining without precancerous changes). The MDS also identified R11 had one stage two (partial-thickness skin loss) pressure ulcer.Throughout the week of the survey, R11 remained on EBP precautions with EBP precaution signage posted on the outside of the door, and personal protective equipment (PPE) was stored in a hanging organizer on the door.Record review on 1/15/26, revealed R11 was placed on EBP precautions on 6/16/25, for infection-related concerns related to wounds. Further record review on 1/15/26, revealed documentation indicated R11 no longer met criteria for EBP precautions. However, precaution signage and isolation status remained in place with no documented reassessment or order to discontinue precautions.R14R14's annual MDS dated [DATE], identified R14 had intact cognition and required assistance with ADLs. R14's diagnoses included arthritis (joint inflammation causing pain and stiffness), osteoporosis (decreased bone density increasing fracture risk), anxiety disorder (persistent excessive worry and fear), depression (mood disorder causing persistent sadness and loss of interest), chronic obstructive pulmonary disease (COPD) (a chronic lung disease causing airflow limitation), respiratory failure (inability of the lungs to adequately exchange oxygen and carbon dioxide), displaced bimalleolar fracture of the right lower leg (fracture involving both ankle bones with bone displacement), complex regional pain syndrome (chronic pain condition affecting a limb), neuralgia and neuritis (nerve pain and nerve inflammation), dysphasia (difficulty swallowing), lymphedema (swelling due to lymphatic fluid buildup), and chronic respiratory failure with hypoxia (long-term inadequate oxygen levels in the blood). The MDS indicated R14 received oxygen therapy and did not have any pressure ulcers or wounds.During observation on 1/12/26 at 1:32 p.m., nursing assistant (NA)-F assisted R14 from the wheelchair to the bathroom utilizing a mechanical lift (EZ Stand) while R14 remained on EBP isolation precautions. NA-F did not don required PPE (gown) prior to resident contact and provided hands-on assistance with toileting and hygiene without following EBP precautions. NA-F exited the room without performing hand hygiene. Throughout the week of the survey, R14 remained on EBP precautions with EBP precaution signage posted on the outside of the door, and PPE was stored in a hanging organizer on the door.R14's electronic medical record, reviewed on 1/15/26, revealed R14 was placed on EBP precautions on 4/14/25, for infection-related concerns related to wounds. Further record review on 1/15/26 revealed documentation indicated R14 no longer met criteria for EBP precautions; however, precaution signage and isolation status remained in place with no documented reassessment or order to discontinue precautions.During an interview on 1/12/26 at 2:04 p.m., NA-F confirmed R14 was on EBP precautions and confirmed she did not don the required PPE before assisting R14 to the bathroom as she was not aware as it was her first time assisting R14 due to being an agency staff and her first day at the facility. During an interview on 1/15/26 at 10:10 a.m., NA-D stated staff relied on posted signage to determine which precautions residents were on. NA-D (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	confirmed both R11 and R14 were on EBP precautions but was unsure of the reason and stated both residents had been on precautions for a long time. NA-D stated staff were to don gloves, a gown, and a face mask when assisting residents, on EBP, with high-contact ADLs.During an interview on 1/15/26 at 10:24 a.m., NA-E confirmed R11 and R14 were on EBP precautions and had been on them for some time. NA-E stated R14 was on precautions for a wound on her foot that had been healed for a while. NA-E stated staff were to don gloves, a face mask, and a gown when assisting residents, on EBP, with high-contact cares.During an interview on 1/15/26 at 1:02 p.m., the registered nurse clinical coordinator (RN)-C and assistant director of nursing (ADON)-B stated R11 had been placed on EBP precautions for a wound on the coccyx and back of the thigh that had healed. RN-C and ADON-B stated wound care had been discontinued on 12/24/25. RN-C and ADON-B confirmed R11 remained on EBP precautions and stated precautions should have been removed on 12/24/25. RN-C and ADON-B stated R14 had been placed on EBP precautions for a pressure ulcer on the right medial ankle that had healed. RN-C and ADON-B stated wound care had been discontinued on 11/5/25. RN-C and ADON-B confirmed R14 remained on EBP precautions and stated precautions should have been removed on 11/5/25. RN-C and ADON-B confirmed staff were expected to follow EBP precautions for R14 as long as precautions remained posted.The facility's Enhanced Barrier Precautions policy, dated 3/25, indicated the facility used EBP precautions as recommended by the Centers for Disease Control and Prevention (CDC) to reduce transmission of multidrug-resistant organisms (MDROs) through the use of gowns and gloves during high-contact resident care activities. The policy stated MDROs may be indirectly transferred from resident to resident during high-contact care activities. The policy indicated EBP precautions were intended to remain in place for the duration of a resident's stay or until resolution of the wound that placed the resident at higher risk. The policy further indicated EBP precautions, utilizing a minimum of gown and glove use, were to be initiated for high-contact resident care activities including transferring, providing hygiene, and assisting with toileting.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review, the facility failed to ensure residents wheelchairs were kept clean for 1 of 1 resident (R41) in the sample whose wheelchair (WC) was stained with food debris.Findings include:R41's admission record and Diagnosis Listing documented the diagnoses of Parkinson's disease, and major depression episode.R41's quarterly Minimum Data Set (MDS) dated [DATE], with a correction assessment completed on 1/6/26, indicated R41 required substantial/maximal assistance with most activities of daily living (ADLs), received substantial/maximal assistance with transferring and positioning and was moderately cognitively impaired.On 1/12/26 at 12:17 p.m., R41 was observed in his room, partially seated in adaptive wheelchair (WC) and his upper body leaning over the grab bar attached to his bed, attempting to get into bed. Staff were alerted. It was noted that the right seat area of R41's WC and WC cushion had stains, which were yellow and white and food debris, chunks of food and dried liquid. The stains and food debris was was covering roughly a three inch x three inch are of the WC cushion, the visible under-sling seat which the cushion sat on. On 1/13/26 at 1:43 p.m., R41 was in room leaning to the right over right side of WC. Food debris was still present.During a breakfast dining room observation of R41, on 1/15/26 at 8:16 a.m., R41 was sitting at a dining room table feeding himself after staff set up. R41 was holding on the dining room table with his left hand, while still leaning to the right, feeding himself. As R41 fed himself, his mouth was over the same location of the staining and food debris observed on his WC seat support and cushion. A copy of the nursing assistant kardex was requested but not received. During an observation on 1/15/26 at 9:28 AM, nursing care manager (RN)-B also noted food debris on the right corner and cushion of R41's chair. RN-B stated the WCs are supposed to be cleaned al least weekly by the night shift staff. RN-B stated the WC cleaning is listed on the nursing assistant Kardex. RN-B stated it would be the facility's expectation that when a resident's chair is noted to be soiled, the staff should clean it when they see it. A copy of the nursing assistant kardex was requested but not received. A facility policy for the cleaning of wheelchairs was requested but not received

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F 0577 Level of Harm - Potential for minimal harm Residents Affected - Many	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. Based on observation, interview and document review, the facility failed to ensure survey results were placed in a prominent place and contained or directed where to obtain the last three years of survey results. This had the potential to affect all 64 residents residing in the facility, along with family, visitors and staff.Findings include:During interview on 1/14/26 at 1:09 p.m., R4 stated was not sure where the survey results were kept. During observation and interview on 1/15/26 at 12:14 p.m., business office manager (BOM) stated the binder that had, Resource Book, on the front of it had the survey results in it, there was a tab for survey results. Observed white, three ring, binder on edge of reception desk within easy reach of anyone. Binder had a front, clear, pocket and contained a white piece of paper that included the facility name and, Nursing Home Residents' Resource Binder. The edge of binder included the facility name and, Documents Available for Review. However, there was no indication on outer part of binder that survey results were inside. No signage was observed regarding where survey results were located for review. When interviewed on 1/15/2026 12:46 p.m., regional director of operations (RDOO) stated survey results were located in a binder in the front lobby area, there should be a sign that stated where to locate the survey results. RDOO stated no indication of location of results made them hidden from anyone that wanted to review them. RDOO expected there was the signage, and the binder should have indicated facility name - Survey Results, so residents, visitors and staff could review if desired. Facility policy regarding survey results was requested, however, none was provided.