STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245558	A. Building B. Wing	02/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Good Samaritan Society - Windom	705 Sixth Street Windom, MN 56101

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 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to ensure the infection preventionist provided the Quality Assurance Performance Improvement (QAPI) members with employee surveillance and illness data during monthly meetings. This had the potential to affect all 56 residents. TBReview of RN-A's employee file identified she had a hire date of 8/13/25. On 8/13/25, RN-A completed a baseline screening questionnaire and was given a first step TB skin test (TBT) which was negative for TB exposure. On 8/26/25, RN-A was given her second TST, On 8/29/25, the TST site on RN-A's arm was reviewed by the tester and determined positive as it showed induration (thickened, raised skin). Employee file note entitled Regarding [name] TB testing identified an un-named staff noted:RN-A's 1st TST was negative.Second TST was reviewed at 48 and showed redness and induration. Staff waited until the 72-hour (8/29/25) timeframe and re-evaluated. On 8/29/25, the redness was improved, however, the induration remained so the plan was to send RN-A for a blood TB test and scheduled RN-A to be tested at the local clinic.On 9/2/25, staff were looking for the blood test results as it was routine for the clinic to fax over result documentation to the facility. No fax was received. The clinic was contacted. They had no record of RN-A being seen for testing. RN-A was called. She is in the building working on floor orientation. RN-A's lack of blood test results was discussed. RN-A stated to facility staff that the clinic did not draw blood on 8/29/25, as the [laboratory] courier was already gone for the day. RN-A was then scheduled to go back to the clinic by 3:00 p.m. on 9/2/25 for the blood test. She has been on the floor today interacting with staff and residents. She states she does not feel sick, but yet, does not feel comfortable being out there if there is a problem with her TB test. A plan was made to consult with the interim director of nursing (DON) (currently the DON), but the staff advised holding RN-A from [having] contact with residents until the test results came back. RN-A was noted to have agreed with the plan.On and unidentified later date, a note was made the staff consulted with the IDON and the administrator, and they would allow RN-A to remain on the floor for orientation while wearing a mask.On 9/5/2, staff noted they received a report of the TB blood test. It was positive for TB exposure. Staff noted the spoke with a physician, administrator, and Minnesota Department of Health nurse (TB specialist). Staff would hold off of work until after a physician exam and chest x-ray. An appointment was made for RN-A to be seen on 9/9/25 by a physician.On 9/12/25, the note identified RN-A's appointment was rescheduled to 9/15/25. Review of the 9/15/25, physician (MD)-A note regarding RN-A identified RN-A was seen on 9/15/25 via telemedicine consultation for evaluation of her positive TST and blood test. RN-A was evaluated on 9/9/25, by MD-B who noted in his exam RN-A's lung sounds were normal. RN-A also had a chest x-ray which showed RN-A had latent TB (infected with TB bacteria, but do not have active TB disease). RN-A was offered treatment but declined at that time. RN-A was not contagious and was able to return to work without restriction. Review of the 4/17/25, Clinical Overview of Latent Tuberculosis Infection, located at https://www.cdc.gov/tb/hcp/clinical-overview/latent-tuberculosis-infection.html, identified People with latent TB infection are infected with TB bacteria, but they do not have TB disease. However, if (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 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	these bacteria become active and multiply, latent TB infection can develop into TB disease. Treating people with latent TB infection substantially reduces the risk that latent TB infection will progress to TB disease. Once active, TB can be spread from person to person through the air. People with latent TB infection should be treated to prevent the development of TB disease. Short-course latent TB infection treatments are effective, safe, and have higher completion rates than treatment regimens. Further review of the note entitled Regarding [name] TB testing identified on 9/15/25, staff noted RN-A had been seen as noted in the above physician note. Staff spoke to RN-A about treatment, and she was noted to be considering it. No further documentation was made on the note. Review of the Absence/[NAME] Report forms identified there were no ill call-ins from RN-A from September 2025 through January 2026. Further review of RN-A's employee file identified there was no signed education provided to RN-A about signs and symptoms of active TB, nor any mention of mitigating measures or exclusions to work required if RN-A showed signs or symptoms of active TB or her acknowledgement of any education having been provided. The facility infection preventionist was terminated from employment 9/9/26 and was unable to be interviewed. Review of the facility's 5/7/25, TB risk assessment identified the facility risk was low. The DON and infection preventionist (IP) were responsible for TB infection control (IC) in the facility. The IC committee members listed were the DON, the IP, RN case managers, along with the dietary and the activities directors. There was no indication another risk assessment had been completed after RN-A was identified to have latent TB to see if the facility's risk would remain low. Review of the infection control surveillance data identified RN-A was not listed on any surveillance as being monitored. Review of the IC Safety Meeting November 2025 minutes, presented to Quality Assurance Performance Improvement (QAPI) committee identified there was a section for:Employee health. There were no recorded illnesses for October 2025.TB. One new hire (RN-A) with a positive TB was noted. It was documented that RN-A was not taking medication treatment, but a sign/symptom screening was to be done every year while they worked at the facility. It was not identified in the meeting notes if the facility would ensure RN-A would be seen by a physician and prevented from working if she showed new evidence of signs or symptoms of active disease, or if the facility planned to send RN-A for annual evaluation and chest x-ray by a physician to identify the continued absence of active disease. Interview and document review on 2/12/26 at 11:22 am., with regional nurse consultant (RNC)-A, who was also the interim infection preventionist identified she was unaware of RN-A's latent TB diagnosis or that RN-A was allowed to work before given medical clearance from a physician. RNC-A reviewed the Regarding [name] TB testing note and agreed the facility needed heightened surveillance and mitigation measures in place for RN-A if she became symptomatic with signs or symptoms of active TB (fever, night sweats, weight loss, loss of appetite, sense of illness or loss of energy). Further interview on 2/12/26 at 11:46 a.m., with RNC-A and the administrator identified RN-A was to receive yearly chest x-rays and physician exams, however, they agreed, there was no enhanced surveillance of RN-A that was identified in the infection control surveillance documentation, that staff were to be aware of active TB symptoms, or that RN-A had received education to those symptoms and not report to work if that should occur and seek medical evaluation by a physician. RNC-A and the administrator identified they felt RN-A declined treatment due to expense. Both RNC-A and the administrator were unaware of the Minnesota Tuberculosis Medication Program that served to eliminate financial barriers to medication for the treatment of latent TB infection (LTBI) or active TB disease for state residents. Both the RNC-A and administrator identified they would work with RN-A to assist her with treatment accessibility, and would work on implementing heightened mitigation measures and surveillance for RN-A. Review of the 6/1/25, Tuberculosis Control Plan and Screening policy identified prior to or upon hire, all staff were to be screened and tested for TB. Employees with newly identified positive TST or blood tests would be required to be evaluated by a medical provider to rule out active TB. Employees were to be instructed about signs and symptoms of TB and reporting requirements to the IP or designee. Employees with untreated latent TB were to receive yearly symptom screening to detect (continued on next page)

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F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	evidence of active TB and to re-evaluate to risks and benefits of treatment. An employee with suspected or confirmed TB was not to be allowed on the facility until the employee had been confirmed to be non-contagious by a physician. Employees with symptoms were to be evaluated promptly for TB and not return to work until active TB was excluded by a physician and written documentation from that physician was required. EMPLOYEE SURVEILLANCE and RETURN TO WORK Review of employee Absence/[NAME] Report forms identified the form listed:Employee name.Date of absence.Reason for absence.Comments.Recorded by.Date recorded.A section for If absence was an illnessDate of return to work.Signature of nurse verifying the employee was cleared for work.There was no indication on the forms of which nursing staff were trained and able to sign the form to ensure employees were appropriate to return to work (RTW), kept out of work for an appropriate timeframe, or what professional standards the facility followed to ensure staff followed specific guidelines ensure transmission of potential infectious disease did not occur. Review of the October 2025 through January 2026 Absence/[NAME] forms identified in:October 2025, 25 of 26 staff call-ins were due to staff or family illness with illnesses varying with gastrointestinal illnesses (stomach flu, nausea, vomiting, diarrhea) , respiratory illnesses, etc.November 2025, 6 of 23 staff call-ins were due to staff illnesses such as diarrhea, not feeling well, personal sick or sick, heading to the emergency room (ER)December 2025, 22 of 28 staff call-ins were reported for staff illnesses of stomach flu, sick, fevers, diarrhea, and nausea and/or vomiting.January 2026, of 23 of 28 staff call-ins were related to staff or family illness of flu, sore throats, body aches, stomach aches, nausea, diarrhea, vomiting, flu, and one with a child with Respiratory Syncytial Virus (RSV) (highly contagious respiratory disease) and one with Strep throat (bacterial infection of the throat easily spread).None of the forms identified what date an employee was allowed to RTW, if any trained nursing staff had made that determination, or what criteria was used to determine the appropriateness of RTW. or what staff had identified they were appropriate to return to work. Review of the IC Safety Meeting minutes, presented to Quality Assurance Performance Improvement (QAPI) committee identified there was a section for Employee Health each month. In:November 2025's meeting, there were no recorded illnesses of staff reported. The action plan noted they would review staff illnesses at the next meeting.Decembers 2025's meeting, there was no recorded illnesses of staff reported. The action plan remained that the committee would review staff illnesses at the next meeting. Interview on 2/12/26 at approximately 1:30 p.m., with RNC-A identified she agreed staff were not appropriately screened for their appropriateness to return to work and the forms lacked critical information on what criteria were to be used. There was no other employee surveillance data they were aware of from the previous IP who was terminated on 2/9/26. Review of the November 2025, and December 2025 QAPI meeting minutes identified there was no information on employee surveillance brought forth to QAPI from the Infection Control Committee Meetings. Review of the 11/18/25, Infection Prevention and Control Program policy identified the facility was to have a system of surveillance for employees to report signs, symptoms and diagnosed illnesses that may present a risk to residents, employees, and other individuals. Education to employees was to occur as appropriate. Review of the 9/30/25, Surveillance policy identified appropriate surveillance of residents was identified, however, there was no mention on the inclusion of employee illnesses, the collection of that data, or how the facility was to ensure employees returned to work appropriately after an illness using professional standards to mitigate potential spread of infection by employees.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to ensure there was appropriate surveillance and subsequent mitigation efforts and education identified for 1 of 1 staff (registered nurse (RN)-A) who was found to be positive for Tuberculosis (TB) during routine pre-employment testing. Additionally, the facility failed to ensure employees were cleared to return to work (RTW) after illness using professional standards and appropriately surveilled for illness, for 4 of 4 months (October 2025 through January 2026) reviewed. The facility also failed to ensure 3 of 3 whirlpool tubs were cleaned and disinfected according to manufacturer's guidelines and failed to ensure 1 of 1 nebulizer (inhaled medication) treatment devices were cleaned, rinsed, and left to air dry after each medication administration. These deficient practices had the potential to affect all 56 residents or other staff and visitors in the facility.Findings include: TBReview of RN-A's employee file identified she had a hire date of 8/13/25. On 8/13/25, RN-A completed a baseline screening questionnaire and was given a first step TB skin test (TBT) which was negative for TB exposure. On 8/26/25, RN-A was given her second TST, On 8/29/25, the TST site on RN-A's arm was reviewed by the tester and determined positive as it showed induration (thickened, raised skin). Employee file note entitled Regarding [name] TB testing identified an un-named staff noted:RN-A's 1st TST was negative.Second TST was reviewed at 48 and showed redness and induration. Staff waited until the 72-hour (8/29/25) timeframe and re-evaluated. On 8/29/25, the redness was improved, however, the induration remained so the plan was to send RN-A for a blood TB test and scheduled RN-A to be tested at the local clinic.On 9/2/25, staff were looking for the blood test results as it was routine for the clinic to fax over result documentation to the facility. No fax was received. The clinic was contacted. They had no record of RN-A being seen for testing. RN-A was called. She is in the building working on floor orientation. RN-A's lack of blood test results was discussed. RN-A stated to facility staff that the clinic did not draw blood on 8/29/25, as the [laboratory] courier was already gone for the day. RN-A was then scheduled to go back to the clinic by 3:00 p.m. on 9/2/25 for the blood test. She has been on the floor today interacting with staff and residents. She states she does not feel sick, but yet, does not feel comfortable being out there if there is a problem with her TB test. A plan was made to consult with the interim director of nursing (DON) (currently the DON), but the staff advised holding RN-A from [having] contact with residents until the test results came back. RN-A was noted to have agreed with the plan.On and unidentified later date, a note was made the staff consulted with the IDON and the administrator, and they would allow RN-A to remain on the floor for orientation while wearing a mask.On 9/5/2, staff noted they received a report of the TB blood test. It was positive for TB exposure. Staff noted the spoke with a physician, administrator, and Minnesota Department of Health nurse (TB specialist). Staff would hold off of work until after a physician exam and chest x-ray. An appointment was made for RN-A to be seen on 9/9/25 by a physician.On 9/12/25, the note identified RN-A's appointment was rescheduled to 9/15/25. Review of the 9/15/25, physician (MD)-A note regarding RN-A identified RN-A was seen on 9/15/25 via telemedicine consultation for evaluation of her positive TST and blood test. RN-A was evaluated on 9/9/25, by MD-B who noted in his exam RN-A's lung sounds were normal. RN-A also had a chest x-ray which showed RN-A had latent TB (infected with TB bacteria, but do not have active TB disease). RN-A was offered treatment but declined at that time. RN-A was not contagious and was able to return to work without restriction. Review of the 4/17/25, Clinical Overview of Latent Tuberculosis Infection, located at https://www.cdc.gov/tb/hcp/clinical-overview/latent-tuberculosis-infection.html, identified People with latent TB infection are infected with TB bacteria, but they do not have TB disease. However, if these bacteria become active and multiply, latent TB infection can develop into TB disease. Treating people with latent TB infection substantially reduces the risk that latent TB infection will progress to TB disease. Once active, TB can be spread from person to person through (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	the air. People with latent TB infection should be treated to prevent the development of TB disease. Short-course latent TB infection treatments are effective, safe, and have higher completion rates than treatment regimens. Further review of the note entitled Regarding [name] TB testing identified on 9/15/25, staff noted RN-A had been seen as noted in the above physician note. Staff spoke to RN-A about treatment, and she was noted to be considering it. No further documentation was made on the note. Review of the Absence/[NAME] Report forms identified there were no ill call-ins from RN-A from September 2025 through January 2026. Further review of RN-A's employee file identified there was no signed education provided to RN-A about signs and symptoms of active TB, nor any mention of mitigating measures or exclusions to work required if RN-A showed signs or symptoms of active TB or her acknowledgement of any education having been provided. The facility infection preventionist was terminated from employment 9/9/26 and was unable to be interviewed. Review of the facility's 5/7/25, TB risk assessment identified the facility risk was low. The DON and infection preventionist (IP) were responsible for TB infection control (IC) in the facility. The IC committee members listed were the DON, the IP, RN case managers, along with the dietary and the activities directors. There was no indication another risk assessment had been completed after RN-A was identified to have latent TB to see if the facility's risk would remain low. Review of the infection control surveillance data identified RN-A was not listed on any surveillance as being monitored. Review of the IC Safety Meeting November 2025 minutes, presented to Quality Assurance Performance Improvement (QAPI) committee identified there was a section for:Employee health. There were no recorded illnesses for October 2025.TB. One new hire (RN-A) with a positive TB was noted. It was documented that RN-A was not taking medication treatment, but a sign/symptom screening was to be done every year while they worked at the facility. It was not identified in the meeting notes if the facility would ensure RN-A would be seen by a physician and prevented from working if she showed new evidence of signs or symptoms of active disease, or if the facility planned to send RN-A for annual evaluation and chest x-ray by a physician to identify the continued absence of active disease. Interview and document review on 2/12/26 at 11:22 am., with regional nurse consultant (RNC)-A, who was also the interim infection preventionist identified she was unaware of RN-A's latent TB diagnosis or that RN-A was allowed to work before given medical clearance from a physician. RNC-A reviewed the Regarding [name] TB testing note and agreed the facility needed heightened surveillance and mitigation measures in place for RN-A if she became symptomatic with signs or symptoms of active TB (fever, night sweats, weight loss, loss of appetite, sense of illness or loss of energy). Further interview on 2/12/26 at 11:46 a.m., with RNC-A and the administrator identified RN-A was to receive yearly chest x-rays and physician exams, however, they agreed, there was no enhanced surveillance of RN-A that was identified in the infection control surveillance documentation, that staff were to be aware of active TB symptoms, or that RN-A had received education to those symptoms and not report to work if that should occur and seek medical evaluation by a physician. RNC-A and the administrator identified they felt RN-A declined treatment due to expense. Both RNC-A and the administrator were unaware of the Minnesota Tuberculosis Medication Program that served to eliminate financial barriers to medication for the treatment of latent TB infection (LTBI) or active TB disease for state residents. Both the RNC-A and administrator identified they would work with RN-A to assist her with treatment accessibility, and would work on implementing heightened mitigation measures and surveillance for RN-A. Review of the 6/1/25, Tuberculosis Control Plan and Screening policy identified prior to or upon hire, all staff were to be screened and tested for TB. Employees with newly identified positive TST or blood tests would be required to be evaluated by a medical provider to rule out active TB. Employees were to be instructed about signs and symptoms of TB and reporting requirements to the IP or designee. Employees with untreated latent TB were to receive yearly symptom screening to detect evidence of active TB and to re-evaluate to risks and benefits of treatment. An employee with suspected or confirmed TB was not to be allowed on the facility until the employee had been confirmed to be non-contagious by a (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	physician. Employees with symptoms were to be evaluated promptly for TB and not return to work until active TB was excluded by a physician and written documentation from that physician was required. EMPLOYEE SURVEILLANCE and RETURN TO WORK Review of employee Absence/[NAME] Report forms identified the form listed:Employee name.Date of absence.Reason for absence.Comments.Recorded by.Date recorded.A section for If absence was an illnessDate of return to work.Signature of nurse verifying the employee was cleared for work.There was no indication on the forms of which nursing staff were trained and able to sign the form to ensure employees were appropriate to return to work (RTW), kept out of work for an appropriate timeframe, or what professional standards the facility followed to ensure staff followed specific guidelines ensure transmission of potential infectious disease did not occur. Review of the October 2025 through January 2026 Absence/[NAME] forms identified in:October 2025, 25 of 26 staff call-ins were due to staff or family illness with illnesses varying with gastrointestinal illnesses (stomach flu, nausea, vomiting, diarrhea) , respiratory illnesses, etc.November 2025, 6 of 23 staff call-ins were due to staff illnesses such as diarrhea, not feeling well, personal sick or sick, heading to the emergency room (ER)December 2025, 22 of 28 staff call-ins were reported for staff illnesses of stomach flu, sick, fevers, diarrhea, and nausea and/or vomiting.January 2026, of 23 of 28 staff call-ins were related to staff or family illness of flu, sore throats, body aches, stomach aches, nausea, diarrhea, vomiting, flu, and one with a child with Respiratory Syncytial Virus (RSV) (highly contagious respiratory disease) and one with Strep throat (bacterial infection of the throat easily spread).None of the forms identified what date an employee was allowed to RTW, if any trained nursing staff had made that determination, or what criteria was used to determine the appropriateness of RTW. or what staff had identified they were appropriate to return to work. Review of the IC Safety Meeting minutes, presented to Quality Assurance Performance Improvement (QAPI) committee identified there was a section for Employee Health each month. In:November 2025's meeting, there were no recorded illnesses of staff reported. The action plan noted they would review staff illnesses at the next meeting.Decembers 2025's meeting, there was no recorded illnesses of staff reported. The action plan remained that the committee would review staff illnesses at the next meeting. Interview on 2/12/26 at approximately 1:30 p.m., with RNC-A identified she agreed staff were not appropriately screened for their appropriateness to return to work and the forms lacked critical information on what criteria were to be used. There was no other employee surveillance data they were aware of from the previous IP who was terminated on 2/9/26. Review of the November 2025, and December 2025 QAPI meeting minutes identified there was no information on employee surveillance brought forth to QAPI from the Infection Control Committee Meetings. Review of the 11/18/25, Infection Prevention and Control Program policy identified the facility was to have a system of surveillance for employees to report signs, symptoms and diagnosed illnesses that may present a risk to residents, employees, and other individuals. Education to employees was to occur as appropriate. Review of the 9/30/25, Surveillance policy identified appropriate surveillance of residents was identified, however, there was no mention on the inclusion of employee illnesses, the collection of that data, or how the facility was to ensure employees returned to work appropriately after an illness using professional standards to mitigate potential spread of infection by employees. WHIRLPOOL TUB CLEANING Observation, interview, and document review on 2/10/26, of bath aide (BA)-F in the 400-wing tub room identified the facility had Cascade brand whirlpool jetted tubs. BA-F proceeded to fill the bottom of the tub well with a disinfectant mix connected to the tub from the manufacturer's container for approximately 2 gallons of disinfectant mix. BA-F scrubbed the walls and bottom and chair of the whirlpool tub for 3 minutes then released the water and rinsed the rub. BA-F then engaged the whirlpool jets to blow out and remaining disinfectant from the jets. BA-F stated she had worked at the facility for 30 years. She noted instructions for the process were on the wall. BA-F then opened the side of the whirlpool tub to show the disinfectant and verified on the manufacturer's instructions of the disinfectant; there was a wet-contact time of 10 minutes that was required to ensure appropriate disinfection would occur. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	BA-F was unaware of the instructions on the bottle and pointed to typed up instructions on the wall. Those instructions were posted in all 3 of the whirlpool tub rooms. All 56 residents were bathed and/or showered in one of the three whirlpool tubs (one for each wing) and that process posted was completed after each resident bath. Interview on 2/10/26 at 12:45 with BA-G in the south hall tub room identified she followed the same posted instructions as above and verified the instructions lacked the disinfectant note portion for there to be a wet-contact time of 10 minutes to ensure disinfection. Review of the undated, Bath Cleaning After Every Bath posted instructions identified staff were to:Close and lock the tub door.Rinse the tub using the sprayer.Put the drain in the tub.Press and hold the disinfectant button on the left side of the tub.Release the button when staff saw cleaning solution coming out of all jets and there was 1.5 to 2 gallons of disinfectant solution in the tub.Use the scrub brush to thoroughly scrub all interior surfaces of the tub with the solution.Remove the drain plug.Rinse the interior surfaces thoroughly.Press and hold the rinse button until clear water ran from the jets.Finish rinsing the tub interior.Start the air blower for all jets and allow to run for 30-45 seconds to push all the water out.Unlock the tub door and leave it slightly open.There were no posted instructions that included the [NAME] disinfectant criteria for appropriate disinfection using a 10-minute wet-contact time in any of the 3 whirlpool tub rooms. Interview on 2/10/26 at 12:56 p.m., with the DON identified she would expect staff to follow the disinfectant instructions on allowing a 10-minute wet-contact time for appropriate disinfection to occur. Review of the current, Cascade [NAME] Operation and Daily Maintenance Instructions, located at https://www.pennerbathing.com/wp-content/uploads/2020/12/Alcove-Tub-operation-manual-360750A.pdf, identified the tub instructions were the same as above, however, it was noted for staff to clean and disinfect the tub after every bath with [NAME] Cleaner/Disinfectant. [NAME] Cleaner/Disinfectant was a special non-abrasive cleaning and disinfecting solution and was the only cleaning solution designed and recommended for use with the Cascade Tub. Review of the current, [NAME] Bathing Spas Disinfection Quick Guide, located at https://express.adobe.com/page/dGLlnlGnBbk3E/, Step 4, identified for staff to allow the disinfectant to remain in contact for 10 minutes. All other instructions were the same and followed Cascade instructions. NEBULIZER ADMINISTRATION Observation on 2/10/26 at 4:50 p.m., of licensed practical nurse (LPN)-A identified she proceeded to administer a nebulizer treatment to R43. LPN-A went to the countertop in R43's room, and retrieved his nebulizer that was intact and assembled on the counter. LPN-A then opened the nebulizer medication cup (residue was noted to be inside the cup), poured in R43's medication, connected to the nebulizing machine and administered his medication. LPN-A stated staff were to disassemble the medication cup and mouthpiece after each medication administration, clean and rinse them out and leave on the counter to air-dry. LPN-A stated she should have either rinsed and cleaned his medication cup and mouthpiece or gathered new nebulizer supplies before she administered R43 his medication. She agreed not cleaning and rinsing the mouthpiece and cup had the potential to cause a respiratory infection for residents when they were not cleaned and rinsed after each use. Interview on 2/10/26 at approximately 5:00 p.m., with the DON identified she expected staff to clean and rinse nebulizers after each administration. Review of the 12/10/25 Nebulizer policy identified following medication administration, staff were to disconnect the nebulizer parts (mask/mouthpiece and cup) and wash them in warm soapy water and rinse thoroughly, set on a paper towel, and let air-dry.

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. Based on interview and document review the facility failed to provide the CMS-10055 Skilled Nursing Facility Advance Beneficiary Notice of Non-Coverage (SNF-ABN) to 3 of 3 (R13, R24, R40) sampled resident when they ended their Medicare Part A skilled services with days remaining.Findings include: R13's CMS-10123 Notice of Medicare Non-Coverage (NOMNC) form identified R13's services ended on 9/16/25. There was a handwritten note dated 9/11/25 on the CMS-10123 form that the wife had been called and notified that the skilled services would end on 9/16/25. R13 was not provided with the CMS-10055 Skilled Nursing Facility Advance Beneficiary Notice of Non-Coverage (SNF-ABN) that identified the estimated cost of services if R13 would choose to continue with the skilled services on his own. R24's CMS-10123 Notice of Medicare Non-Coverage (NOMNC) form identified R24's services ended on 8/22/25. There was a handwritten note dated 8/20/25 on the CMS-10123 form that the resident had been notified that the skilled services would end on 8/22/25. R24 was not provided with the CMS-10055 Skilled Nursing Facility Advance Beneficiary Notice of Non-Coverage (SNF-ABN) that identified the estimated cost of services if R24 would choose to continue with the skilled services on his own. R40's CMS-10123 Notice of Medicare Non-Coverage (NOMNC) form identified R40's services ended on 12/15/25. There was a handwritten note dated 12/10/25 on the CMS-10123 form that the wife had been called and notified that the skilled services would end on 12/15/25. R40 was not provided with the CMS-10055 Skilled Nursing Facility Advance Beneficiary Notice of Non-Coverage (SNF-ABN) that identified the estimated cost of services if R40 would choose to continue with the skilled services on his own. Interview on 2/12/26 at 1:00 p.m., with the director of nursing (DON) identified she was responsible for providing the beneficiary notices when a resident discharged from skilled services. She was unaware that she needed to provide the CMS-10055 form. She confirmed she had not provided the CMS-10055 form with the estimated cost to continue if the resident would choose to do so.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on interview and document review, the facility staff failed to report allegations of potential abuse timely to the facility management for 3 of 3 residents (R7, R26, and R39) sampled. Findings include: Review of the 11/24/25 reports to the State Agency identified three individual reports were received identifying:R7 no longer wanted nursing assistant (NA)-C to assist because NA-C was too rough when providing cares, and disregarded R7's complaints of discomfort and pain.On 11/16/26, NA-C was rough during cares with R39, was unorganized, did not respond to call lights of certain residents, did not knock on resident doors before entering a resident's room, slammed doors and continued to assist residents who did not want NA-C's help.On 11/15/25, NA-C did not respect R26's privacy when providing cares and would leave her exposed during cares. R26's had requested to speak to the nurse twice, and NA-C just wanted R26 to tell her what she needed verses going to get the nurse for R26. R7's 12/19/25 quarterly Minimum Data Set (MDS) assessment identified she was admitted in October 2025, her cognition was moderately impaired, she was dependent on staff to complete daily activities, and she had a diagnosis of vascular disease, renal failure, diabetes, arthritis, asthma, and depression. Interview on 2/10/26 at 5:25 p.m., with R7 stated the staff here are really good to me, I have no complaints. R39's 1/16/26, accepted comprehensive Minimum Data Set (MDS) assessment identified R39's cognition was moderately impaired, and she was dependent on staff to assist with cares. R39 took a daily antidepressant and had diagnoses of depression, diabetes, and hemiplegia. Interview on 2/11/26 at 7:37 a.m., with R39 identified that there had been no staff that had ever treated her rough however, they did go fast at times as they were always in a hurry. She identified there was one staff member who took longer to answer her call light, but she worked slowly with everything. She denied any staff being rough with her during cares or being disrespectful to her.R26's accepted 12/27/25, quarterly Minimum Data Set (MDS) assessment identified R26's cognition was intact. She required staff assistance with care. R26 took an antipsychotic, antianxiety, and antidepressant. She had diagnoses of anxiety, depression, hypertension, and diabetes.Interview on 2/11/26 at 9:00 a.m., with R26 identified that she did have a concern with a staff leaving her exposed during cares. She reported she told him that it bothered her, and he has been good now about covering her up as much as possible during cares, and she had no further concerns with him. She denied any other staffing concerns and stated she was not shy and had no problems expressing concerns. Interview on 2/11/26 at 10:07 a.m., with licensed practical nurse (LPN)-A identified that NA-C started at the facility around November, after working at the facility for about a month, residents started reporting to LPN-A that NA-C was rough when providing cares, does not knock on the door before entering, and slams the door when she leaves the room. When residents complained, LPN-A gathered written statements from them and slid the information under the director of nursing door. She received an email from the director of nursing saying she would take care of it. Interview on 2/11/26 at 2:13 p.m., with the director of nursing identified when she arrived at the facility on 11/19/15, she found a report related to resident care concerns that had been slid under her office door. She interviewed some residents and the staff member that was being reported. She asked them specifically if they felt safe and they said they did. She did not interview any of the staff that made the reports. We reached out to our leadership team because the report did not point to any abuse or neglect. Review of the 11/18/25, Formal Complaint letter provided to the director of nurses (DON) from LPN-A identified LPN-A noted various concerns that had been reported to her with the statements from residents and staff attached that identified: On 11/16/25, R39 signed a statement written by an unknown source that identified concerns regarding NA-C of not taking advice from residents, being rough when handling clients/residents and was unorganized.R10 wrote in an undated note that NA-C slammed doors and was rude. Various staff between 11/16/25 and 11/18/25, identified concerns regarding NA-C for not knocking on resident doors prior to entering, not providing (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	privacy, avoiding cares for certain residents, turning up resident oxygen to 5 liters when resident had not been on oxygen for a while, being bossy and passive aggressive with coworkers. Interview on 2/12/26 at 11:00 a.m., with trained medication aide (TMA)-A identified if a resident made a complaint that someone was rough with them, she would report that right away to the case manager and if the case manager was not there, she would report that to the director of nursing. Interview on 2/12/26 at 4:22 p.m., with the administrator identified that on 11/19/25, the director of nursing (DON) had received a report under her office door from licensed practical nurse (LPN)-A, regarding concern related to NA-C being rough while providing cares. At the time neither the administrator nor the DON had identified one of the allegations received by LPN-A that was signed by a resident had been reported to LPN-A on 11/16/25. LPN-A did not report this allegation of potential abuse until the Formal Complaint was given to the DON 3 days later on 11/19/25, when the DON arrived at work that morning. Interview on 2/12/26 at 4:43 p.m., with medication aid (TMA)-B identified they had received reports from R26 (date known) that NA-C was rough when providing cares. TMA-B reports they left a note at the nurse's desk but does not recall who was working at the time. They have received training on abuse reporting and stated we are supposed to report to our direct supervisor unless the complaint involves the direct supervisor. In that case they would report to the administrator. Review of 4/7/25, Abuse and Neglect policy identified allegations of mistreatment, neglect, exploitation or abuse would be reported immediately to the administrator, but not later than two hours after the allegation was made. If administrator was unavailable staff were to report to the director of nursing or the supervisor of social services. The designated individuals had the authority to intervene in any situation to protect residents, including removing any individuals from the location to protect residents. If there was an allegation of abuse from an employee to a resident, the employee would be removed from providing direct care to all residents. Additionally, the employee will be placed on suspension pending the results of the internal investigation.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. Based on interview and document review, the facility failed to thoroughly investigate allegations of potential abuse for 3 of 3 (R7, R26, R39) sample residents. Findings include: Review of the 11/24/25 reports to the State Agency identified three individual reports were received identifying:R7 no longer wanted nursing assistant (NA)-C to assist because NA-C was too rough when providing cares, and disregarded R7's complaints of discomfort and pain.On 11/16/26, NA-C was rough during cares with R39, was unorganized, did not respond to call lights of certain residents, did not knock on resident doors before entering a resident's room, slammed doors and continued to assist residents who did not want NA-C's help.On 11/15/25, NA-C did not respect R26's privacy when providing cares and would leave her exposed during cares. R26's had requested to speak to the nurse twice, and NA-C just wanted R26 to tell her what she needed verses going to get the nurse for R26. R7's 12/19/25 quarterly Minimum Data Set (MDS) assessment identified she was admitted in October 2025, her cognition was moderately impaired, she was dependent on staff to complete daily activities, and she had a diagnosis of vascular disease, renal failure, diabetes, arthritis, asthma, and depression.Interview on 2/10/26 at 5:25 p.m., with R7 stated the staff here are really good to me, I have no complaints. R39's 1/16/26, accepted comprehensive Minimum Data Set (MDS) assessment identified R39's cognition was moderately impaired, and she was dependent on staff to assist with cares. R39 took a daily antidepressant and had diagnoses of depression, diabetes, and hemiplegia. Interview on 2/11/26 at 7:37 a.m., with R39 identified that there had been no staff that had ever treated her rough however, they did go fast at times as they were always in a hurry. She identified there was one staff member who took longer to answer her call light, but she worked slowly with everything. She denied any staff being rough with her during cares or being disrespectful to her.R26's accepted 12/27/25, quarterly Minimum Data Set (MDS) assessment identified R26's cognition was intact. She required staff assistance with care. R26 took an antipsychotic, antianxiety, and antidepressant. She had diagnoses of anxiety, depression, hypertension, and diabetes.Interview on 2/11/26 at 9:00 a.m., with R26 identified that she did have a concern with a staff leaving her exposed during cares. She reported she told him that it bothered her, and he has been good now about covering her up as much as possible during cares, and she had no further concerns with him. She denied any other staffing concerns and stated she was not shy and had no problems expressing concerns. Interview on 2/11/26 at 10:07 a.m., with licensed practical nurse (LPN)-A identified that NA-C started at the facility around November, after working at the facility for about a month, residents started reporting to LPN-A that NA-C was rough when providing cares, does not knock on the door before entering, and slams the door when she leaves the room. When residents complained, LPN-A gathered written statements from them and slid the information under the director of nursing door. She received an email from the director of nursing saying she would take care of it. Interview on 2/11/26 at 2:13 p.m., with the director of nursing identified when she arrived at the facility on 11/19/15, she found a report related to resident care concerns that had been slid under her office door. She interviewed some residents and the staff member that was being reported. She asked those residents specifically if they felt safe, and they said they did. She did not interview any of the staff that made the reports. The DON stated she reached out to the corporate leadership team for direction because the report in her opinion did not point to any abuse or neglect. The DON did not elaborate on direction received. Interview on 2/11/26 at 2:20 p.m., with registered nurse consultant (RNC)-A identified after reviewing the Formal Complaint letter and seeing that the staff pointed out a potential relationship between the DON and the staff identified in the complaint, it would have been better if someone other than the DON completed the investigation. Review of the 11/18/25, Formal Complaint letter provided to the director of nurses (DON) from LPN-A identified LPN-A noted, I am writing this letter to bring to your attention the various complaints expressed by staff and resident regarding NA-C. Over the past month, I have had a total of five residents express dissatisfaction with the care provided on numerous (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	occasions. This ongoing dilemma has significantly impacted and continues to affect the quality of care provided to our residents, as well as other CNAs, who often feel as though they must do double the work. In creating this letter, the intention is not to berate the individual but to advocate for the residents and staff, who have personally brought to my attention the actions and behaviors that have been carried out. I would be more than happy to visit with you in person, if needed. Most of us are aware of the work history between you, the named individual, and other staff members; however, it is my goal to see that this situation is resolved in an unbiased manner. Included with the Formal Complaint letter was statement from residents and staff as follows:On 11/16/25, R39 signed a statement written by an unknown source that identified concerns regarding NA-C of not taking advice from residents, being rough when handling clients/residents and was unorganized.R10 wrote in an undated note that NA-C slammed doors and was rude.Various staff between 11/16/25 and 11/18/25, identified concerns regarding NA-C for not knocking on resident doors prior to entering, not providing privacy, avoiding cares for certain residents, turning up a resident's oxygen to 5 liters when the resident had not been on oxygen for a while, and being bossy and passive aggressive with coworkers. Review of the facility investigation identified it was completed by the DON on 11/19/25, with interviews with R7, R10, R26, and R39, who reported to the DON they felt safe at the facility, felt safe with the people who cared for them, and denied that anyone ever verbally or physically abused them. Also, on 11/19/25, the DON spoke to NA-C via phone and her notes identified she explained she had received some complaints from residents about door slamming, privacy concerns, and not listening to residents. The DON investigative notes identified quotes from NA-C of [I] don't have any problems with the employees.only here on PRN basis.not working with them every day so [I] don't know them real well. NA-C expressed it was hard when there were only two staff on the floor. The DON noted she explained to NA-C to be aware of these items, and she would be circling back with the residents in a couple of weeks to see if things were better. The DON's investigation documentation failed to identify:The DON addressed the allegation of rough handling of residents during cares with NA-C.Additional staff were interviewed.Other residents were interviewed who were not identified in the complaint.Late reporting occurred from LPN-A to management after becoming aware on 11/16/25, related to allegations of potential abuse. Interview on 2/12/26 at 11:00 a.m., with trained medication aide (TMA)-A identified if a resident made a complaint that someone was rough with them, she would report that right away to the case manager. If the case manager was not there, she would report that to the director of nursing. Interview on 2/12/26 at 4:22 p.m., with the administrator identified that on 11/19/25, the director of nursing (DON) had received a report under her office door from licensed practical nurse (LPN)-A, regarding concern related to NA-C being rough while providing cares. By the time she had learned the details of the letter that morning on 11/19/25, the DON had reported she had addressed the issues and found it to be nothing. Interview on 2/12/26 at 4:43 p.m., with medication aid (TMA)-B identified they had received reports from R26 that NA-C was rough when providing cares (unknown date). TMA-B reports staff left a note at the nurse's desk but had not recalled who was working at the time. TMA-B received training on abuse reporting and stated We are supposed to report to our direct supervisor unless the complaint involves the direct supervisor. In that case they would report to the administrator. Review of the 4/7/25, Abuse and Neglect policy identified the facilities investigation may include interviewing employees, residents or other witnesses to the event. The facility was to interview all involved (employees, residents and family) individually. The investigation should be documented. The facility will have evidence that all alleged or suspected violations were thoroughly investigated and would prevent further potential abuse while the investigation was in progress.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to ensure 1 of 14 sampled resident (R26) code status was accurately reflected in all parts of the medical record. Findings include: R26's current face sheet identified she was admitted to the facility in [DATE] with diagnoses of obstructive sleep apnea (absence of breathing while asleep), asthma, chronic kidney disease, a history of multiple surgeries on her back and abdomen, diabetes, anxiety, history of shortness of breath, edema (swelling from fluid retention), arthritis in her bones, and a history scoliosis and other curvatures in her back. R26's quarterly, Minimum Data Set, accepted on [DATE], identified R26 had intact cognition and had no behaviors noted. R26 required the use of a wheelchair and required either extensive assistance or was dependent upon staff for most Activities of Daily Living such as toileting, dressing, and bathing. Observation on [DATE] at 6:22 p.m., of R26's electronic medical record identified on the main screen for R26's electronic medical record (EMR) (at the top in the banner section), R26 was listed as a FULL CODE (all resuscitative measures performed in an emergency). R26's [DATE], Minnesota Health Care Directive identified R26 was her own person but had designated family to act on her behalf with her wishes if R26 was unable to make decisions about her life or care. R26 gave the following instructions about her health care surrounding her values and beliefs, what she did and did not want to do, medical treatments, concerns, fears, etc When my heart no longer circulates my blood, I do not want CPR [cardiopulmonary resuscitation]. I do not want to be on a ventilator. I do not want hemodialysis unless I am coherent and able to decide for myself. I want pain control even that may affect my breathing or circulation. R26 signed the agreement under witness of a Notary Public. R26's [DATE], Care Conference note identified R26 and a family member were in attendance. Staff noted R26 had a physician's order on file for CPR and R26 commented on wanting to update her code status. R26 was given a copy of a blank POLST (Physician Orders Life Saving Treatment) to review. Review of R26's progress notes made no mention of any follow-up after the care conference to identify staff had ensured an updated POLST was obtained, or if staff had checked her current Healthcare Advanced Directive from 2024 that was on file and verified with R26 for accuracy in coordination with her wishes. Interview and document review, on [DATE] at 6:32 p.m., with registered nurse (RN)-C identified when verifying code status, staff look in the EMR but also have a paper copy in a book to reference. The book had a screen shot of the EMR record indicating the incorrect FULL CODE status. The book contained no POLSTs or original physicians' order regarding each resident's code status. Interview on [DATE] at 7:13 p.m., with the social worker (SW) identified he was responsible to check residents' code status, and the Director of nursing (DON) was responsible to ensure the EMR was accurate in the EMR. He indicated R26 was currently a FULL CODE but had recently wanted to change that. He was not aware of the status of her decision. Either he or the DON would assist a resident with updating a POLST, and an RN or care leader would be responsible for getting the code status changed. Interview on [DATE] at 7:24 p.m. with R26 identified at the last care conference ([DATE]), R26 told staff she wanted to change her code status discussed in care conferences from CPR to Do Not Resuscitate (DNR). Staff gave her a new POLST to fill out that day. R26 thought she had given it to a staff nurse to put in her medical record. R26 did not want CPR. R26 was unaware the current electronic medical record entry still identified her as a Full Code (CPR). Interview on [DATE] at 7:53 p.m. with the DON and the corporate consultant identified she agreedR26's POLST and EMR inconsistencies should have been addressed and followed up on after care conference in [DATE]. The EMR should have been updated and the physician contacted. The DON and RNC-B noted they would check all other 55 residents' EMR for accuracy. No other errors or inconsistencies were noted. Review of the [DATE] Advanced Directive including CPR and Automated External Defibrillator policy identified if a cardiac arrest were to occur, CPR must be initiated unless the resident had a valid DNR (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	order on file or a valid Advanced Directive on file. Advanced Directives were to be reviewed with residents and or health care decision-makers at each care plan (conference) meeting to ensure no changes were needed. If a resident informs a staff member, he or she had changed their decision, the resident's wishes for different measures were to be followed and the physician contacted for updated orders. In an emergency, the method to identify code status that was most expedient to determine code status was to be used.

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. Based on interview and document review the facility failed to identify target behaviors or symptoms for psychoactive medication for 3 of 5 (R3, R7, R26) sampled residents for monitoring. Findings include: R26's accepted 12/27/25, quarterly Minimum Data Set (MDS) assessment identified R26's cognition was intact. She required staff assistance with care. R26 took an antipsychotic, antianxiety, and antidepressant medications. R26 had diagnoses of anxiety and depression. R26's care plan identified she was on medication with FDA boxed warning or warnings of adverse consequences related to major depressive disorder and anxiety. The facility would consult with the pharmacy and health care provider to consider dosage reduction when clinically appropriate. R26 had a depression diagnosis, and the facility would attempt non-pharmacological interventions. R26 enjoyed playing games on her ipad, she enjoyed visits from the companion dogs. R26 used psychopharmacological medications (Seroquel an anti-psychotic medication, duloxetine an anti-depressant medication, and buspirone an anti-anxiety medication) related to anxiety and depression. The care plan identified that a dosage reduction was not clinically appropriate and had been documented as contraindicated on 10/7/24. WAH Behavior Health provider prescribed the medications. The care plan had no mention of target behaviors or symptoms related to the psychoactive medications that R26 took to monitor for effectiveness. Review of the 10/7/24, Certified Nurse Practitioner (NP) specialty in Psychiatry encounter visits notes identified, that R26 had Seroquel increased to 200 milligrams (mg) at bedtime, her duloxetine (Cymbalta) 60 mg twice a day and her buspirone 15 mg in morning and buspirone 30 mg at bedtime would continue. The NP notes had diagnosis listed for each medication. The physician note identified R26 had denied feeling depressed, had paranoia or delusional thoughts and denied any mania however, it was unsure if those were R26's target behaviors or symptoms that all the medication were ordered to treat or not. There was no mention that a dose reduction was contraindicated with a rationale. Review of R26's 2/10/26, printed Order Summary Report identified buspirone HCl 15 mg twice a day for anxiety and mood related to anxiety disorder. Duloxetine HCl 60 mg every day for depressed mood related to major depressive disorder. Seroquel 200 mg at bedtime for major depressive disorder. The orders had no mention of monitoring for side effects of the medication and no mention of target behaviors or symptoms that the medications were ordered to treat. Interview on 2/10/26 at 4:35 p.m., with director of nursing (DON) identified that the facility monitored residents that took psychoactive medication by watching the residents each shift. If a resident was noted to have increased anxiety or stayed in their room and that was not normal, that would be something that she would report to the physician. She was unable to identify specific behaviors or symptoms they monitored R26 for. Interview on 2/10/26 at 4:41 p.m., with registered nurse consultant (RNC)-A identified target behaviors should be identified on the care plan and the nursing assistant Kardex for monitoring of symptoms. RN-C identified the facility was working on reviewing each care plan related to a recent survey where it was identified that the care plans did not reflect the resident's status. The facility had been focusing on reviewing the residents with wounds as that was what the recent survey was (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	about. She confirmed that the facility had not reviewed any care plans to ensure target behaviors or symptoms were identified and would imagine there are care plans with no target behaviors identified. The expectation was that the facility would identify target behaviors or symptoms for each psychoactive medication and that those target behaviors would be monitored for effectiveness of the medication. Review of the 12/9/25, Psychotropic Medications policy identified each resident's medication must have an indication for use and adequate monitoring. The facility behavior committee would ensure that the resident's care plan was up to date and reflect non-pharmacological intervention to be used and the symptoms the medication was treating. A facility RN would complete an antipsychotic medication assessment and abnormal involuntary movement scale assessment for any antipsychotic medication ordered. Throughout the use of psychotropic medication, the facility would document the resident mood and behavior to monitor the effectiveness of the medication on the behavior. The facility would also monitor side effects of medications and notify the physician if side effects occur or worsen. The facility reduction committee would review the need for psychotropic medications every 3 months and document the rationale to continue the medication. The committee would further monitor the resident target symptoms and the effect of the medication. R3's 12/27/25, quarterly Minimum Data Set (MDS) assessment identified he admitted to the facility in December of 2024. His cognition was moderately impaired, and he had diagnoses of Alzheimer's Disease, anxiety disorder, depression, and post-traumatic stress disorder (PTSD). R3's current undated care plan identified he has a diagnosis of anxiety, depression, and PTSD. The goal was for R3 to remain free of signs and symptoms of distress, symptoms of depression, anxiety or sad mood. The facility staff were to offer companionship visits, invite him to social activities, engage in life review, offer opportunities to express feeling/suggestions/concerns, and receive dog visits. The care plan made no mention of target behaviors that staff should monitor for to determine if the intervention or medications used were effective in treating R3's mental illness. R3's February 2026, medication administration record (MAR) identified he was administered citalopram hydrobromide (antidepressant medication) 10 milligrams (mg) daily for PTSD, anxiety, and mood disorder due to a known physiological condition with depressive features. The MAR made no mention that staff should monitor R3 for target behaviors to determine if the medications he was being administered were effective. R7's 12/19/25 quarterly Minimum Data Set (MDS) assessment identified she was admitted in October 2025, her cognition was moderately impaired, and she had a diagnosis of depression. R7's current, undated care plan identified she has a diagnosis of depression. Staff were to consult with pharmacy, and health care provider to consider dosage reduction when clinically appropriate, monitor conditions based on clinical practice guidelines or clinical standards of practice for the medications she is taking, and attempt non-medication approaches (visits with pastor, staff, or reading kindle). The care plan made no mention staff should be monitoring target behaviors to identify if the medication or treatment was effective for R7. R7's February 2026, MAR identified she was administered citalopram (anti-depressant) 20 mg daily in the morning related to a diagnosis of major depressive disorder. The MAR made no mention that staff should be monitoring for target behaviors to determine if the mediations she was being administered were effective. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 2/12/26 at 3:00 p.m., with the director of nursing identified the target behaviors should be indicated on the resident's care plan or the administration record; however, she was not sure if that had been completed for all residents with behaviors or residents who were taking psychotropic medications. She is aware they have some issues with care plans not being complete and/or updated with the correct information, but they are working on it. She would expect staff to add the target behaviors to the care plan so that licensed nurses and nursing assistants can access the information.

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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 interview and document review the facility failed to notify the ombudsman of a discharge for 2 of 2 (R6, R61) sampled residents.Findings include: R61's 12/19/25, accepted discharge Minimum Data Set (MDS) identified an unplanned discharge return not anticipated. R61 had discharged on 12/15/25 and returned home. R61's 12/15/25, progress note identified that R61 had discharged home with family against medical advice. Interview on 2/12/26 at 3:00 p.m., with social service designee (SSD) identified that she had just clarified discharge reporting with the ombudsman on 2/11/26, as she was unsure of the process. She reported that the licensed social worker (LSW) had not reported R61's or R6's unplanned discharge from the facility to the ombudsman. She further identified she had not reported the discharges to the ombudsman either. She identified that neither she nor the LSW were aware of reporting all discharges including an unplanned discharge or discharge against medical advice. R6's 11/21/25, discharge Minimum Data Set (MDS) assessment identified she discharged to the hospital on [DATE]. R6's transfer form identified she was sent to the hospital emergency department for evaluation following a fall on 11/13/25. R6's 11/21/25, hospital discharge summary identified she was admitted to the hospital on [DATE] for hip repair surgery. She remained in the hospital for 7 days and was discharged to a long-term care facility on 11/21/25. Review of 1/15/26, Discharge and Transfer policy identified when a discharge or transfer occurred that information would be documented in the resident's medical record. The Office of the State Long-Term Care Ombudsman must be notified of a transfer or discharge with the location of the discharge or transfer.

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F 0638 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assure that each resident?s assessment is updated at least once every 3 months. Based on interview and document review, the facility failed to complete and submitted a timely quarterly Minimum Data Set (MDS) assessment for 1 of 1 (R56) resident reviewed.Findings include: R56's 2/12/26, printed admission Record identified that R56 had been admitted to the facility at the end of September 2025. R56's MDS section in Point Click Care (PCC), the facilities electronic medical record identified that R56's last MDS was completed with an Assessment Reference Date (ARD) of 9/26/25 as an MDS admission/5-day assessment. There had been no other MDS's initiated or started under the MDS section of the facilities PCC electronic medical record. Interview on 2/12/26 at 9:07 a.m., with registered nurse (RN)-B identified that she was responsible for completing and submitting the MDS assessments. She revealed that PCC did not automatically calculate R56's MDS schedule and she had missed completing a quarterly assessment for R56. She confirmed that the quarterly MDS should have been completed in December of 2025. Interview on 2/12/26 at 3:21 p.m., with the senior clinical reimbursement specialist for the facility identified that R56 had a missed quarter assessment. Review of 10/27/25, MDS 3.0 (Minimum Data Set) RAI (Resident Assessment Instrument) policy identified that the facilities PCC system automatically calculated the MDS schedules. Centers for Medicare & Medicaid Services (CMS) mandates MDS transmission no later than completion date plus 14 calendar days, the facility completes weekly transmission of MDS data. The policy referred to the RAI manual for guidance not reflected in the policy. There was no identification of time requirements for completing the various MDS assessments. The Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual dated October 2025, identified quarterly MDS assessment would be conducted every 92 days and submitted within 14 days of completion.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities Based on interview and document review, the facility failed to ensure a Pre-admission Screening and Resident Review (PAS) level I was completed accurately for 1 of 1 resident (R3) reviewed for PASARR. Findings include: R3's 1/2/25, comprehensive Minimum Data Set (MDS) assessment identified he was admitted to the facility in December of 2024, his cognition was moderately impaired, and he had diagnoses of anxiety, depression, and post-traumatic stress disorder (PTSD). R3's diagnosis report identified he had a diagnosis of PTSD, insomnia due to other mental illness condition, anxiety disorder, and mood disorder due to known physiological condition with depressive features upon admission. R3's 12/18/24, initial pre-admission screen (PAS) completed by the facility and submitted to Senior LinkAge indicated that R3 had no major mental health disorders diagnosable as listed in the diagnostic and statistical manual of mental disorders (DSM). R3 did not meet the criteria for mental illness (MI) however, final determination would be made by Senior LinkAge Line. Interview on 2/11/26 at 8:41 a.m., with the facilities registered nurse consultant (RNC) reviewed R3's PAS and identified he had PTSD that should have been noted on the PAS. She would expect the facility to complete a more thorough assessment and ensure the pre-admission screen be completed correctly to ensure residents receive appropriate care. Review of the facility provided 12/29/25 Pre-admission Screening and Resident Review (PASARR) policy identified All prospective residents will be screened for possible serious mental disorders or intellectual disabilities and related conditions. The initial pre-screening is referred to as PASARR Level I. A positive Level 1 screen necessitates an in-depth evaluation of the individual, known as PASARR Level II, conducted by the state-designated authority prior to admission.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. Based on interview and document review, the facility failed to have an integrated care plan to coordinate and delineate what services hospice was to provide and what services the facility was to provide, to ensure oversight and services would be provided for 1 of 1 sampled resident (R5) reviewed for hospice care.Findings include: R5's 2/6/26, quarterly Minimum Data Set (MDS) identified R5 had severe cognitive impairment and was dependent on staff to assist with his cares. R5 had a condition or chronic disease that may result in life expectancy of less than 6 months and was currently receiving hospice services. R5's hospice care plan identified the hospice NA would perform or assist with duties as directed. The hospice aid would apply lotion, assist with incontinent cares, dressing, and shampoo and haircare. The hospice aid would clean and tidy R5's room and report to the registered nurse with any questions or concerns. The hospice staff would effectively collaborate with facility/agency staff or providers. The collaboration with the facility staff would include discussion of the plan of care and discussion of a schedule and with an invite to the agency interdisciplinary group. R5's 11/19/25, care plan identified a terminal prognosis related to end stage dementia and cardiovascular disease as evidence by requiring hospice care. R5 would have support from the hospice provider. Hospice visits from a registered nurse and a nursing assistant would be twice a week or more often as needed. The social worker was to come 1-2 times a month or as needed. The facility staff would encourage support systems from family and friends. There was no mention of what services hospices would provide to R5 to ensure coordination of care. Interview on 2/10/26 at 12:44 p.m., with trained medication aide (TMA) identified that the hospice nurse would complete wound care when she was here. She was unsure if the hospice aid did any type of care with R5. She had only observed the hospice aid sitting and visiting with R5. Hospice did have a schedule in the hospice book at the nurse's station, and the hospice staff typically came to see R5 on Monday and Thursdays. Interview on 2/12/26 at 10:45 a.m., with nursing assistant (NA)-M identified that hospice staff came to the facility and typically just sat with R5. The facility staff completed all his cares. She revealed she reviewed the Kardex for directions on how or what cares to provide to R5 and was unaware of the hospice care plan. Interview on 2/12/26 3:15 p.m., with the director of nursing (DON) identified she was unaware that the facility care plan needed to have more information other than the hospice provider's name and phone number. The hospice provider typically provided their own care plan and the facility kept that in a book at the nurse's station. She confirmed there was no mention in the facility care plan of what type of cares or services hospice would provide as was identified in the hospice care plan. Review of the 4/8/24, hospice agreement identified coordinated plan of care meant the plan of care for a resident would clearly delineate what services to be provided by hospice and the facility, based on assessments, and the residents current medical, physical, psychological, and social needs. The facility will immediately notify hospice with a significant change in the residents' physical, mental, emotional, or social status. If clinical complications appear or a need to transfer the hospice resident from the facility for any condition, or the resident dies.

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. Based on observation, interview, and document review, the facility failed to ensure 1 of 1 resident (R1) who had impaired hearing was provided hearing aids daily. Findings include: R1's 10/29/25 comprehensive Minimum Data Set (MDS) assessment identified hearing and cognition are moderately impaired. R1's current, undated care plan identified he has impaired thought process and decision making related to the aging process and he would be able to communicate basic needs on a daily basis. R1 would need assistance with all decision making and staff were to ask him yes or no questions in order to determine his needs. R1 had a communication problem related to his hearing deficit. Staff were to ensure and document hearing aids are both in place during the day and removed at bedtime. R1's care plan did not identify a behavior of refusing hearing aids nor did it identify what staff should do if R1 refused his hearing aids. R1's December 2025 through February 2026, Treatment Administration Record (TAR) identified an order for staff to insert hearing aids at 7:00 a.m., daily and remove them at 8:00 p.m., daily. Staff were to irrigate ears as needed. Staff had signed off on the TAR that R1 had refused his hearing aids all but 5 of 73 days. R1's TAR did not identify that staff had completed a treatment to irrigate his ears at any time during this period. Observation and interview on 2/9/26 at 2:59 p.m., R1 had a difficult time hearing and identified he had hearing aids, but they were in the office. He said if he wants them, he must ask staff for them. Observation and interview on 2/11/26 at 9:45, am identified R1 did not have his hearing aids placed. R1 identified he was having difficulty hearing and stated his ears needed to be cleaned. R1 identified staff had not offered him his hearing aids. Observation and interview on 2/12/26 at 8:59 a.m., identified R1 did not have his hearing aids and had already eaten breakfast. He identified when he has asked for his hearing aids or when he has complained that his ears need cleaning, staff say they will come back but they do not return with his hearing aids or come back to clean his ears. Observation and interview on 2/12/26 at 9:04 a.m., with the medication aid (TMA)-A stated, he refuses his hearing aids everyday. She identified that when R1 refuses she marks the treatment administration record (TAR) to note refusal and write a progress note. TMA-A retrieved the hearing aids from her cart and went into R1's room. She asked R1 if he would like his hearing aids in. He responded yes and told the TMA his ears needed to be cleaned. The TMA inserted the hearing aids and left the room. Review of the facility provided 12/1/25, Hearing Services, Hearing Device Care policy identified if a resident is unable to handle his/her hearing aids, the staff needs to develop a plan for the insertion of the hearing aid in the morning and the removal in the evening for safe keeping. Staff should check ear canals periodically for was buildup and document findings.

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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. Based on observation, interview, and document review, the facility failed to have signage posted outside the door for 1 of 1 medication room (South) identifying oxygen canisters were stored within. Findings include: Observation on 2/10/26 at 4:32 p.m., of the South medication room with licensed practical nurse (LPN)-A identified a cupboard to the far right of the door, with a pullout drawer containing 3 canisters of oxygen (O2). The canisters were held in place in individual holders inside the cabinet. Upon inspection, the outside of the medication room did not have signage posted notifying staff oxygen was being stored in the medication room. LPN-A normally did not work on that wing and was unaware of the oxygen being stored there. Interview on 2/10/26 at 5:44 p.m., with the director of nursing identified she agreed when O2 was stored in a room, signage should be placed on the outside of the room, identifying O2 was being stored within. Review of the 7/30/25, Oxygen Administration, Safety, Mask Types policy identified its purpose was to store O2 in a safe manner. All appropriate signage was to be displayed according to federal, state, and local laws. O2 was noted to be dangerous. Staff were to avoid use of flammable materials (oils, greases, alcohol-based products). O2 cannisters were to be stored on a clean, controlled area. There was no mention of O2 signage placement outside of rooms that contained oxygen within the policy. Review of the current, National Fire Prevention Association (NFPA) 99, published 2012, section 11.3.4.1, identified for storage of oxygen, a precautionary sign, readable from a distance of 1.5 m (5 ft), shall be displayed on each door or gate of the storage room or enclosure.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on observation, interview, and document review, the facility failed to ensure controlled narcotic medication awaiting destruction were easily reconciled in 1 of 3 med rooms (South) to prevent potential diversion.Findings include: Observation and interview with licensed practical nurse (LPN)-A in the South medication room identified a locked cupboard that contained medication awaiting destruction. Of those medications, the following controlled/narcotic blister-pack medication had been discontinued, but were not noted on any list to verify the medications were tracked and secured from potential diversion:R26 had 4 tablets of tramadol (pain), each 50 milligram (mg) awaiting destruction. R17 had 12 tablets of tramadol, each 50 mg dose awaiting destruction.R24 had 5 tablets of lorazepam (anti-anxiety), each 0.5 mg awaiting destruction.R7 had 1 tablet of preglabin (anti-convulsant) at 150 mg.R17 had 30 tablets of lorazepam, each 0.5 mg awaiting destruction.R2 had 9 tablets of Xanax (anti-anxiety), 0.5 mg each and another blister pack of Xanax 0.5 mg with 10 tablets remaining awaiting destruction.LPN-A noted she normally had not worked on the South wing, but stated the facility kept all controlled medication awaiting destruction in the locked cabinet. Nursing staff had access to the key. The facility practice was to store medications awaiting destruction in that locked cabinet within the locked medication room. Staff would wait for the director of nursing (DON) to destroy medications. Staff would not keep track of the medications once in the cabinet in order to be able to easily reconcile those medications to prevent potential diversion from being easily recognized. Interview on 2/10/26 at 5:44 p.m., with the DON identified she was aware the narcotics were stored in the cabinet awaiting destruction and verified the medications were no longer tracked for easy reconciliation of potential diversion. A policy for medication storage was requested but not received prior to the end of the survey.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. Based on interview and document review, the facility failed to ensure pharmacist consultant recommendations were acted upon for 1 of 5 sampled resident (R26).Findings include: R26's accepted 12/27/25, quarterly Minimum Data Set (MDS) assessment identified R26's cognition was intact. She required moderate to total assistance from staff for Activities of Daily Living (ADL'S). R26 took an antipsychotic, antianxiety, and antidepressant medications. R26's current undated, care plan identified she was on medication with warnings of adverse consequences related to major depressive disorder and anxiety. R26 used psychopharmacological medications Seroquel (an anti-psychotic), duloxetine (an anti-depressant), buspirone (an anti-anxiety) related to anxiety and depression. R26's 2/10/26, printed Order Summary Report identified that R26 took quetiapine fumarate (Seroquel) an antipsychotic medication daily. R26's 1/28/26, pharmacist recommendation identified for nursing to complete an abnormal involuntary movement scale (AIMS) assessment. The AIMS assessment was a tool to detect and monitor the severity of tardive dyskinesia (TD) in residents taking antipsychotic medication. R26's electronic medical record identified under the assessment section the last AIMS assessment had been completed on 5/9/25. Interview on 2/11/26 at 10:50 a.m., with director of nursing (DON) identified she was responsible to ensure that the pharmacy recommendations were acted upon. She confirmed the 1/28/26, pharmacy recommendation for the facility nursing staff to complete an AIMS assessment did not get done. She identified the last AIMS assessment was completed on 5/9/25 eight months ago and should be completed every six months. Review of the 10/9/25, Psychotropic Medication policy identified a registered nurse must complete an AIMS assessment for each resident prescribed an antipsychotic medication. The AIMS assessment was to be completed every 6 months. Any changes in the AIMS assessment, the facility would notify the family/representative and physician with the notification documented in the resident's medical record.

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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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Based on observation, interview, and document review, the facility failed to ensure the overall medication error rate was below 5% for 2 of 25 observations resulting in an 8% medication error rate.Findings include: Observation on 2/10/26 at 11:54 p.m., with licensed practical nurse (LPN)-B identified she went to administer 1 tablet of Baclofen (muscle relaxant) 10 milligrams (mg) and 1 tablet of spironolactone (diuretic) 25 mg, inside of a medication cup to R47 who was reported to be in her room. LPN-B knocked on R47's room door. R47 was not inside her room, so LPN-B left the medication cup containing the medications on R47's dresser drawer just inside her room and shut the door. LPN-B stated R47 was able to self-administer her medications, so she would leave them there for her to take them later. LPN-B then returned to the medication cart and finished the medication pass identifying and marked the medication had been administered in the electronic medical record (PCC). Interview on 2/10/26 at 5:44 p.m. with the director of nursing identified staff were not to leave medications unattended inside of a resident room or mark the medications administered. Review of the 4/8/25, Medication Administration Including Scheduling and Medication Aides policy identified medications were to be administered according to the Six Rights of medication administration [right patient, right medication, right dose, right route, right time, and right documentation]. In the section of self-administration, the policy noted staff were to be aware of medications kept in the room. There was no mention staff should ensure security of those medications in the policy.