STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245589	A. Building B. Wing	01/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Buffalo Lake Health Care Center	703 West Yellowstone Trail Buffalo Lake, MN 55314

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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 appropriate infection control technique was maintained during 1 of 1 meal service. This had the potential to affect all 42 residents. Findings include: Observation on 1/5/26 at 12:25 p.m., in dining room during noon meal service identified dietary aid (DA)-A serving food from the hot holding steam table in the dining room. After dishing up the food and passing it to the resident, she placed the plate in front of the resident while resting her hand on the back of the resident's wheelchair. DA-A reached for a multi-use menu sitting in the center of the table, handed it to another resident and asked her what her food choices were. She returned to the steam table, picked up a plate, and used the serving utensils to dish up the food. DA-A was not observed to wash her hands, use hand sanitizer, or wear gloves. While DA-A was standing at the steam table dishing food, another aide, DA-B approached and picked up a plate. DA-B reached over DA-A and started dishing up another resident's food. He picked up a plate touching the surface, reached over DA-A to grab the serving scoops and dished the food onto the plate. DA-B then went to the table, served the plate to the resident, then picked up the multi-use menu from the table, and handed it to another resident. DA-B then took that resident's order and returned to the steam table and dished another plate. DA-B was not observed to wash or sanitize hands between tasks during the observation. Cook-B was observed picking up the multi-use menu, handing it to the resident, taking her order, then returning to the steam table to dish up another plate. DA-A was then observed to approach the steam table and pick up a stack of condiment cups and stuck her thumb inside the cup to pull one apart from the stack. She filled the cup with coleslaw and served it to a resident. None of the staff washed or sanitized their hands between tasks or wore gloves. Interview on 1/5/26 at 1:17 p.m., with DA-A, DA-B, and Cook-B identified this was how we have always done meal service and reported they do not wash hands between tasks or wear gloves unless they are touching food directly. Observation on 1/6/26 at 12:16 p.m., identified Cook-C was serving food from the steam table in the hallway between two dining areas. The lids were removed from the containers of food. Cook-C would dish the food, then walk away from the steam table to give it to the residents. The steam table also had a tray of pastries on the bottom shelf about 5 above the floor without a cover. All the food on the steam table and the pastries on the bottom shelf remained uncovered for the entire food service. Interview on 1/6/26 at 10:00 a.m., with the registered dietician identified she has never observed or audited food service at the facility and only does audits upon request of the facility per her contract. She would expect the DM to complete audits to ensure staff were following good infection prevention practices. Interview on 1/8/26 at 4:02 p.m., with the administrator in training identified it was her expectation staff would practice infection prevention while serving meals. They should always wash their hands after touching unclean surfaces and prior to dishing up food. All food on the steam table should be covered prior to stepping away from the steam table. She would expect the DM to audit and provide training to staff as needed. A policy regarding infection prevention in the dining room was requested but nothing was provided before the end of the survey period.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
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 employee illnesses were tracked to identify when employee would be able to return to work after an illness, dependent upon their symptoms for 1 of 3 sampled staff (dietary aide) (DA)-A. This had the potential to affect all 41 residents in the facility. In addition, the facility failed to ensure a comprehensive ongoing infection control surveillance log to adequately track all staff illnesses and failed to update their infection control policies, annually. Findings include: Review of Dietary Absence Report log from May 2025 to November 2025 identified employee name, department and illnesses reported. However, the facility did not accurately complete the logs to ensure all necessary information was monitored. December 2025 employee illness log identified; DA-A was noted to have left early from work with symptoms of vomiting on 12/11/25. Review of DA-A timesheet identified that DA-A had worked on 12/11/25 from 7:10 a.m. to 09:30 a.m., for a total of 2.33 hours. DA-A returned to work on 12/13/25 and worked 11:05 a.m. to 300 p.m. and 3:38 p.m., to 7:37 p.m., for a total of 7.90 hours. Overall, there was no mention when or if DA-A symptoms resolved prior to returning to work. Interview on 1/06/2026 at 10:32 a.m., with dietary manager (DM) identified the process for her employees was to call her about their reported illness and was to remain at home until their symptoms improved. However, she had no process in place to ensure employees were to be symptom-free, unless the employee had informed her the employee was symptom free or had received treatment outside of work. She updated her staff illness logs, as needed, however, she did not communicate to the infection preventionist (IP) of her employee's symptoms. She identified the department had no formal communication process to ensure that the IP was aware of when staff were sick and when they were able to appropriately return to work. Interview on 1/08/26 at 9:57 a.m., with interim administrator (former director of nursing (DON), who is the infection preventionist (IP), identified the facility had no formal process in place to ensure all staff illnesses were recorded on an ongoing basis. Department heads did not communicate with the IP on a consistent basis of staff illnesses and identified there was a lack of monitoring of those employees with illnesses to determine, when an employee was appropriate to return to work, prior to returning. Further interview on 1/08/2026 at 9:57 a.m., with interim administrator identified the infection control program was discussed at QAPI meetings with the committee. However, there was no discussion about identifying improvement of tracking staff illnesses and the expectation of when those employees was to return back to work with the governing body. Review of current, undated BLHCC Scheduling Process sheet identified facility staff was to notify the charge nurse when ill and to report symptoms of their infection. Facility staff were expected not to return to work unless the employee was symptoms free or had no signs of infection within 24 hours. Review of October 2023 Infection Prevention & Control Policy and Procedure identified the facility was to follow national standards and guidelines to prevent, recognize and control onset and spread of infection and communicable diseases, whenever possible. The infection prevention and control program was to include a system for preventing, identifying, reporting, investigating, and control infections and communicable diseases for all residents, staff, volunteers, visitors and students from affiliated academic institutions or individuals providing services under a contractual arrangement according to regulatory standards. In addition, circumstances in which the facility was to prohibit employees with a communicable disease or infection, or skin lesions from direct contact with residents or their food if direct contact transmits the disease. Written health policies were to address reporting of staff illnesses, following work restrictions, prohibiting contact with residents or their food, and monitoring and evaluating patterns or outbreaks of illnesses among staff. IP was to identify necessary interventions, document infections, signs, and symptoms and was to keep an update map of infection to identify trends or clusters for action. Lastly, surveillance reports were to be shared with medical director, staff and practitioners to help identify impact of their care on infection rates and outcomes. Infection data and analysis was to be reported to the quality assurance (QA) committee at minimum (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	on a quarterly basis and was to be communicated to the appropriate departments, including sharing active implementation and reporting on quality assurance and performance improvement (QAPI) projects.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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 oversight of the infection control (IC) program to ensure thorough infection control and antibiotic stewardship program. This had the potential to affect all 42 residents in the facility.Findings include: Review of Monthly Infection Summary reports from May 2025 to November 2025 identified the columns for resident's name, infection date, body system affected, date symptoms resolved, infection, medication, source of the infection and if the criteria was met. However, the log lacked evidence that the antibiotic met criteria for continuation of use. R19Review of October 2025 infection log identified that R19 was to take cefuroxime (antibiotic) 250 milligrams (mg) by mouth twice a day for 5 days related to urinary tract infection (UTI) with a start date of 10/17/25 and was to end on 10/22/25. The organism was listed as Escherichia coli (E. coli) (a type of bacteria found in the intestines of humans and animals leading to diarrhea, vomiting, and fever) had met criteria for infection. On 10/24/25, R19 was to take cephalosporin (antibiotic) 500 mg by mouth twice a day for 7 days for symptoms of UTI and was to end 10/31/25. The organism was listed as Escherichia coli and was noted to have met criteria for infection. Review of R19's progress notes identified on:1) 10/15/25 at 11:30 a.m., identified family members of R19, identified on a previous occurrence that R19 that was experiencing symptoms of dizziness, fatigue, lightheadedness, and low blood pressure was linked to R19 having signs of a UTI. The facility faxed an order to R19's primary physician for a urinalysis order and to check for dehydration. 2)10/15/25 at 2:32 p.m., the facility received a fax from R19's primary physician for urinalysis to be completed.3) 10/17/25/25 at 7:17 a.m., R19 experienced the need to void, however could not produce urine. On 2 attempts, nursing staff was unsuccessful in collected urine from R19 through straight catheterization (procedure used to temporarily drain urine from the bladder, often performed by individuals who have difficulty emptying their bladder naturally) and by voiding into a cup.4) 10/17/25 at 4:00 p.m., facility staff were unsuccessful obtaining urine collection from R19. R19 had voice that she did not feel well, had chest pain with dizziness, and edema of the bilateral lower legs. R19's family was to take her to the emergency room for an evaluation. 5) 10/17/25 at 6:47 p.m., R19 returned to the nursing home from the local hospital with a diagnosis of UTI. R19's order was to started cefuroxime 250mg twice a day for 5 days. Overall, from 10/18/25 to 10/21/25 lacked an indication of an assessment to determine if the antibiotic was effective.6) 10/23/25 at 11:11 a.m., R19 complained of chest fullness and dizziness. R19 was unable to urinate and had not improved with the antibiotic she was administered. A family member was concerned that R19 was not recovering well from her urinary tract infection. The facility staff faxed R19's primary physician of R19 and family concerns, including R19's antibiotic and its susceptibilities (sensitivity of bacteria specific antibiotics determined through testing methods that was to guide effective treatment options). 7) 10/24/25 at 8:56 a.m., nursing staff left voicemail was sent to R19's primary physician to review fax that was sent the day prior. 8) 10/24/25 at 6:17 p.m., R19 returned from appointment along with family member with new order to start cephalexin 500 mg twice a day for 7 days. R19 was to take one dose on Friday evening with food and encourage water intake. From 10/25/25 to 10/28/25 lacked an indication of an assessment to determine if the antibiotic was effective. Review of 10/28/25 Hospital & Clinic emergency room note identified that R19 was treated with cephalexin antibiotic medication related to UTI. R19's urine culture on 10/24/25 showed less than 10,000 colony-forming units (CFM) per milliliter (ml) of mixed bacteria growth and identified a true bladder infection was unlikely. R31Review of August 2025 infection log identified that R35 was to take cephalexin (antibiotic) 500 mg three times a day for urinary tract infection with a start date of 8/31/25 for a total of 15 administrations of the antibiotic. The log lacked indication of an end date of the antibiotic and f a urine culture was obtained. The log identified that R35 met criteria to be treated with the antibiotic. On 9/01/25, R31 was to take cefdinir (antibiotic) 300 mg twice a day for 5 days (continued on next page)

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F 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	with a start date of 9/05/25 and an end date of 9/10/25. The log identified R19's urine culture was noted to be negative and met criteria to be treated with the antibiotic. Review of R31 progress notes identified on:1) 8/31/25 at 6:23 p.m., R31 had increased difficulty in standing from a fall and was sent to the local hospital for an evaluation.2) 8/31/25 at 11:59 p.m., local hospital informed nursing staff was to send R31 back to the facility tonight and had evidence of a UTI and was to start of cephalexin. A urine culture was ordered and R31's white blood cell count (WBC) was 15 (normal range of WBC was 4,500- 11,000). R31's imaging results came back negative with no acute findings.3) 9/01/25 at 2:21 a.m., identified R31 arrived back to the facility at 12:30 a.m., with orders for cephalexin 500mg three times a day for acute cystitis (infection of the bladder caused by E. coli) with hematuria (presence of blood in the urine).4) 9/01/25 at 6:52 a.m., R31 had received 1st dose of cephalexin 500mg that was pulled from the emergency kit (Ekit).4) 9/04/25 at 11:14 a.m., identified R31 was readmitted to the local hospital and returned to the facility with diagnosis of a fracture and new orders to start cefdinir 300mg twice a day for 5 days for UTI.5) 9/06/25 at 11:35 p.m., 9/07/25 at 3:32 p.m., and 9/08/25 at 2:48 p.m., identified R31 had a UTI and was currently on antibiotics. However, the progress notes lacked an indication of an assessment to determine if the antibiotic was effective. Employee SurveillanceReview of Dietary Absence Report log from May 2025 to November 2025 identified employee name, department and illnesses reported. However, the facility did not accurately complete the logs to ensure all necessary information was monitored. December 2025 employee illness log identified; DA-A was noted to have left early from work with symptoms of vomiting on 12/11/25. Review of DA-A timesheet identified that DA-A had worked on 12/11/25 from 7:10 a.m. to 09:30 a.m., for a total of 2.33 hours. DA-A returned to work on 12/13/25 and worked 11:05 a.m. to 300 p.m. and 3:38 p.m., to 7:37 p.m., for a total of 7.90 hours. Overall, there was no mention when or if DA-A symptoms resolved prior to returning to work. Interview on 1/08/2026 at 9:57 a.m., with interim administrator (former director of nursing (DON), who was the infection preventionist (IP) identified facility nursing staff who worked on the evenings, who had not obtained IP training or certification, was assigned to update and maintain resident surveillance infection logs monthly. The process was for nursing staff to identify resident symptoms to rule out potential illness. If an illness was to occur, nursing staff was to use the McGeer criteria (a template used to identify infections) that was accessible to nursing staff on the units. A call was to be placed to the resident's primary provider to obtain a specimen. The specimen was collected and sent for testing and antibiotics were ordered for the resident, depending on their symptoms. Medication administration was given, and an antibiotic timeout or assessment was to be completed by the nursing staff within the 48-to-72-hour timeframe. The local pharmacy was to send reminders to the facility of a pending antibiotic assessment; however, it was not done consistently. IP acknowledged the surveillance logs were not monitored on a consistent basis and found the logs had discrepancies to identify indication of antibiotic use. She acknowledged her oversight as the IP was not up to her standards and would implement a process to ensure compliance of the infection control program. Further interview on 1/08/2026 at 9:57 a.m., with interim administrator identified the infection control program was discussed at QAPI meetings with the committee. However, there was no discussion to identify improvement of tracking staff illnesses and the expectation of when those employees were to able to appropriately return back to work with the governing body. Review of October 2023 Infection Prevention & Control Policy and Procedure identified the facility was to follow national standards and guidelines to prevent, recognize and control onset and spread of infection and communicable diseases, whenever possible. The infection prevention and control program was to include a system for preventing, identifying, reporting, investigating, and control infections and communicable diseases for all residents, staff, volunteers, visitors and students from affiliated academic institutions or individuals providing services under a contractual arrangement according to regulatory standards. In addition, circumstances in which the facility was to prohibit employees with a communicable disease or infection, and skin lesions from direct contact with resident or their food if direct contact transmits the disease. Written health (continued on next page)

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F 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	policies were to address, reporting of staff illnesses, following work restrictions, prohibiting contact with residents or their food, and monitoring and evaluating patterns or outbreaks of illnesses among staff. IP was to identify necessary interventions, document infections, signs, and symptoms and was to keep an update map of infection to identify trends or clusters for action. Lastly, surveillance reports were to be shared with medical director, staff and practitioners to help identify impact of their care on infection rates and outcomes. Infection data and analysis was to be reported to the quality assurance (QA) committee at minimum on a quarterly basis and was to be communicated to the appropriate departments, including sharing active implementation and reporting on quality assurance and performance improvement (QAPI) projects.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. Based on interview and document review the facility failed to provide timely notification to the designated family member of a change in condition for 1 of 1 resident (R47) with a change of condition requiring hospitalization, failed to update the physician of additional signs and symptoms of physical decline for 1 of 1 resident R45, who had continued high blood sugar levels and bloody stools, and timely notify the physician to a previous choking episode for 1 of 1 resident R7. Refer also to F684 and F808.Findings include: R47's 12/23/25-Significant Change Minimum Data Set (MDS) assessment identified she had moderate cognitive impairment and required moderate assistance with activities of daily living (ADLs). She was transferred via ceiling sling lift and utilized a wheelchair for mobility. R47 had diagnosis including a kidney infection, bone infection of her left foot, heart failure, diabetes, high blood pressure, Methicillin-resistant Staphylococcus Aureus (MRSA) (bacterial infection resistant to several common antibiotics), cognitive impairment, hydronephrosis (swelling of one or both kidneys due to a backup of urine), diabetic ulcer of her right foot, and chronic obstructive pulmonary disease (COPD). Interview on 1/7/26 at 2:40 p.m., with family member (FM)-A identified R47 had been hospitalized multiple times over the past year with multiple concerns including wound infections, and UTIs. FM-A reported the most recent hospitalization was from 12/23/25 until 1/2/26, with a diagnosis of a kidney infection. It was reported R47 had been experiencing blood in her urine for 2 days before being sent to the clinic for evaluation and as a result, was hospitalized . FM-A reported concerns of not being timely notified of R47's change in condition as she felt it could have been prevented with earlier notification and intervention. R47's progress notes identified:12/21/25 at 7:57 p.m. staff reported R47's urine was a little pinkish in color. She failed to voice any urinary complaints and reported ongoing pain in her lower back.12/22/25 at 7:00 a.m. had a large dark colored, foul-smelling stool and reported nausea, but did not vomit, BP 118/62.12/22/25 at 10:15 a.m. staff reported two black stools that smelled like old blood. R47 was receiving iron supplement, but the old blood smell was new. MD updated via fax.12/22/25 at 10:34 p.m. R47 continued to be quiet and sleepy this shift. R47 went to an appointment with FM-B during the afternoon and complained of a stomachache. R47's color was noted to be paler than normal and had decreased appetite. Staff noted no stools were reported during the afternoon and R47 went to bed early. The MD was updated via fax of changes, but no emergent needs were identified. R47 declined going to the emergency room (ER) for evaluation of their condition when offered. 12/23/25 at 8:18 a.m., staff documented they called to update the MD and reported symptoms to the care team who directed R47 be brought to clinic for further evaluation. R47 did not respond when updated about going to clinic for evaluation. 12/23/25 at 10:19 a.m. FM-B was contacted for transfer of R47 for further evaluation and was referred to contact FM-C for transport in facility van. 12/23/25 at 3:44 p.m. MD responded to the previously sent fax on 12/22/25, with order for lab tests, and suggested R47 be sent to urgent care or the ER for further evaluation and was updated R47 had been sent to the ER by 12:00 p.m. 12/23/25 at 4:35 p.m., the facility was updated R47 had been admitted to the hospital. Interview on 1/8/26 at 3:21 p.m., with licensed practical nurse (LPN)-A identified R47's doctor (MD) was faxed with updates on 12/22/25 and 12/23/25, but the family was not contacted until 12/23/25, when they were contacted to arrange for transportation to urgent care for further evaluation. There were no indication family members were notified that R47 was experiencing bloody urine prior to her being sent for further evaluation. She agreed family should have also been updated following updates sent to the MD. Interview with on 1/8/26 at 3:30 p.m. with registered nurse (RN)- B and LPN-B identified they confirmed R47's family was not updated when she began experiencing bloody urine, and they should have been notified following notification of the provider of a change in condition. Interview on 1/8/26 at 3:52 p.m. with the assistant director of nursing (ADON) and administrator in training reported their expectation was for families to be notified of changes in condition in a timely manner. The agreed R47's family should (continued on next page)

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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 notify the county (designated State Mental Health Authority (SMHA) when 1 of 12 (R17) sampled residents had new on-set of mental illness since admission.Findings include: R17's, March 2023 Preadmission Screening Results (PASAR) had a diagnosis of Parkinson's disease and did not have a current diagnosis of a mental illness. R17's, undated, current medical dx sheet, identified R17 had a diagnosis of Parkinson with dyskinesia with fluctuations 4/16/24 and depressive episodes on 3/23/25. R17 received a new diagnosis of generalized anxiety disorder on 3/25/25, dementia with anxiety on 9/16/25, and major depressive disorders with severe psychotic symptoms on 9/24/25. R17s medical record lacked any indication that the county SMHA had been notified since the new onset of R1's mental illnesses. R17's, accepted 11/04/25 at 3:05 a.m., quarterly Minimum Data Set (MDS) identified R17 was cognitively alert and had no behaviors. R17 had little interest or pleasure in doing things, felt down, depressed or hopeless never to 1 day, and had sometimes experience social isolation. R17 taken antipsychotics, antianxiety and antidepressant medications. Review of undated, current care plan identified that R17 had potential for drug related complications associated with use of Seroquel (antipsychotic) that was ordered September 2025. Interventions was to administer medication, monitor/document for side effects and effectiveness, monitor/record/report to MD as needed (PRN) and adverse reactions of psychoactive medications, such as unsteady gait, refusal to eat, difficulty swallowing, dry mouth, diarrhea, insomnia, weight loss, vomiting, behavior symptoms, pharmacy review of medications, alert MD of pharmacist recommendations for gradual dose recommendations or changes and follow MD orders, educate resident, family, caregivers about risks, benefits, and side effects of toxic symptoms of Seroquel, monitor/report to MD an behavior feelings, signs and symptoms of anxiety, feeling nervous, restless or tense, having sense of impending danger, panic or doom, increased heart rate, and trouble concentrating or thinking about anything other than the present worry. R17's progress notes identified on: 1) 9/10/25 at 10:22 a.m., R17 experienced difficulty managing her distress and was not a candidate for hospice services. R17 called her primary provider requesting an increase in her Xanax (antianxiety medication), valium (used to treat anxiety, muscle spasms and alcohol withdrawal, and baclofen (treats spasms and muscle pain in people with spin cord conditions) to assist with muscle contraction and relaxation.2) 9/16/25 at 7:59 p.m., R17 was visited by her primary provider along with R17's family member in attendance by phone. Staff were to administer Seroquel 25 milligrams (mg) by mouth every night.3) 10/21/25 at 8:04 p.m., R17 was seen during physician rounds through web access with orders to increase Seroquel to twice a day. Nursing staff were to check orthostatic (lying, sitting, and standing) blood pressures twice weekly for 2 weeks and send the results to R17's primary physician in 2 weeks. Review of 12/17/25, rural psychiatry provider initial assessment identified R17 was referred for psychiatric evaluation. R17 reported progressive weakness and tremors throughout the day, medication-related nausea, severe early morning pain in extremities, and obsessive behaviors regarding medication timing. She expressed sadness of missing family activities, visitations with her family, and was frequently calling her primary provider for medication changes. Review of 12/30/25, rural psychiatry follow up provider note identified R17 had experience mood fluctuations with periods of feeling like she was not going to make it or was dying. R17's anxiety worsened around noon, and she had social isolation due to worrying about Parkinson's movement symptoms. R17 anxiety significantly impacted her daily functioning, as she rarely came out of her room, and worried about not fitting in. R17's Seroquel was increased in October 2025 but had no significant improvement in her condition since that time. Interview on 01/07/2026 3:15 PM with licensed social worker stated a level II PASARR was not completed and would implement a process to review and address changes of residents diagnoses to determine if a Level II was needed to ensure compliance. Review of September 2025 Pre-admission Screening and Resident Review (PASARR) policy identified the facility was to identify indicators was present for a referral for Level II (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	evaluation. A resident who experiences a significant change in condition, a new diagnosis of mental illness was identified and determined, a Level II was to be completed. In addition, the facility was to monitor PASARR compliance through routine audits to ensure compliance.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to appropriately assess, monitor, update the physician of additional signs and symptoms of physical decline, and intervene for 1 of 1 sampled resident (R45) who had continued high blood sugar levels and bloody stools, and intervene when immediate medical evaluation warranted a face-to-face by a physician. Findings include: R45's [DATE], hospital discharge summary identified R45 had been sent to the emergency room (ER) for concerns of high blood sugar. At the ER, R45's family reported R45 had been passing dark/bloody stools since yesterday as well. An occult stool test was administered and was positive for blood. Upon arrival and during treatment, R45 presented to the ER as pale in color, with high blood sugars and very low blood pressure. ER evaluation by the medical doctor revealed evidence of hemorrhagic shock (life-threatening condition caused by significant blood loss, leading to inadequate blood flow and oxygen delivery to vital organs), GI (internal abdominal) bleeding, low oxygen, and associated heart attack. R45 was placed on comfort cares after conferring with family and was returned to the facility. R45's primary physician was updated. R45's [DATE], accepted comprehensive Minimum Data Set (MDS) identified R45 had moderately impaired cognition, and required substantial to total assistance with cares. R45 received scheduled pain medication, insulin, antidepressant, and antipsychotic medication. R45's [DATE], accepted MDS identified she had died in facility on [DATE]. R45's [DATE], Medical Diagnosis list identified R45 had diagnoses of diabetes, psychotic disorder with hallucinations, major depression, high blood pressure, peripheral vascular disease (decreased blood flow to extremities), Alzheimer's disease, insomnia, long term use of aspirin, low magnesium, low iron, and a history of stroke. R45's undated, care plan identified R45 was on a diabetic diet. R45 had diabetes with potential for complications. Staff were to administer medication and monitor for side effects, monitor weight and report significant changes to R45's physician, obtain ordered labs, monitor blood sugars, and monitor for hypo or hyper-glycemia. Review of R45's physician orders identified on [DATE], R45 was to be administered 24 units once daily of Lantus (long-acting insulin) subcutaneously (injected into fat layer under skin). Staff were to cut her dose in half if she had not eaten and call the physician if her BS (blood sugars) were lower than 60 deciliter/millimeters of mercury (dL/mmhg) or greater than 400 dL/mmhg. Review of R45's documented blood sugars (in dL/mmhg), and corresponding progress notes identified:On [DATE] at 5:41 p.m., R45's BS was 514. The physician (MD)-E was notified via fax that R45's BS had risen, however, MD-E had not replied back via fax until [DATE]. From [DATE] through [DATE], R45's BS ranged from 171 to 378.On [DATE] at 9:01 a.m., R45's BS rose again to 418 and MD-E was notified. Staff documented R45 had complained of feeling dizzy while standing. It is unclear if staff reported those finding to MD-E as well.On [DATE] at 11:48 a.m., R45's BS rose to 587 and MD-E was again notified. MD-E gave a verbal order to give R45 10 units of fast acting insulin and recheck her BS in one hour and call back with the results.On [DATE] at 12:44 p.m., BS was 581. MD-E was notified of the result and ordered staff to administer 20 more units of fast acting insulin and to recheck R45's BS. If the BS was over 300, staff were to call back for more orders. Staff rechecked R45's BS and it had lowered to 412. MD-E then ordered another 10 units of fast acting insulin and instructed staff to watch R45 closely throughout the evening and overnight and report back if R45's BS stayed higher or dropped too low.On [DATE] at 4:52 p.m., R45's BS was 144.On [DATE] 9:28 p.m. R45's BS was 391. Staff notified MD-E who gave another order for staff to administer 10 units of fast acting insulin (Humalog) and to increase her Lantus (long-acting insulin) to 34 units beginning [DATE]. From [DATE] after 9:28 p.m., until [DATE] at 6:52 a.m. there was no indication staff had followed MD-E's orders and monitored R45's BS throughout the night or had taken other vitals to identify a change of condition that warranted a face-to-face evaluation by a physician. Review of [DATE], facility 24-hour report identified documentation next to R45's name that R45 had large loose dark stools 3 or 4 times yesterday with no (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	emesis. Further review of R45's documented BS and corresponding progress notes identified:On [DATE] at 6:54 a.m., staff noted R45 slept well overnight and did not have any loose stools or vomiting. She continued to be very thirsty and out on her call light for water. R45 refused to get up to use the bathroom overnight. On [DATE] at 5:00 a.m Staff noted they took R45's BS and it was high again at 508. Her blood pressures were low at 91/44 millimeters of mercury (mm/hg) (normal 120's/80's), pulse was 70, respirations at 19 and her temperature was 97.4 degrees Fahrenheit (F). Staff noted she was asleep in her recliner. There is no indication staff had identified the consistent high blood sugars combined now with her low blood pressure indicated the necessity to be seen by a physician for a face-to-face medical exam.On [DATE] at 11:51 a.m, staff left a message for MD-E asking for orders to check a urine sample to rule out a bladder infection. There was no indication staff had also notified MD-E of any current BS levels.On [DATE] at 12:08 p.m., staff noted R45's BS was 493. On [DATE] at 4:09 p.m., staff noted R45 performed upper body exercises and noted she was not feeling well.On [DATE] at 6:18 p.m., a medication administration progress note identified staff attempted to take R45's BS, however they were unable to get a reading. At 6:20 p.m., staff finally sent R45 to the ER for medical examination after they noted she was declining. Color waxy and pale.On [DATE] at 11:59 p.m., staff documented they assisted R45 up for supper and to the table. They noted they were unable to get a BS reading after taking it twice and it just said it was high with no associated number. R45 was noted to be pale and waxy looking and had confusion. Staff called R45's family and requested permission to send R45 to the ER and a 911 call was placed at that time. Staff then called the ER and was told R45 was not doing well and family decided to implement comfort cares. R45 was noted to be returning that evening. Staff also noted R45's hemoglobin (a protein in blood. Low levels can be caused by conditions such as blood loss) was low.There was no documentation in R45's progress notes identifying all staff were aware of R45's bloody stools, or any indication that had been reported to MD-E, nor evidence staff had identified a change of condition timely and delayed R45 in sending her to the ER for medical evaluation. Interview on [DATE] at 9:16 a.m., with registered nurse (RN)-A identified R45 really struggled with her BS but she had other medical issues going on also. Interview on [DATE] at 11:45 a.m., with RN-C identified on [DATE], after morning report and hearing that R45's BS was so high she had re-checked the BS and let the charge nurse know, who then called MD-E to update them. She reported she had a hard time telling if R45's BS was high as R45 did not act any different. R45 typically liked to sleep a little later as she stayed up at night. MD-E did order for staff to administer insulin and to check on her frequently that day. R45 came out for meals and conversed with staff on [DATE] but might have acted a little more tired that day and been flushed in the face. RN-C was unaware of any dark loose stools other than what had been reported during report that morning on [DATE]. There had been a similar situation with another resident when that resident had a BS of 500 as that resident was sent to the ER for evaluation. RN-C noted she was surprised R45 had not been sent to the ER to be evaluated by a physician. In general, for residents with BS below 90 or above 300, staff were to contact the physician. Interview on [DATE] at 12:24 p.m., with nursing assistant (NA)-B identified R45 did have dark colored stools the day before she was sent to the hospital [[DATE]]. The stools were black, almost tar looking. The charge nurse (LPN-C) was notified of the dark stools. R45 continued to have loose, dark stools that evening on [DATE]. Interview on [DATE] at 12:36 p.m., with RN-D identified any resident with extremely high or low BS would be sent to the ER for evaluation if it was out of their normal limits. Nurses were to use their critical thinking skills. There was a change in condition policy that could be referenced by staff for procedures, or the nurse could contact the physician for direction on how to proceed if unsure of what to do. Interview on [DATE] at 1:05 p.m., with licensed practical nurse (LPN)-C identified she had been the nurse on duty the night of [DATE] into [DATE]. She reported R45 had been running high BS and the provider had made some insulin changes. R45 had gained a little weight the week before [DATE]. She had noted R45 had fluid in her legs however, R45 denied that her legs hurt. She had been made aware of the dark stools and reported that R45 even had (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	blood when staff had wiped her after toileting. She thought that another family remember had been made aware of the blood in the stool but she herself had not made MD-E aware of the bloody stools after becoming aware by the NA's. Review of R45's progress notes identified there was no mention that a family member or MD-E had been notified of R45's bloody stools. Interview on [DATE] at 2:38 p.m., with the administrator-in-training identified typically, any BS over 300 was concerning and staff should contact a provider and for BS over 500 along with any accompanying symptoms. If a resident also had symptoms, the resident should be seen by the physician for a face-to-face medical evaluation. The facility glucometer machine will register as high if a BS was over 600. She noted the nurse did send R45 to the ER when she was unable to get a reading on the glucometer. She agreed that on [DATE] when R45 developed dark bloody stools and with her continued unstable BS, the physician should have been notified. She further agreed that the medical record lacked any documentation of dark loose stools. Nursing staff were able to use the policy book from Pathways as a professional standard or they were able to search online. The nurse can also call the on-call physician for direction if there were questions. Interview on [DATE] at 10:36 a.m., with medical director identified he was unfamiliar with R45 and her baseline blood sugars. He noted some residents do good with high BS and other do not and would need to be evaluated in the ER. The symptoms of the high BS of 508 at 5:00 am on [DATE] and dark stools the day before, at a minimum, should have been conveyed to a physician. Interview on [DATE] at 11:45 a.m., with RN-D identified during her shift on [DATE], she had communicated a lot with the provider related to R45's high BS and stated she had advocated for R45 asking MD-E if she needed to be seen, however there was no documentation to support RN-D had made those recommendations for a face-to face evaluation. MD-E had ordered additional insulin and a urine culture. On [DATE], she kept a close eye on R45 and sat with her during meals. She was unaware of any dark loose stools, and none had been reported to her while she was working as the charge nurse on [DATE]. R45's blood sugars were much higher than normal for her on [DATE]. Interview on [DATE] at 2:20 p.m., with MD-E identified R45 was a [AGE] year-old who was diabetic and wanted to stay on insulin. Staff had notified her of R45's high blood sugars and she had provided orders for additional insulin to be given to control the high BS, which was appropriate treatment. The family did not want aggressive treatment and it was reported R45 seemed to be acting herself during these times of high BS until she was sent into the ER. MD-E was not aware of the large dark stools until she had been updated by the ER provider. MD-E felt there was no correlation with the bloody stools with her high BS. She would have expected to be notified of high BS and if R45 had started to have dark loose stools. The outcome would not have changed considering her age and declining health, along with her multiple comorbidities. She had no indication previously of a GI bleed concern until the ER provider updated her. Review of Assure Glucometer manufactures book identified BS levels more that 600 would read as HI on the glucometer and BS levels less than 20 would read as LO on the glucometer. Review of [DATE], Proper Glucose Management policy identified blood glucose levels would be monitored, documented, and addressed. Hyperglycemia was defined as BS levels above specified by the physician orders. Residents were to have ongoing reassessment as clinically indicated. BS's would be monitored per the physician orders and reported to the physician if outside ordered parameters. The facility would monitor for signs and symptoms of hyperglycemia, including increased thirst, frequent urination, fatigue, and blurred vision. Persistent or significantly elevated BS would be reported promptly to the provider. Abnormal readings and provider notification were to be clearly documented in the resident's record. Review of undated, Hyperglycemia policy provided identified BS checks would be done for signs or symptoms of hyperglycemia. BS over 300 would be reported to the provider immediately or if the resident was displaying severe signs of hyperglycemia staff were to call 911. Review of the revised [DATE], Change of Condition policy identified a resident's condition was to be assessed and reported to the MD immediately if a resident experienced vital signs that varied significantly from the residents normal limits, or have been monitored for 24 hours and have not improved with basic nursing interventions, any dramatic fluctuations in diabetic (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	status such as BS levels, and levels of consciousness changes, and any other significant change of condition as determined by the licensed nurse. Residents' condition was to be assessed and reported in a timely manner either verbally or in writing. There was no mention in the policy of what change of condition warranted immediate face-to-face medical evaluation by a physician, or when staff should send the resident to the ER.

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure therapeutic diets are prescribed by the attending physician and may be delegated to a registered or licensed dietitian, to the extent allowed by State law. Based on observations, interview, and document review, the facility failed to ensure 1 of 1 resident (R7) had received the appropriate therapeutic diet as ordered by the physician, timely notify the physician of a previous choking episode, and follow policy and procedure by having only cooks dish up food from the serving line to serve to residents in order to ensure diets were accurately given as ordered to each resident. Findings include: Review of the 12/25/25, facility reported incident to the State Agency identified R7 had been seated at a table in the dining room. Nursing assistant (NA)-A observed R7 coughing and turning red. NA-A approached R7 and patted him on the back and directed him to spit the food out of his mouth. R7 was able to cough up the food, and he spit a piece of hamburger out and told staff he was okay. NA-A reported R7 had spit out chunks of hamburger. Medication Aid (TMA)-A summons the charge nurse licensed practical nurse (LPN)-B to the dining room. LPN-B arrived in the dining room and noted R7's face to be purple/maroon in color and was coughing. His oxygen was on top of his nose as he was spitting. LPN-B applied his oxygen and removed resident from the dining area and took him to his room. R7 maintained an open airway and his color quickly returned to normal. R7 was alert and talking. LPN-B assessed temperature, lung sounds, and oxygen saturations. LPN-B reported R7 did not receive the appropriate texture diet of puree meat per his care plan. R7's accepted 10/29/25 quarterly Minimum Data Set (MDS) assessment identified his cognition was severely impaired, he had diagnosis of dysphasia (difficulty swallowing) and dementia. R7's Section K: Swallowing and Nutritional Status identified he had no coughing or choking during meals during the 7-day lookback period. R7'S 2/9/25, progress note identified R7 had a choking spell while eating the ground turkey, which did have gravy on it. The nurse aide (NA) had called nursing to dining area. Staff observed R7's face was a deep red color. He was coughing and taking a breath at that time. The NA reported she felt he did lose his airway. Staff assisted him back to his room and noted they felt like everything [food] was cleared [from his airway} at that time. His color was back to normal, and he was talking to staff. Staff were to check R7's temperature and O2 [oxygen] saturation levels, along with assessing his lung sounds every shift x 3 days for assessment of aspiration. Staff noted they were questioning if R7 shouldn't be on pureed meat for safety and passed that information along in the nursing report. There was no indication in the note that R7's physician had been notified at the time of the incident to determine if R7 needed immediate medical evaluation. R7's 2/10/25, facility communication with the physician note identified staff documented May we please have ST (Speech Therapy) orders to evaluate and treat due to a choking episode on 2/9/25. The physician responded with new orders to proceed with ST for evaluation due to diagnosis of dysphagia. R7's 2/19/25 ST summary identified a 7-day trial of puree meats with moisture was completed from 2/11/25 through 2/18/25. ST recommendation for pureed meats with moisture, cut food into bite size, supervision at meals, upright for oral intake, thin liquids within functional limits (WFL) chewing of puree and no refusal of meals. R7 demonstrated no choking and coughing event with the current trial diet. R7 agreed at that time to continue with the above diet. If R7 requested an upgrade of his food, a risks verses benefit was to be completed. ST provided patient and caregiver training in safe swallowing strategies, specifically R7's current dietary modification. Supervision by staff was required when eating. Staff were to ensure R7 was given an NDD3 diet consisting of pureed meats with moisture and thin liquids. Staff were to cut other food into bite size pieces. R7 was to be upright for intake and use safe swallowing strategies, such as eating at a slow pace, chewing all food well, taking small sips of fluids, and alternate liquids and solids in order to preserve R7's current level of function with 100% carryover demonstrated during the session. Observation on 1/5/26 at 12:25 p.m., identified multiple staff dishing food for residents in the dining room. DA-B observed standing at the steam table, while she was dishing a plate of food DA-A approached the steam table and reached over DA-B and dished up another resident's food. [NAME] B was also observed dishing food from the (continued on next page)

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	steam table. Interview on 1/5/26 at 7:07 p.m., with dietary aid (DA)-A identified he had dished up R7's meal on 12/25/25, from the food off the steam table. The food was already prepared. He said the containers are not normally marked to their contents, but the meat looked pureed from the top. DA-A stated, I wasn't really paying super close attention. I was going too fast, and I put it on the plate and served it. R7's 8/19/25 physician telephone order identified the facility was to change his diet order to NDD3, pureed meat regular texture and fluid. R7 may have potato chips. R7's current, undated care plan identified he was to maintain a healthy nutritional status during his stay at the facility. R7 was to use adaptive devices to stay as independent as possible. He was to have a National Dysphasia Diet level 3 (NDD3) thin liquid diet with pureed meats. The care plan noted he had No difficulty chewing. R7 was to have covered cups to prevent spillage, and potato chips were approved by ST when on the menu. There was no revision of the care plan to include ST's instructions for staff noting staff were to cut food into bite size pieces. R7 was to be upright for intake and use safe swallowing strategies, such as eating at a slow pace, chewing all food well, taking small sips of fluids, and alternate liquids and solids. Interview on 1/6/26 at 11:11 a.m., with NA-A identified on 12/25/25, staff were bringing residents into the dining room. She was waiting for a dietary staff to bring food in. R7 was seated across from her and eating his food. R7 started coughing. When she looked at him, his face was turning red, and he was hunched over. She got up and started patting him on the back [since he was coughing and not obstructed] and told him to keep coughing and spit out what was in his mouth. He spit food out onto his shirt, and it was chunks of ground beef, a little bigger than a pea but not as big as a bean. By that time trained medication aide (TMA)-A came in and said if he is coughing do not intervene. R7 managed to get the food out and clear his own throat. TMA-A alerted licensed practical nurse (LPN)-B. LPN-B came to the dining room and assessed R7. NA-A and LPN-B took R7 back to his room to clean him up and change his clothes. NA-A reported to LPN-B what happened, and LPN-B said R7 was supposed to have pureed meat. NA-A was a contracted staff and was not aware R7 was on a mechanically altered diet. She did not receive any training from the facility that was specific to each resident, when her employment began at the facility, but had been instructed to read and review each resident's care plan and stated she had not done that. Interview on 1/6/26 at 12:09 p.m., with cook-A, identified she was not in the dining area on 12/25/25, and did not dish up the food that R7 received. The DA told her what happened later, and she thought the meat placed into the serving station steam table had been appropriately pureed. After food is prepared, it is placed in containers on the steam table. The containers are not marked to what consistency or food was held within the container. The DA's dish up and serve the food. The kitchen does not use diet cards in the dining room to ensure residents receive the correct diet at time of placing their plate at the table, but noted there is a list of residents with diet cards in a drawer on the steam table. She received training when she started on how to puree food. She was told to add liquid with the food to a blender and blend until no chunks were visible. Interview on 1/7/26 at 10:00 a.m., with the registered dietician (RD) identified she was not aware of the incident on 12/25/25. She would expect the facility to have one person dishing from the steam table. Typically, it should be the cook who prepared the food since they are the most aware of the different diets. The DA's and other support staff would assist in passing the trays. She has never observed or audited food service at the facility and only does audits upon request of the facility per her contract. She would expect the dietary manager (DM) to complete competencies with kitchen staff that are responsible for preparing or serving therapeutic diets and all kitchen staff should receive training on therapeutic diets upon hire. Interview on 1/6/26 at 9:30 a.m., with the DM identified she had completed competencies prior to the incident but had not completed any updated competencies or audits following the training that occurred after the incident at the time of this interview. The facility provided documentation of International Dysphasia Diet Standardization Initiative (IDDSI) training provided to the dietary staff on 12/26/25, along with a sign-off sheet identifying all kitchen staff had attended. Review of the facility provided undated Dining Service Policy identified the facility would serve food at the proper temperature and texture as ordered by the (continued on next page)

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	245589	A. Building B. Wing	01/08/2026

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Buffalo Lake Health Care Center	703 West Yellowstone Trail Buffalo Lake, MN 55314

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	physician using the mobile steamtables to deliver the food to all parts of the facility. The cook was to prepare the food in the kitchen area following the texture requirements needed for each meal and place the food into the steamtable. The cook was to serve the food to the residents following their tray cards [diet cards]. The assistants (DA) would then be able to serve fluids, any yogurts, fruit cups, etc. to the residents while following their diet orders. When the assistant was done serving from the juice cart, they were to assist the cook with serving meals to any residents that do not have their food yet, following diet try cards. Review of the [NAME] checklist identified at meal service; the cook was to serve the meal for the small dining room and then continue to the main dining room.

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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 sampled residents (R19 and R31) 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 Infection Summary reports from May 2025 to November 2025 identified the columns for resident's name, infection date, body system affected, date symptoms resolved, infection, medication, source of the infection and if the criteria were met. However, the log lacked evidence that the antibiotic met criteria for continuation of use. R19Review of October 2025 infection log identified that R19 was to take cefuroxime (antibiotic) 250 milligrams (mg) by mouth twice a day for 5 days related to urinary tract infection (UTI) with a start date of 10/17/25 and was to end on 10/22/25. The organism was listed as Escherichia coli (E. coli) (a type of bacteria found in the intestines of humans and animals leading to diarrhea, vomiting, and fever) had met criteria for infection. On 10/24/25, R19 was to take cephalosporin (antibiotic) 500 mg by mouth twice a day for 7 days for symptoms of UTI and was to end 10/31/25. The organism was listed as Escherichia coli and was noted to had met criteria for infection. Review of R19's progress notes identified on:1) 10/15/25 at 11:30 a.m., identified family members of R19, identified on a previous occurrence that R19 that was experiencing symptoms of dizziness, fatigue, lightheadedness, and low blood pressure was linked to R19 having signs of a UTI. The facility faxed an order to R19's primary physician for a urinalysis order and to check for dehydration. 2)10/15/25 at 2:32 p.m., the facility received a fax from R19's primary physician for urinalysis to be completed.3) 10/17/25/25 at 7:17 a.m., R19 experienced the need to void, however could not produce urine. On 2 attempts, nursing staff was unsuccessful in collected urine from R19 through straight catheterization (procedure used to temporarily drain urine from the bladder, often performed by individuals who have difficulty emptying their bladder naturally) and by voiding into a cup.4) 10/17/25 at 4:00 p.m., facility staff were unsuccessful obtaining urine collection from R19. R19 had voice that she did not feel well, had chest pain with dizziness, and edema of the bilateral lower legs. R19's family was to take her to the emergency room for an evaluation. 5) 10/17/25 at 6:47 p.m., R19 returned to the nursing home from the local hospital with a diagnosis of UTI. R19's order was to started cefuroxime 250mg twice a day for 5 days. Overall, from 10/18/25 to 10/21/25 lacked an indication of an assessment to determine if the antibiotic was effective.6) 10/23/25 at 11:11 a.m., R19 complained of chest fullness and dizziness. R19 was unable to urinate, and symptoms had not improved with the antibiotic she was administered. A family member was concerned that R19 was not recovering well from her urinary tract infection. The facility staff faxed R19's primary physician of R19 and R19's family concerns, including R19's antibiotic and its susceptibilities (sensitivity of bacteria specific antibiotics determined through testing methods that was to guide effective treatment options). 7) 10/24/25 at 8:56 a.m., nursing staff left voicemail was sent to R19's primary physician to review fax that was sent the day prior. 8) 10/24/25 at 6:17 p.m., R19 returned from appointment along with family member with new order to start cephalexin 500 mg twice a day for 7 days. R19 was to take one dose on Friday evening with food and encourage water intake. From 10/25/25 to 10/28/25 lacked an indication of an assessment to determine if the antibiotic was effective.Review of 10/28/25 Hospital & Clinic (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	emergency room note identified that R19 was treated with cephalexin antibiotic medication related to UTI. R19's urine culture on 10/24/25 showed less than 10,000 colony-forming units (CFM) per milliliter (ml) of mixed bacteria growth and identified a true bladder infection was unlikely. R31Review of August 2025 infection log identified that R35 was to take cephalexin (antibiotic) 500 mg three times a day for urinary tract infection with a start date of 8/31/25 for a total of 15 administrations of the antibiotic. The log lacked indication of an end date of the antibiotic and f a urine culture was obtained. The log identified that R35 met criteria to be treated with the antibiotic. On 9/01/25, R31 was to take cefdinir (antibiotic) 300 mg twice a day for 5 days with a start date of 9/05/25 and an end date of 9/10/25. The log identified R19's urine culture was noted to be negative and met criteria to be treated with the antibiotic. Review of R31 progress notes identified on:1) 8/31/25 at 6:23 p.m., R31 had increased difficulty in standing from a fall and was sent to the local hospital for an evaluation.2) 8/31/25 at 11:59 p.m., local hospital informed nursing staff was to send R31 back to the facility tonight and had evidence of a UTI and was to start of cephalexin. A urine culture was ordered and R31's white blood cell count (WBC) was 15 (normal range of WBC was 4,500- 11,000). R31's imaging results came back negative with no acute findings.3) 9/01/25 at 2:21 a.m., identified R31 arrived back to the facility at 12:30 a.m., with orders for cephalexin 500mg three times a day for acute cystitis (infection of the bladder caused by E. coli) with hematuria (presence of blood in the urine).4) 9/01/25 at 6:52 a.m., R31 had received 1st dose of cephalexin 500mg that was pulled from the emergency kit (Ekit).4) 9/04/25 at 11:14 a.m., identified R31 was readmitted to the local hospital and returned to the facility with diagnosis of a fracture and new orders to start cefdinir 300mg twice a day for 5 days for UTI.5) 9/06/25 at 11:35 p.m., 9/07/25 at 3:32 p.m., and 9/08/25 at 2:48 p.m., identified R31 had a UTI and was currently on antibiotics. However, the progress notes lacked an indication of an assessment to determine if the antibiotic was effective.Interview on 1/08/2026 at 9:57 a.m., with interim administrator (former director of nursing (DON), who was the infection preventionist (IP) identified facility nursing staff who worked on the evenings, who had not obtained IP training or certification, was assigned to update and maintain resident surveillance logs monthly. The process was for nursing staff to identify resident symptoms to rule out potential illness. If an illness was to occur, nursing staff was to use the McGeer criteria (a template used to identify infections) that was accessible to nursing staff on the units. A call was to be placed to the resident's primary provider to obtain a specimen. The specimen was collected and sent for testing and antibiotics were ordered for the resident, depending on their symptoms. Medication administration was given, and an antibiotic timeout or assessment was to be completed by the nursing staff within the 48-to-72-hour timeframe. The local pharmacy was to send reminders to the facility of a pending antibiotic assessment; however, it was not done consistently. IP acknowledged the surveillance logs were not monitored on a consistent basis and found the logs had discrepancies to identify indication of antibiotic use. She acknowledged her oversight as the IP was not up to her standards and to was implement a process to ensure compliance with the infection control program. Review of Alixa RX Antibiotic Stewardship Program Addendum to Clinical Pharmacist Service Agreement identified the company was to render a clinical pharmacist to perform a review of antibiotics issued on site, review supporting lab work, to serve on an infection control committee on a quarterly basis, provide and conduct, when request by the facility annual education in-service sessions, appropriate educational material related to antibiotic stewardship, including annual updates to policies/procedures with supporting documentation, regular evaluation of facility antibiotic utilization of trends and missed opportunities to facility leadership. In addition, reports were to be sent in writing, may be sent electronically for any irregularities when appropriate. Review of July 2025 Antibiotic Stewardship Policy identified the facility was to promote appropriate use of antibiotics to treat infections and reduce advents events associated with antibiotic use. The facility administration was to identify a lead to be responsible for the program oversight. Leadership was to communicate annually with nursing staff and clinicians to antibiotic stewardship and expectations of the nursing home enforcement of antibiotic stewardship policies. At minimum the (continued on next page)

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