STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245553	A. Building B. Wing	05/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Parkview Manor Nursing Home	308 Sherman Avenue Ellsworth, MN 56129

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation and interview, the facility failed to ensure food was not outdated, foods were thawed in a safe and sanitary manner, and the walk-in freezer and the floors of the walk-in cooler were kept in a sanitary manner in 1 of 1 kitchen. This has the potential to affect all 30 residents.Findings include: Observation and interview on 5/10/26 at 11:02 a.m., with dietary cook (C)-A on initial tour of the kitchen identified in the refrigerator next to the prep area in the kitchen had a 1/2 gallon milk container with the lid off, and what looked like pancake batter on the outside of the container and inside. C-A stated oh, I am throwing this and reported it was butter milk, and the best used-by date was 4/6/26. Also, in the same refrigerator there were 5 bowls of undated pre-made salad, covered with plastic wrap with lettuce starting to turn brown. C-A confirmed the butter milk was expired and the salads should have been dated and proceeded to remove all items and dispose of them. As we entered the walk-in cooler there were 2 sheet pans on the bottom shelf of a wire rack the first one had a bag of turkey thawing with juice noted on the tray. The second tray had 2 items wrapped in tin foil and a 10-pound sleeve of ground beef sitting on the tray. All items were sitting in blood juice from one of the items. C-A moved the tray and one item wrapped in tin foil had label on it that identified prepared date 4/29/26, she thought that was turkey, but it did not say on the label, the other item wrapped in tin foil had label on it that identified it was ground beef, and dated 5/3/26. The 10-pound sleeve of ground beef had a hole in the plastic with a dark, hard looking, exposed ground beef. Continued observation on 5/10/26 beginning at 11:02 a.m., identified C-A then opened the walk-in freezer that was inside of the walk-in cooler. Once the door to the freezer was opened it was observed to be full of multiple boxes stacked on top of each other in the walk-through space. Some of the boxes were tipped over, some directly on the floor, and some on top of a plastic crate. The shelves within the walk-in freezer were full. One box tipped over directly on the floor was labeled sea food. The outside of the box identified 15 pieces of fish were left and dated it had been opened on 3/27/26. The box was not closed and the bag inside the box was not closed or secured. There was a plastic tote cover tipped upside down with 5 bags of thawed chicken sitting in the cover directly onto the floor. C-A stated she had just placed the remaining chicken in the freezer that she had not used for the noon meal. There was no room to place the chicken on the shelf, so she placed it on the plastic cover and just put it in the freezer on the floor. C-A confirmed there was no way to step into the walk-in freezer due to all the boxes in the walk-through space. Back inside the walk-in cooler it was observed to have a large amount of blood or brown juices spilled on the floor under both wire racks in the cooler. There were also a couple of butter packets mixed in with the dried meat juices and/or debris under one rack and a dirty plastic cup in the spilled juices under the other rack. C-A confirmed that the observed blood or brown dried areas was probably juices from thawing meat spilled. She identified there was no schedule for cleaning and no specific person oversaw cleaning; staff were just to clean as they needed. Interview and observation on 5/10/26 at 11:50 a.m., for follow up tour of kitchen with C-B identified inside the walk-in cooler remained the tray of 2 items wrapped in tin foil and the 10-pound sleeve of ground beef sitting in blood juices on the tray. Also noted was a large item wrapped in tin foil sitting on top of a box back towards the back on the bottom shelf. C-B pulled that (continued on next page)

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

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

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	out and it was labelled ham and dated 5/5/26. C-B stated, the meat should each be on their own tray to thaw. He then stated, they should not be together (the ground beef and the turkey). He confirmed that all items were sitting in blood juices on the one tray. He removed the tray from the walk-in cooler, and he opened both items in tin foil. One was sliced turkey, and the other one was 10 pounds of ground beef. He confirmed there was a hole in the plastic of the 10-pound sleeve of ground beef and that the exposed area appeared dried and crusty. C-B then entered the walk-in freezer, and stated, oh no! that should not be there and pointed to the chicken sitting on the floor inside the plastic cover. He confirmed that you could not step into the walk-in freezer as it was full of boxes in the walk-through space, and confirmed the boxes were tipped over, some on the floor, and some on top of a plastic crate. Interview on 5/11/26 at 9:48 a.m., with the administrator identified, he has had multiple conversations in the past with the dietary manager and staff about keeping the kitchen neat, clean, and organized not only for infection control purposes, but also for ordering supplies. He revealed there had been some ongoing concerns with expired items and cleaning in the kitchen with newer staff. He had even done some spot checks in the kitchen related to the concern and had asked the dietary manager to make sure she was checking for expired items as well. He further revealed he had completed a check one time and found a 10-pound sleeve of ground beef sitting on the wire rack with no tray under it dripping onto the floor. He talked with the dietary manager and staff about thawing items in the walk-in cooler and making sure the item was on a tray. Items thawing in the walk-in refrigerator should be on a tray by itself and not with other food. He was unaware that the walk-in freezer had so many items on the floor that you could not step into the walk-in freezer or that the walk-in cooler had spilled drippings from thawing items on the floor. If the kitchen staff could not reach under the wire rack to clean that up, they should have asked for maintenance to assist. His expectation was that the kitchen monitored for expired items and removed those items, thawed foods appropriately, did not place items on the floor, and maintain a clean and sanitary kitchen. Interview on 5/11/26 at 5:09 p.m., with dietician identified she had been at the facility the week prior and discussed all the identified area's of concern with the dietary manager. She would expect the meat to be thawed on individual trays on the bottom shelf in the refrigerator, and any spills would be cleaned up, and the kitchen would be maintained in a sanitary manor. She revealed that having more than one type of meat thawing on the same tray was a concern for cross contamination. Nothing should be stored on the floor and the walkways inside the freezer and refrigerator should remain clean and items should be kept on the shelves. The facility should be monitoring for expired items on a regular basis. She revealed that the facility needed to have a better protocol for monitoring and cleaning of the kitchen with audits to ensure things were getting done. A policy on infection control in the kitchen was requested but not provided. A policy on safe food storage was requested but not provided.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. Based on interview and document review, the facility failed to ensure employees were documented as having been tested and illnesses monitored and tracked to identify potential or actual correlation between residents with known COVID and staff exposure and/or subsequent illness, or indicate when an employee would be able to return to work (RTW) after illness, according to the Centers for Disease Control, for 7 of 9 staff (Nursing assistant (NA)-B, NA-C, NA-E, NA-F, NA-G, NA-H, and NA-I) with symptoms of COVID during an outbreak. This had the potential to affect 11 remaining residents who showed no documented signs and/or symptoms of COVID, but who may have been exposed to staff.Findings include: Review of the March 2025, Centers for Disease Control (CDC), Symptoms of COVID-19 article, located at https://www.cdc.gov/covid/signs-symptoms/index.html, identified the following list does not include all possible symptoms. Symptoms may change with new COVID-19 variants and can vary depending on vaccination status. Possible symptoms include:Fever or chillsCoughShortness of breath or difficulty breathingSore throatCongestion or runny noseNew loss of taste or smellFatigueMuscle or body achesHeadacheNausea or vomitingDiarrhea Review of the 3/18/24, CDC article, Interim Guidance for Managing Healthcare Personnel with SARS-CoV-2 Infection or Exposure to SARS-CoV-2, located at https://www.cdc.gov/covid/hcp/infection-control/guidance-risk-assesment-hcp.html, identified:Health care personnel (HCP) with even mild symptoms of COVID-19 should be prioritized for viral testing with nucleic acid or antigen detection assays. When testing a person with symptoms of COVID-19, negative results from at least one viral test indicate that the person most likely does not have an active SARS-CoV-2 infection at the time the sample was collected.If using NAAT (molecular), a single negative test is sufficient in most circumstances. If a higher level of clinical suspicion for SARS-CoV-2 infection exists, consider maintaining work restrictions and confirming with a second negative NAAT.If using an antigen test, a negative result should be confirmed by either a negative NAAT (molecular) or second negative antigen test taken 48 hours after the first negative test.For HCP who were initially suspected of having COVID-19 but, following evaluation, another diagnosis is suspected or confirmed, return-to-work decisions should be based on their other suspected or confirmed diagnoses. HCP with mild to moderate illness who are not moderately to severely immunocompromised could return to work after the following criteria have been met:At least 7 days have passed since symptoms first appeared if a negative viral test* is obtained within 48 hours prior to returning to work (or 10 days if testing is not performed or if a positive test at day 5-7), andAt least 24 hours have passed since last fever without the use of fever-reducing medications, andSymptoms (e.g., cough, shortness of breath) have improved.*Either a NAAT (molecular) or antigen test may be used. If using an antigen test, HCP should have a negative test obtained on day 5 and again 48 hours later Review of the January 2026, Resident Infection Surveillance log identified 12 residents (R27, R11, R14, R4, R19, R6, R25, R33, R3, R34, R9, and R2) had been diagnosed with COVID during an outbreak and showed signs and symptoms of cough, runny nose, congestion and wheezing. 5 additional residents (R20, R1, R29, R26 and R4) also showed signs of potential COVID (loose stools and vomiting) however; it was unknown if those residents had been tested or had been found to be positive for COVID. Review of the January 2026 Employee Illness Log identified the following columns:Report dateEmployee nameVomitingDiarrheaJaundiceFeverRespiratory (cough, sore throat, runny nose)Comments or additional symptomsDate returned to workDiagnosed with a pathogen?If diagnosed, was local health agency contacted?None of the monthly employee illness logs were filled out completely and the date returned to work was left blank each time. There was also no indication staff had been tested for COVID after becoming symptomatic during a COVID outbreak. Review of January 2026, Monthly Employee Illness log identified on:1/3/26, NA-E reported a sore throat, headache and congestion.1/3/26, NA-I called in with a headache.1/5/26, NA-F reported dizziness, lightheadedness, and a sore throat.1/7/26, NA-I called in again and reported a headache.1/21/26, (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	NA-G called in with diarrhea.1/22/26, NA-C reported vomiting.1/22/26, NA-H reported diarrhea.1/28/16, NA-B called in with sinus congestion and cough.1/29/26, NA-B called in with vomiting and diarrhea.1/30/26, NA-C called in with vomiting and a fever. There was no indication on the forms, the above-mentioned staff had been tested for COVID, nor if they had been vetted before potentially returning to work according to CDC guidance. Interview on 5/11/26 at 8:30 a.m., with the infection preventionist (IP) identified that she had been in that position for less than a year. Her hours working in the IP role depended on current staffing levels and if she had to work on the floor as a charge nurse, however; she typically worked on infection control only 4-5 hours a week. She tracked staff call-ins on an absence report form that went to the business office first. If staff were sick, she would get a copy of the form from the business office and then transferred that information to the employee illness logs. Staff were to be off work for a minimum of 24 hours after symptoms were resolved for vomiting, fever, or diarrhea. She attempted to review the infection control information at least weekly, but that was dependent on staffing and if she had to work as a charge nurse on the floor. She confirmed the surveillance logs were not thoroughly completed and she had not really looked for trends or patterns since starting the infection preventionist role. The IP made no mention if she felt the 4-5 hours she was able to dedicate to her role was enough to provide appropriate oversight and vetting for employee RTW. Interview on 5/11/26 at 11:04 a.m., with the director of nursing (DON) identified she provided oversight of the infection control program by reviewing the IP's monthly data prior to the QAPI meeting. She had not been reviewing any of the surveillance logs since the new IP started. Review of the undated, Infection Control policy identified the program was to minimize the risk of infection between residents, staff, volunteers, and visitors. The facility would monitor, assess, identify, and manage infections through education and record keeping. Review of the undated, Surveillance for Infection policy identified surveillance of infections would be monitored for trends to guide appropriate interventions to slow or stop the spread of infections. Review of the undated, current Return to Work Policy for Infectious Illness identified it included guidance on RTW for suspected or confirmed cases of COVID. Staff were able to RTW at least 3 days after symptom onset, must be fever free for at least 24 hours, symptoms improving, and use source control upon RTW. There was no indication, this return to work followed the CDC guidance above.

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F 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home. Based on interview and document review, the facility failed to ensure 1 of 1 infection preventionist (IP) had appropriate time allowed to dedicate to oversight of the infection control program. This had the potential to affect all 28 residents. Findings include: Review of the January 2026 Employee Illness Log identified the following columns:Report dateEmployee nameVomitingDiarrheaJaundiceFeverRespiratory (cough, sore throat, runny nose)Comments or additional symptomsDate returned to workDiagnosed with a pathogen?If diagnosed, was local health agency contacted?None of the monthly employee illness logs were filled out completely and the date returned to work was left blank each time. There was also no indication staff had been tested for COVID after becoming symptomatic during a COVID outbreak. Review of January 2026, Monthly Employee Illness log identified on:1/3/26, NA-E reported a sore throat, headache and congestion.1/3/26, NA-I called in with a headache.1/5/26, NA-F reported dizziness, lightheadedness, and a sore throat.1/7/26, NA-I called in again and reported a headache.1/21/26, NA-G called in with diarrhea.1/22/26, NA-C reported vomiting.1/22/26, NA-H reported diarrhea.1/28/16, NA-B called in with sinus congestion and cough.1/29/26, NA-B called in with vomiting and diarrhea.1/30/26, NA-C called in with vomiting and a fever. There was no indication on the forms, the above-mentioned staff had been tested for COVID, nor if they had been vetted before potentially returning to work according to CDC guidance. Interview on 5/11/26 at 8:30 a.m., with the infection preventionist (IP) identified that she had been in that position for less than a year. Her hours working in the IP role depended on current staffing levels and if she had to work on the floor as a charge nurse, however; she typically worked on infection control only 4-5 hours a week. She tracked staff call-ins on an absence report form that went to the business office first. If staff were sick, she would get a copy of the form from the business office and then transferred that information to the employee illness logs. Staff were to be off work for a minimum of 24 hours after symptoms were resolved for vomiting, fever, or diarrhea. She attempted to review the infection control information at least weekly, but that was dependent on staffing and if she had to work as a charge nurse on the floor. She confirmed the surveillance logs were not thoroughly completed and she had not really looked for trends or patterns since starting the infection preventionist role. The IP made no mention if she felt the 4-5 hours she was able to dedicate to her role was enough to provide appropriate oversight and vetting for employee RTW. Interview on 5/11/26 at 11:04 a.m., with the director of nursing (DON) identified she provided oversight of the infection control program by reviewing the IP's monthly data prior to the QAPI meeting. She had not been reviewing any of the surveillance logs since the new IP started. Review of the undated, Infection Control policy identified the program was to minimize the risk of infection between residents, staff, volunteers, and visitors. The facility would monitor, assess, identify, and manage infections through education and record keeping. Review of the undated, Surveillance for Infection policy identified surveillance of infections would be monitored for trends to guide appropriate interventions to slow or stop the spread of infections. Review of the undated, current Return to Work Policy for Infectious Illness identified it included guidance on RTW for suspected or confirmed cases of COVID. Staff were able to RTW at least 3 days after symptom onset, must be fever free for at least 24 hours, symptoms improving, and use source control upon RTW. There was no indication, this return to work followed the CDC guidance above. Review of the 9/21/20, undated Infection Control Policy identified the facility was to ensure effective implementation of infection control. Records of IC activities were to be maintained. There was no mention in the policy how the IP was to perform her duties and have appropriate oversight. Review of the 6/10/25, Facility Assessment identified the assessment was to describe how the facility would evaluate if the IC program included effective systems for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents and staff that followed accepted national standards and referred to the Centers for Disease Control (CDC).

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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. Based on observation, interview, and document review, the facility failed to timely notify the physician for 1 of 1 sampled resident (R15) when she experienced worsening cough with no relief. Findings include: R15's quarterly Minimum Data Set (MDS) assessment, accepted on 3/20/26, identified her cognition was intact, and she had diagnosis of edema (swelling), heart failure, high blood pressure, premature contractions of the heart ventricles, and tricuspid regurgitation (a heart condition that can cause extreme tiredness, shortness of breath and swelling in the belly, legs, or neck veins). R15 required moderate assistance of one staff for transfers, dressing, and hygiene. Intermittent observations on 5/10/26 from 11:30 a.m., to 7:00 p.m., and again on 5/11/26 from 7:33 a.m., to 4:30 p.m., identified R15 remained in her room was seated in her recliner. She could be heard coughing continuously and the cough was worsening. Review of R15's nursing progress notes identified on 5/6/26, at 4:30 p.m., R15 returned from AN appointment with new orders to provide comfort cares only. Staff were advised to not hospitalize R15, stop metolazone, increase Lasix to 80 milligrams (MG) twice daily, and discontinue any labs per family request. R15's physician progress notes identified that she was seen at the clinic by MD-B on 5/6/26, for concerns of fluid retention in her legs. The physicians' progress note identified R15 had a history of heart failure and chronic fluid retention and was experiencing weight gain, generalized edema, and decreased strength. Although R15's diuretic medications had been increased previously, they were not seeing an improvement. R15's weight gain over the past month was significant despite the medication changes. R15's respiratory symptoms included occasional shortness of breath and persistent cough, though she generally reports her breathing as pretty good. MD-B identified after discussion of prognosis and limited benefit of further hospitalization; the family opted for comfort care. The plan was to include no further lab draws, do not hospitalize R15, continue morphine (pain medication) as needed for comfort at the facility and the family did not want hospice at this time. R15's undated, current care plan identified R15 was on diuretic therapy (medication is given to alleviate excess fluid buildup in the tissues) related to edema (swelling from excess fluid) and high blood pressure with a focus for R15 to be free of discomfort. Staff were to administer diuretic medication as ordered and monitor for their side effects and report pertinent lab results to the physician. The care plan made no mention that R15 was to be provided comfort care at the facility, should not be hospitalized , or that staff were to discontinue all lab draws. In addition, the care plan did not identify how the facility should maintain comfort if R15's overall condition were to change. Further review of R15's Nursing progress notes identified on:5/7/26 at 1:52 p.m., R15's family member requested the nurse to arrange for R15 to receive the catholic last rights. A call was place to the Catholic church. 5/8/26 at 4:45 a.m., staff noted R15 was not resting well that night and had been coughing chronically since 10:45 p.m They administered as needed morphine 0.25 milliliters (ML) in attempts to alleviate her discomfort from chronic cough related to fluid overload. 5/8/26 at 5:28 a.m., staff noted the morphine was ineffective and R15 reported her pain scale was 8 of 10 which is considered severe. R15 did not appear to have any relief from her cough and discomfort. The nurse will continue to monitor. Interview on 5/11/26 at approximately 2:00 p.m., with registered nurse (RN)-A identified she was aware of R15's coughing. She presumed it was caused by fluid retention. She identified they had received an order from the physician to not send R15 to the hospital. Interview on 5/11/26, at 2:34 p.m., with the director of nursing (DON) identified she was aware of R15's cough. She had been seen at the clinic on 5/6/26 and had new orders for comfort care and was not to be transported to the hospital. She agreed comfort measures should have been added to the care plan. Additional review of R15's progress notes identified on 5/11/26 at 2:47 p.m., a nursing assistant reported R15 was coughing. Staff documented a nurse assessment identified R15 was not feeling well, was short of breath, and continued to cough. Nurse administered cough syrup and 0.25 milliliters (ML) of morphine and brought her some warm (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	coffee. R15 experienced very little relief from these measures. Follow up interview on 5/11/26 at 3:32 p.m., with the director of nursing identified they had sent a fax to the physician earlier but had not received a response. She further identified they could not call the doctor during clinic hours and had been advised to fax. They could call the nurse triage line but were told calling that line would be no faster than sending a fax. She agreed R15's care plan should have been revised to identify what staff were to do to provide comfort for R15 if her condition worsened. Additional review of R15's progress notes identified on 5/11/26 at 2:47 p.m., a nursing assistant reported R15 was coughing. Staff documented a nurse assessment identified R15 was not feeling well, was short of breath, and continued to cough. Nurse administered cough syrup and 0.25 milliliters (ML) of morphine and brought her some warm coffee. R15 experienced very little relief from these measures. Follow up interview on 5/11/26 at 3:32 p.m., with the director of nursing identified they had sent a fax to the physician earlier that day on 5/11/26 but had not received a response. She further identified they could not call the doctor during clinic hours and had been advised to fax. They could call the nurse triage line but were told calling that line would be no faster than sending a fax. R15'S progress note review identified on:5/11/26 at 5:00 p.m., the nurse noted communication with the family to ask if they would be in agreement with increasing R15's morphine dose to help with her frequent coughing and to discuss a hospice referral. The family agreed. 5/11/26 at 6:43 p.m., a call was placed to the on-call physician (MD-C), who ordered staff to increase the frequency of as needed morphine to every 2 hours as needed for pain, shortness of breath, or cough and monitor if it was more effective for the cough.5/11/26 at 8:05 p.m., staff documented following the morphine administration, they felt the cough was better this evening.5/11/26 at 10:39 p.m., a fax was sent to the clinic to request an order for a hospice referral per the family's request. Review of the facilities May 2017, Change in a Resident's Condition or Status policy identified the nurse would notify the resident's attending physician or physician on-call when there has been a significant change in the resident's physical/emotional/mental condition, there is a need to transfer the resident to the hospital. A significant change of condition is a major decline or improvement in the resident's status that will not normally resolve itself without intervention by staff or by implementing standard disease related clinical interventions. The policy made no mention of how the facility staff should contact the physician for guidance if a residents change of condition was not emergent but needed to be reviewed in a timelier manner.

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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. Based on interview and document review, the facility failed to accurately code medication on the Minimum Data Set (MDS) assessment for 1 of 1 resident (R5) who was reported to be receiving insulin.Findings include: R5's, quarterly MDS assessment, accepted on 2/3/26 and 4/15/26. identified R5 received an INSULIN injection (1) time during the last 7 days. R5 had a diagnosis of diabetes, but her current physician orders identified no orders for insulin. R5'S current physician orders included an order dated 12/17/25, for Semaglutide (0.25 or 0.5 milligrams (mg/dose,) subcutaneous (SQ) 2 mg/3 milliliter (ml). staff were to inject R5 with 0.25 mg subcutaneously (SQ) in the morning, every Wednesday for diabetes with hyperglycemia for 4 Weeks, and then 0.5 mg sq every Wednesday morning. Interview on 5/10/26 at 2:30 p.m. with R5 identified she was diabetic and received an oral medication daily for her diabetes. She reported she did not receive insulin, but received a weekly injection of a GLP1 medication that was administered on Wednesdays. Interview on 5/11/26 at 8:14 a.m. with registered nurse (RN)-B confirmed she had incorrectly coded both the 1/16/26 and 4/10/26 quarterly MDS assessments as R5 received no insulin. She identified she would need to complete and submit a modification of the assessment. Interview on 5/12/26 at 11:28 a.m., with director of nursing (DON) identified she would expect the MDS to be accurate and reflect the status of each resident. There was no policy related to accuracy of the MDS provided by the end of survey.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on interview and document review the facility failed to develop a care plan for 1 of 13 residents (R15) who was identified as being at risk for falls upon admission.Findings include: R15's quarterly Minimum Data Set (MDS) assessment, accepted on 3/20/26, identified her cognition was intact, her vision was severely impaired (no vision or sees only light, colors or shapes). R15 required moderate assistance of one staff for transfers, dressing, and hygiene. R15's comprehensive MDS assessment accepted on 12/22/25, identified the Care Area Assessment (CAA) portion of the MDS identified falls would be addressed on the care plan. Staff were to monitor for fall risks related to medication, new surroundings and adjustment due to vision and hearing deficits. They were to ensure the call light was within reach, ensure R15 knew where it was located, and attach the call light so it would not slide away due to her vision impairment. Interview on 5/10/26 at 1:38 p.m., with R15's family member (FM)-A identified R15 recently had a fall. She had been sitting in her wheelchair in her room. She fell asleep and fell face forward out of her chair hitting her face on the nightstand sustaining facial bruising. R15's 5/1/26 at 2:43 p.m., nursing progress note identified R15 had a fall on 5/1/26 at 10:01 a.m., that was not witnessed. The fall occurred in R15's room. She forgot to lock her brakes on her wheelchair, fell asleep, and leaned too far forward and tipped out of the chair. R15 sustained a facial bump and bruise and a skin tear on her right ring finger. Review of R15's current undated care plan made no mention that R15 was at risk for falls. There was nothing to identify what staff were to do to minimize R15's risk of falls. Interview on 5/12/26 at 10:18 a.m., with the MDS nurse identified R15 had no history of falls prior to admission to the facility. If a resident was identified as being at risk for falls upon admission but has no history of falls she does not always add that to the care plan regardless of the Care Area Assessment findings. Interview on 5/12/26 at 12:42 p.m., with the director of nursing (DON) identified it was her expectation that any resident who was assessed to be at risk for falls would have a section on the care plan to alert staff of those risks and how they were to provide care and minimize risk for injury. Review of the facilities 2/20/20, Care Plan policy identified staff were to develop a care plan within 7 days after completion of the comprehensive assessment. The care plan was to address the resident's needs, strengths, and preferences as identified in the comprehensive assessment with measurable objectives and timetable to meet the residents long and short-term goals for medical, nursing, and psycho-social needs that are identified in the assessment. The care plan was to list services that will be furnished to attain or maintain the resident's highest and practicable physical, mental, and psycho-social well-being. The care plan was to be reviewed and revised by the interdisciplinary team, the resident, and/or the legal guardian at least quarterly and updated at any time to account for day-to-day changes in care.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on the facility failed to revise the care plans for 2 of 12 sampled residents (one who was to be receiving comfort cares (R15), and one (R2) who developed a pressure ulcer). Findings include: R15R15's quarterly Minimum Data Set assessment, accepted on 3/20/26, identified her cognition was intact, she had diagnosis of edema, heart failure, high blood pressure, premature contractions of the heart ventricles, and tricuspid regurgitation (a heart condition that can cause extreme tiredness, shortness of breath and swelling in the belly, legs, or neck veins). R15 required moderate assistance of one staff for transfers, dressing, and hygiene. Intermittent observations on 5/10/26 from 11:30 a.m., to 7:00 p.m., and again on 5/11/26 from 7:33 a.m., to 4:30 p.m., identified R15 remained in her room was seated in her recliner. She could be heard coughing continuously and the cough was worsening. Review of R15's nursing progress notes identified on 5/6/26, at 4:30 p.m., R15 returned from AN appointment with new orders to provide comfort cares only. Staff were advised to not hospitalize R15, stop metolazone, increase Lasix to 80 milligrams (MG) twice daily, and discontinue any labs per family request. R15's 5/6/26, physicians (MD-B) progress note identified that she was seen at the clinic for concerns of fluid retention in her legs. The corresponding physicians' progress note identified R15 had a history of heart failure and chronic fluid retention and was experiencing weight gain, generalized swelling, and decreased strength. Although R15's diuretic medications had increased previously they were not seeing an improvement. R15 had weight gain over the past month that had been significant despite the medication changes. R15's respiratory symptoms included occasional shortness of breath and persistent cough, though she generally reported her breathing as pretty good. MD-B identified after discussion of R15's prognosis and limited benefit of further hospitalization; the family opted for comfort care. His plan was to do no further lab draws, not hospitalize her, and continue morphine as needed for comfort at the facility. The family did not want hospice at this time. R15's undated, current care plan identified R15 was on diuretic therapy (medication is given to alleviate excess fluid buildup in the tissues) related to edema (swelling from excess fluid) and high blood pressure with a focus for R15 to be free of discomfort. Staff were to administer diuretic medication as ordered and monitor for their side effects and report pertinent lab results to the physician. The care plan made no mention that R15 was to be provided comfort care at the facility, should not be hospitalized , or that staff were to discontinue all lab draws. In addition, the care plan did not identify how the facility should maintain comfort if R15's overall condition were to change. Further review of R15's Nursing progress notes identified on:5/7/26 at 1:52 p.m., R15's family member requested the nurse to arrange for R15 to receive the catholic last rights. A call was place to the Catholic church.5/8/26 at 4:45 a.m., staff noted R15 was not resting well that night and had been coughing chronically since 10:45 p.m They administered as needed morphine 0.25 milliliters (ML) in attempts to alleviate her discomfort from chronic cough related to fluid overload.5/8/26 at 5:28 a.m., staff noted the morphine was ineffective and R15 reported her pain scale was 8 of 10 which is considered severe. R15 did not appear to have any relief from her cough and discomfort. The nurse will continue to monitor. Interview on 5/11/26 at approximately 2:00 p.m., with registered nurse (RN)-A identified she was aware of the coughing. She presumed it was caused by fluid retention. She identified they had received an order from the physician to not send R15 to the hospital. Interview on 5/11/26, at 2:34 p.m., with director of nursing reported she was aware of R15's cough. She had been seen at the clinic on 5/6/26 and had new orders for comfort care and was not to be transported to the hospital. R15's 5/11/26 at 2:47 p.m., nursing progress note identified a nursing assistant reported R15 was coughing. R15 was not feeling well, was short of breath, and continued to cough. Staff documented they administered cough syrup and 0.25 milliliters (ML) of morphine and brought her some warm coffee. Staff noted R15 experienced very little relief from those measures. Follow up interview on 5/11/26 at 3:32 p.m., with the director of nursing identified they had sent a fax to the (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	physician earlier but had not received a response. She further identified they could not call the doctor during clinic hours and had been advised to fax. They could call the nurse triage line but were told calling that line would be no faster than sending a fax. She agreed R15's care plan should have been revised to identify what staff were to do to provide comfort for R15 if her condition worsened. Review of the facilities March 2018, Palliative/End of Life Care-Clinical Protocol policy identified the interdisciplinary team would complete an assessment of the resident and family for the basis of the individualized palliative care plan. The assessment would include at least:1. Documentation of disease status, including diagnosis and prognosis2. Documentation of co-morbid medical and/or psychiatric conditions3. Functional status4. Strengths5. Concerns, goals and values of the resident and family6. Preferences and documentation for end-of-life decisions and care7. Appropriateness of a hospice referralThe comprehensive assessment was to recur on a regular basis and in response to significant changes of condition or change in resident and family goals or wishes. The physician was to help identify or verify underlying causes of A resident's decline or end stage/terminal status. Palliative (comfort) care was to focus on physical, psychological, social and spiritual quality of life for the resident and family. The physician was to order appropriate interventions for symptom relief, and advise the resident/patient, family, and facility staff about the prognosis and overall medical plan periodically, including any impact of significant changes of condition. The physician and staff were to monitor and assess the resident's course of treatment, identify complications or additional decline, and adjust their approaches accordingly. R2R2's comprehensive MDS, accepted on 3/20/26, identified his cognition was severely impaired, and he required partial to moderate assistance of 1 staff for transfers, dressing, and hygiene. R2 had four Stage II pressure ulcers (top layer of skin has broken down, exposing the pinkish layer underneath the dermis). The Care Area Assessment (CAA) portion of the MDS identified staff were to address the pressure wounds on the care plan to identify that staff were to provide pressure ulcer treatment daily, monitor weekly and as needed, and update the physician of if there was a decline or signs of infection. The care plan goals would be to slow or minimize decline, minimize risks, and provide symptom relief or palliative measures. R2's current treatment administration record (TAR) identified a physician order to apply Calmoseptine (topical barrier cream) and a foam patch to the areas on buttocks daily. Review of R2's current, undated care plan identified he was at risk for skin integrity impairment and staff were to encourage good nutrition, avoid moisture, keep skin clean and dry, apply moisture barrier cream after toileting, and monitor for medication side effects such as rash. R2's care plan did not identify he had an actual pressure ulcer and made no mention what staff were to do to promote healing or reduce/minimize risk for infection or discomfort. Interview on 5/11/26 at 3:18 p.m., with nursing assistant (NA)-A identified she was aware R2 has a rashy area on his bottom. She reported staff ensure the open area on his bottom is clean then the nurse comes in and does his dressing. Staff check him once in the morning and once in the afternoon. She had never been told that he is supposed to be repositioned. He is supposed to have assistance with standing and transferring. Interview on 5/11/26 at 2:04 p.m., with the MDS nurse identified she did not revise the care plan to include R2's pressure ulcers. Normally, she would have added this with interventions and goals for healing but she missed it. She agreed it should have been added so staff were aware of the interventions that should be implemented to promote healing and minimize risks. Interview on 5/11/26 at 2:19 p.m., with the DON identified it was her expectation that a pressure ulcer should be identified on the care plan with appropriate goals and interventions. Review of the facilities 2/20/20, Care Plan policy identified staff were to develop a care plan within 7 days after completion of the comprehensive assessment. The care plan was to address the resident's needs, strengths, and preferences as identified in the comprehensive assessment with measurable objectives and timetable to meet the residents long and short-term goals for medical, nursing, and psycho-social needs that are identified in the assessment. The care plan was to list services that will be furnished to attain or maintain the resident's highest and practicable physical, mental, and psycho-social well-being. The care plan was to be reviewed and revised by the interdisciplinary team, (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the resident, and/or the legal guardian at least quarterly and updated at any time to account for day-to-day changes in care.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. Based on interview and document review, the facility failed to complete a comprehensive assessment for continued use of antibiotics for 2 of 3 (R19 and R22) sampled residents reviewed for antibiotic stewardship.Findings include: Review of the current, undated, Centers for Disease Control (CDC): The Core Elements of Antibiotic Stewardship for Nursing Homes, Appendix A: Policy and Practice Actions to Improve Antibiotic Use, located at https://www.cdc.gov/antibiotic-use/core-elements/pdfs/core-elements-antibiotic-stewardship-appendix-a-508.p identified facilities should evaluate the clinical signs and symptoms when a resident is first suspected of having an infection. Once the resident is placed on an antibiotic, they should be comprehensively reviewed within 48-72 hours after starting the medication to ensure they have been prescribed an effective medication. This is accomplished by reviewing the residents' current symptoms and any laboratory results to identify medication effectiveness. The CDC identifies this process as an antibiotic time-out [ATO]. Review of Monthly Antibiotic surveillance reports from January 2026 through April 2026 identified columns for; resident's name, infection from previous month, infection type, symptoms, onset date, device, infection risk factors, diagnostic performed, date performed, test type, specimen source, results, antibiotic resistant organism, antibiotic name, dose, route, frequency, provider, antibiotic start date, antibiotic end date, total days of therapy, antibiotic reassessment time out, transmission based precautions required, date symptoms resolved, and comments. Review of January 2026 surveillance identified R19 had symptoms of nasal congestion with no onset date. R19 had been started on doxycycline 100 milligrams (mg) orally, twice a day, beginning 1/15/26 with an end date of 1/22/26, and an ATO was documented as completed. The diagnoses listed was a sinus infection. There was no information in the column labeled date symptoms resolved to identify if R19's treatment had been successful or there was a need to change or continue treatment. R19's progress notes identified on:1/15/26, R19 had been seen by doctor at the facility and was started on doxycycline 100 mg for 7 days.1/18/26, (identified as an antibiotic time out) staff documented R19 continued to have symptoms of a sinus infection with thick mucus. R19 reported feeling better. Staff noted R19 would continue taking the antibiotic. The note lacked any identification that the doctor was notified or reviewed the information to make an informed decision if the antibiotic should be continued, changed, or discontinued. Review of March 2026 surveillance identified R22, had symptoms of red, warm to touch with onset date of 2/12/26. R22 had been started on doxycycline 100 mg orally, twice a day, beginning on 3/12/26 with an end date of 3/19/26, and an ATO was documented as completed. The diagnoses listed was cellulitis. There was no information in the column labeled date symptoms resolved to identify if R22's treatment had been successful or there was a need to change or continue treatment. R22's progress notes identified on:3/12/26, R22 had been seen by the doctor at the facility and started on doxycycline 100 mg twice a day for 7 days and refer to vascular surgery if family desires.3/15/26, (identified as an antibiotic time out) staff documented R22 continued Doxycycline for cellulitis to right lower extremity. R22's lower right extremity continued to appear red and slightly swollen and warm to touch. R22 was also noted to have increased confusion, staff were unsure if this was related to antibiotic use or worsening dementia. Staff noted minimal, if any improvement was observed from the antibiotic use. The note lacked any identification that the doctor was notified or reviewed the information to make an informed decision if the antibiotic should be continued, changed, or discontinued. Interview on 5/10/26 at 3:12 p.m., with the director of nursing (DON) identified the antibiotic time-out would be documented in the residents' progress notes. The nurse would complete an assessment of the resident after starting an antibiotic and would documented that in the residents progress notes. That assessment information was not communicated to the prescribing provider. The DON stated, I have talked with the medical director, but she said that she did not think her colleges would want to be bothered with that information. She revealed that the facility determined that the antibiotic was working if the resident (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was getting better or not. Interview on 5/11/26 at 8:30 a.m., with the infection preventionist (IP) identified that she had been in the IP position for less than a year. Her hours working in the IP role depended on staffing and if she had to work in another role. She typically worked on infection control 4-5 hours a week. She identified that if an antibiotic time-out was not completed she had just missed doing it. The providers have told the facility they do not want to see the information or the time-out form. The only way the facility determined if the antibiotic was working was if the residents' symptoms improved. She identified that the nurse made a progress note in the resident record on how the resident was doing on the antibiotic. She revealed the facility did not communicate that information with the prescribing provider that ordered the antibiotic as they did not want that information. Interview on 5/11/26 at 9:48 a.m., with the administrator identified he was unaware that there was an issue with antibiotic time-out and that the ordering physician should be updated on the resident's status after starting an antibiotic. He was unaware that the medical director had reported to the director of nursing that the providers did not want to review the antibiotic assessment information. Review of facility Antibiotic Flow Sheet that facility staff were supposed to be using identified columns for:Resident nameXray yes or noPrescribing Physician and FacilityDate Treatment StartedSpecimen yes or noIndication for AntibioticCulture yes or noAntibiotic Ordered with dosage/durationRoute of AdministrationSpecimen identified from cultureAntibiotic time-out yes or noA place to document vital signsLast date of antibiotic givenNurses signatureHas a different antibiotic been ordered for this same infection?The form lacked a column for the facility to make notes of how the resident was doing and for the provider to respond if the antibiotic should be continued, changed, or discontinued. Review of undated, Antibiotic Stewardship policy, identified the program goal was to reduce adverse events associated with antibiotic use and promote appropriate use of antibiotics to treat infection. The facility will implement policies and practices to improve antibiotic use, will monitor antibiotic use and outcomes, and provide feedback to the prescribing provider on antibiotic use and resistance. Antibiotic time-out at 72 hours after an antibiotic started will be completed to assess antibiotic need, duration, selection, and de-escalation potential and would be recorded in the resident's record.