STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245632	A. Building B. Wing	05/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Therese of Woodbury LLC	7555 Bailey Road Woodbury, MN 55129

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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to ensure safe use of a wheelchair without foot pedals and added cushions was assessed for 1 of 2 residents (R28) reviewed for falls. This resulted in actual harm when R28 fell from the wheelchair during transport, sustained a right leg fracture and required hospitalization. The facility had implemented actions to prevent recurrence prior to survey on 5/26/26, therefore the citation was issued at past noncompliance. Furthermore, the facility failed to provide supervision with meals for 1 of 1 resident (R61) reviewed for nutrition. Findings include: R28's quarterly Minimum Data Set (MDS) dated [DATE], identified that R28 was cognitively intact and had diagnoses of peripheral vascular disease, hallucinations, fractures of the second and third lumbar vertebrae, heart failure, obesity, muscle weakness, and osteoarthritis. The MDS further identified that R28 was dependent on staff for transfers and mobility and was transported in a wheelchair. R28's activities of daily living (ADL) Care Area Assessment (CAA), dated 9/7/25, identified that R28 required extensive assistance with upper and lower body dressing and rolling in bed. R28 was dependent on staff for footwear management, sit-to-lying and lying-to-sit transitions, sit-to-stand activities, and chair-to-bed transfers. R28's fall CAA dated 9/7/26, indicated R28 was at risk for falls related to a history of falls, high risk medications and weakness. R28's care plan dated 3/19/26, identified the following: -R28 had an ADL deficit. Interventions included R28 did not ambulate, required assistance from two staff members for bed mobility, bathing, and toilet hygiene. R28 required a mechanical lift with assistance from two staff members for transfers. -R28 was at risk for falls related to a history of falls, wheelchair dependence, oxygen tubing, increased weakness, incontinence, and increased assistance needs with mobility. Interventions included use of safe footwear, maintaining the bed in the lowest position, and ensuring the call light remained within reach. R28's care plan lacked intervention or instruction regarding foot pedal use or the placement of cushions in the wheelchair. A nursing progress note dated 5/15/26 at 1:59 p.m., indicated R28 fell forward from the wheelchair while being pushed down the hallway to the weight room. R28 landed on the floor on their right side. R28 had abrasions to the right forehead and right knee and complaints of right leg pain. (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 0689 Level of Harm - Actual harm Residents Affected - Few	A nursing progress note dated 5/15/26 at 2:32 p.m., indicated R28 was transported by emergency medical services at approximately 11:30 a.m. due to the fall with right-sided pain. R28's fall incident report dated 5/15/26, indicated she was transferred to the emergency room, had an x-ray which indicated fracture of the right distal femur (upper leg), she was admitted for surgery. The root cause indicated R28 was being pushed in the wheelchair and fell out. R28's medical record lacked indication R28 had been assessed for cushion use in her wheelchair. R28's medical record lacked indication R28 refused foot pedal use during transport or an assessment for safe wheelchair transportation with no foot pedals. During an interview on 5/28/26 at 9:18 a.m., Nursing Assistant (NA)-B stated that R28 disliked the foot pedals and often refused to use them. NA-B stated that R28 could hold her legs up during transport. NA-B further stated footrests were not required for residents who propelled themselves; however, R28 was unable to self-propel. During an interview on 5/28/26 at 9:37 a.m., Licensed Practical Nurse (LPN)-C stated she was on duty at the time of R28's fall. LPN-C reported hearing a thud and finding R28 on the floor lying on her right side. LPN-C performed neurological checks, range-of-motion assessments, and vital sign monitoring. LPN-C stated that NA-G had been pushing R28 in the wheelchair, the foot pedals were resting on R28's lap, and a cushion had been positioned behind R28's back. LPN-C stated R28 could not self-propel and required foot pedals for support. LPN-C further stated that the additional cushions required an evaluation for safety before use. During an interview on 5/28/26 at 10:06 a.m., Physical Therapist (PT)-A stated the assessment for footrest use was based on leg strength. PT-A stated R28 could hold her legs elevated during transport and reported observing R28 perform this task without difficulty. PT-A acknowledged performing strength assessments but stated there was no documentation demonstrating that R28 had been assessed for the safe transport without using foot pedals. PT-A also verified R28's medical record lacked documentation regarding R28's refusal of foot pedals and any associated risks or benefits. During an interview on 5/28/26 at 10:38 a.m., NA-G stated he was pushing R28 to the weight room while carrying her oxygen tank. He stated the foot pedals were on R28's lap and R28 lifted her legs during transport. NA-G reported a cushion approximately four inches thick had been positioned in the wheelchair behind R28's back. NA-G was unaware if the cushion had been assessed or approved for wheelchair use. NA-G verified there were no instructions in the electronic medical record regarding the use of cushions or foot pedals. NA-G further stated the foot pedals were in R28's lap so they could be put on after obtaining her weight to transport to the beauty salon. During an interview on 5/28/26 at 11:59 a.m., the Director of Nursing (DON) stated the facility did not have a specific policy regarding foot pedal use. The DON stated that cushions placed in wheelchairs should comply with manufacturer recommendations and that any modification to the wheelchair needed to be evaluated for safety. The DON further stated the facility's investigation for R28's fall identified both decreased seating space and the absence of foot pedals as contributing factors to the fall. During an interview on 5/28/26 at 12:22 p.m., Family Member (FM)-B stated she had not witnessed the incident. FM-B reported being informed that R28 had been transported without foot pedals while (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	being taken to be weighed and then to the beauty salon. FM-B stated that R28 occasionally did not use foot pedals and could hold her legs up. However, she had been told that during this incident R28's right foot dropped to the floor, causing R28 to fall forward from the wheelchair. FM-B stated that R28 required surgery to the right leg and was still in the intensive care unit and required ventilator (breathing) support. FM-B stated she had provided the cushion from home because R28 complained of back discomfort. FM-B stated that R28 sat on one cushion and had another cushion positioned behind her back. During a follow up interview on 5/28/26 at 3:05 p.m., PT-A stated he was unaware of the origin of the cushion and had not assessed its safety for wheelchair use. PT-A did not document any assessment or discussion regarding the cushion in the medical record. During an interview on 5/28/26 at 3:05 p.m., the Rehabilitation Manager (DRS) stated assessment for foot pedal use was based on the resident's ability to perform lower body dressing tasks. DRS acknowledged that R28 was unable to self-propel. DRS stated that R28 reportedly refused foot pedals because they were uncomfortable. However, verified R28's medical record lacked documentation of assessment, care plan, or interventions addressing foot pedal use. During an interview on 5/28/26 at 3:31 p.m., Registered Nurse (RN)-H stated that cushions or pillows should not be added to wheelchairs without a safety assessment. RN-H stated that when a resident refused foot pedals, staff should assess the situation, notify the provider, obtain appropriate orders, and implement interventions through the care plan and Kardex. During an interview on 5/28/26 at 3:57 p.m., Nurse Practitioner (NP)-B stated residents should be assessed before cushions were added to wheelchairs and any modification to an assistive device required a safety evaluation. NP-B stated foot pedals resting on a resident's lap constituted improper use and that foot pedals should remain attached to the wheelchair to reduce the risk of injury and falls. NP-B stated that the improper use of foot pedals and lack of safety assessment for the cushion use were factors that contributed to R28's fall. During a follow up interview on 5/29/26 at 9:26 a.m., the DON expected cushion use in wheelchairs to be assessed and approved for safety prior to use. The DON stated that cushions could alter seating position, reduce available seating space, and could shift the resident's center of gravity, and increase the risk of falls and injuries. Furthermore, DON expected any refusals to be documented and to be for interventions or education to be care planned. The facility policy titled Use of Assistive Devices, dated 1/26, stated that assistive devices were to be used consistently and appropriately based on the resident's comprehensive assessment and implemented in accordance with the resident's care plan. The past noncompliance began on 5/15/26. The deficient practice was corrected by 5/22/26, and prior to survey after the facility implemented a systemic plan that induced the following actions: immediate education on use of leg rests when transporting residents in wheelchairs and modification of wheelchairs from cushions or pillows for all NA's and nurses, health unit coordinators, managers and directors, an audit of residents who use wheelchairs for mobility to determine their ability to self-propel and when leg rests should be used, and an audit of wheelchairs used for residents to determine if cushions or other modifications were assessed for safe use. Observations of safe wheelchair transports were observed during survey, and staff education, audits, and care plans reviewed to determine compliance. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	R61 R61's admission MDS was in progress. R61's hospital Discharge summary dated [DATE], identified on 5/20/26, R61 had an episode of shortness of breath, oxygen was required, and a chest x-ray was obtained to see if he aspirated. R61 would discharge to a transitional care unit (TCU) and discharge orders for swallowing instructions identified full supervision and assistance with all PO (by mouth). R61's hospital progress notes dated 5/22/26, identified the chest x-ray for questionable aspiration was negative for any infiltrate. Plan was to monitor. R61's facility nursing admission assessment dated [DATE], identified a diagnosis of unstable fracture of the first cervical vertebra. R51 was alert and oriented to person, place, time and situation and always required an Aspen collar (rigid orthotic device worn around the neck to immobilize the cervical spine) on due to cervical fracture. No mealtime supervision was identified. R61's facility diet order dated 5/23/26, identified full supervision and assistance with all PO. R61's facility activities of daily living (ADL) care plan dated 5/23/26, identified set up and clean up assistance was required for eating. No mealtime supervision was identified. R61's Kardex (nursing assistant care guide with interventions pulled from the care plan) printed 5/26/26, identified set up and clean up assistance was required for eating. No mealtime supervision was identified. R61's facility diet order had not been pulled into the care plan or the Kardex for staff to be aware of the order. R61's facility speech language pathologist (SLP) recommendations progress note dated 5/26/26 at 9:53 a.m., identified resident must be supervised during oral intake due to aspiration risk. R61's Point of Care (POC) charting dated 5/23/26 through 5/26/26, identified no mealtime supervision was provided. During an observation on 5/26/26 at 12:06 p.m., R61's was not in his room, and his lunch was on the tray table in his room. At 12:07 p.m., physical therapist (PT)-B brought R61 into his room, moved the bedside table in front of him and set up his meal. PT-B placed an instruction sheet in front of R61 which identified: Sit upright while eating and drinking Eat at a slow rate Take one small bite at a time and chew well Wash down every bite with a small drink Swallow multiple times for each bite drink (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Brush teeth after meals No mealtime supervision was identified. During an observation and interview on 5/26/26 at 12:11 p.m., R61was seated in his wheelchair with his Aspen collar on. He stated he broke his neck and had some trouble swallowing now. They thought he aspirated in the hospital, but he was not sure if he had, so the instruction sheet provided him with some safe swallowing techniques. R61 was asked if he wanted to eat in the dining room and he said it did not matter to him. R61 began to eat his meal. The way R61 was seated in his room, he was not visible to anyone walking past his room due to being seated closer to the bathroom and not in the entrance hallway to his room. A continuous observation started at this time. -At 12:34 p.m., several intermittent unidentified staff walked past the room, no one had gone in to provide supervision. -At 12:46 p.m., no staff entered the room to provide supervision. Several staff in scrubs continue to walk past the room and no one has gone in to provide supervision. -At 12:48 p.m., NA-C walked past R61's room. When asked, she stated most of the residents eat their meals in their rooms and she was not aware of anyone with risk of aspiration or who required supervision during meals. NA-C stated the nurse would tell the NA's residents which needed supervision. NA-C verified on R61's Kardex that he did not require supervision during meals. -At 12:53 p.m., surveyor entered R61's room. He had eaten half of a taco, his side dish. R61 stated he could not remember if anyone told him he needed mealtime supervision. -At 1:02 p.m., NA-D walked past R61's room. When asked she stated R61 ate breakfast independently in his room this morning. NA-D stated the nurse would tell the NA's which residents needed supervision during meals and she was not aware of anyone with this requirement. Supervision was defined as someone close by that could see the resident. NA-D stated R61 was independent with eating in his room. -at 1:09 p.m., SLP walked past R61's room and the continuous observation ended. When asked she stated R61's facility admission orders had not identified supervision with meals, and she added that to the order. She stated she would send an email with any orders to the nursing staff and try to update the NA's verbally on the mealtime supervision, however, had not done that right away as she had another patient appointment to get to. After nursing received the email, they would update the resident plan of care. SLP stated supervision meant R61 should eat in the commons area, out of his room) where staff could supervise due to his risk of choking. Ideally, the order would be implemented immediately. During a follow up observation on 5/26/26 at 5:40 p.m., R61 was in the dining room for his meal with staff supervision. During an interview on 5/26/26 at 5:43 p.m., NA-E stated she was updated by the nurse that R61 required mealtime supervision in the dining room. She would also consult the Kardex for resident care questions. During an interview on 5/26/26 6:03 p.m., registered nurse (RN)-B stated admission orders were (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	verified by two nurses and reviewed by the supervisor. During an interview on 5/26/26 at 6:06 p.m., RN-C stated admission orders were verified by two nurses. During a follow up interview on 5/27/26 at 9:01 a.m., NA-B stated yesterday R61's Kardex had not identified the order for mealtime supervision, however, today the Kardex was updated and the nurse updated her as well, that R61 required mealtime supervision out in the commons area in the dining room where he could be watched. During a follow up interview on 5/27/26 at 9:10 a.m., NA-C stated she was updated by the nurse that R61 required mealtime supervision and needed eyes on him during eating such as in the dining room. R61 should not have meals in his room unsupervised. During an interview on 5/27/26 at 10:57 a.m., RN-E stated she entered R61's admission orders. The root cause of staff not being aware of the mealtime supervision order from the hospital was because the way the order was entered, it did not pull through to the Kardex or care plan so staff could be aware. RN-E stated she would expect orders to be entered in a way that is visible to the staff caring for the residents. RN-E stated there could be a risk of choking because R61's order was not entered correctly. During an interview on 5/27/26 at 10:31 a.m., RN-A stated she was the manager and would review admission orders, history and physicals, and update the care plan within 72 hours and ensure accuracy. RN-A verified R61's hospital orders for mealtime supervision due to risk of aspiration. RN-A verified R61's facility admission assessment lacked indication for mealtime supervision, therefore that intervention had not pulled into the care plan or Kardex for staff to be aware. RN-A verified the order should have been entered in the computer in a way that the staff caring for the residents were aware of the mealtime supervision, the way the order was entered into the medical record was not initially correct. During an interview on 5/27/26 at 11:57 a.m., license practical nurse (LPN)-B stated she helped enter R61's admission orders. For residents that require mealtime supervision, that should pull through on the toe treatment administration record (TAR), care plan and Kardex. LPN-B was not aware of any issues with the order transcription yet. LPN-B stated she was not able to observe R61 at mealtimes when he was admitted , and that he ate his evening meal in his room without supervision. During an observation on 5/27/26 at12:19 p.m., R61 was seated in the dining room with supervision for his noon meal. During an interview on 5/27/26 at 12:20 p.m., R61's family member (FM)-A stated while in the hospital R61 had swallowing issues because of his neck fracture and having to wear the Aspen collar during meals. FM-A stated it was hard to eat when a person cannot open their mouth all the way. During an interview on 5/27/26 at 1:37 p.m., the DON stated two nurses would check admission orders for accuracy. Mealtime supervision orders should be entered in a way they pull through to the care plan and Kardex so the staff caring for the residents would be aware. After the SLP noticed the order transcription error, she updated nursing and the order was corrected. The DON stated the way the order was initially entered, not all staff could see it clearly. The DON stated he expected orders to be entered correctly and to reach the appropriate staff caring for the residents. The DON stated R61 (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	would potentially be at risk of choking without mealtime supervision. During an interview on 5/27/26 at 2:19 p.m., R61's NP-A stated he was at moderate to high risk of aspiration since he had an order for full supervision at mealtimes. NP-A stated when she did her admission visit with R61 on 5/26/26, he had no respiratory concerns, and she noted he was eating 50-100% of his meals. NP-A stated his choking risk was related more so to the Aspen collar needing to be on at mealtimes. He has been eating 50-100%. NP-A stated she would expect admission orders to be entered accurately. The facility's Meal Supervision and Assistance policy dated 1/2026, identified the resident will be prepared for a well-balanced meal in a calm environment, location of his / her preference and with adequate supervision and assistance to prevent accidents, provide adequate nutrition, and assure an enjoyable event.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to ensure that a resident's call light was accessible and within reach while the resident was in the shower for 1 of 1 resident (R47) reviewed for call light accessibility. This failure had the potential to impact all residents who use the shower. Findings include:R47's quarterly Minimum Data Set (MDS), dated [DATE], identified that R47 was cognitively intact and had diagnoses of hemiplegia and hemiparesis (severe or complete paralysis of one side of the body) following a cerebral infarction (stroke) affecting the left non-dominant side, heart failure, abnormalities of gait and mobility, and muscle weakness. The MDS further identified R47 had required maximal assistance with showering and toilet hygiene.R47's care plan, dated 9/5/25, identified that R47 had experienced an activity of daily living (ADL) self-care performance deficit. Interventions included assistance from one staff member with showering and toilet hygiene. Additionally, the ADL fall-risk interventions included ensuring the call light was within reach.During an observation and interview conducted on 5/27/26 at 12:14 p.m., R47 stated he had been seated in a shower chair while the water had been running. An unidentified nursing assistant (NA) had received a call on a walkie-talkie and had left R47's room. R47 stated that the bathroom call light box was located across the room next to the toilet. R47 was unable to reach the call light cord and had not been able to contact staff or call for help if necessary. Observation of R47's bathroom confirmed the placement of the call light box and the resident's inability to call for assistance while in the shower.During an interview conducted on 5/28/26 at 9:29 a.m., NA-B stated that residents used their call lights if they had experienced an issue. She stated that there had not been a call light available in the shower and that residents had not been left alone while showering. She further stated that it had never been acceptable to leave the room while a resident had been taking a shower.During an interview conducted on 5/28/26 at 9:48 a.m., licensed practical nurse (LPN)-C stated that staff had never been permitted to leave a resident unattended in the shower. She stated that residents had not been able to use the call light due to the location of the call light box next to the toilet.During an interview conducted on 5/28/26 at 11:52 a.m., the Director of Nursing (DON) stated that the expectation for staff had been to never leave a resident unattended while in the shower. The DON stated that, following installation of the new call light system, the call light box had been moved to the wall next to the toilet to provide easier access for residents while using the facilities. However, there had no longer been a call light box or cord accessible while a resident had been in the shower. The DON stated it was important for residents to have access to a call light to alert staff to any issue, emergency, or need.The policy titled Call Light Accessibility and Timely Response, dated January 2026, directed that the facility had been adequately equipped with a call light at each resident's bedside, toilet, and shower/bathing facility to allow residents to call for assistance.

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review, the facility failed to ensure dignity was preserved for 1 of 1 resident (R50) reviewed for dignity.Findings include: R50's quarterly Minimum Data Set (MDS) dated [DATE], identified intact cognition with a BIMS (Brief Interview of Mental Status) score of 15 out of 15. His hearing was adequate without hearing aids and speech was clear. R50 required partial/moderate assist from staff for toileting hygiene. He was occasionally incontinent of urine and always continent bowel. No toileting program was in place. Diagnoses included arthritis, non-Alzheimer's dementia, and anxiety. R50's Care Area Assessment (CAA) dated 6/30/25, identified he was at risk for incontinence due to dementia, diabetes, congestive heart failure and diuretic medication use. R50's toileting care plan dated 11/11/25, identified he may self-toilet during the day and requires minimum assist of one in the evening and overnight. The care plan had not mentioned a preference to have his adult incontinence briefs called diapers. R50's nursing progress notes dated 6/30/25 through 5/27/26, had not mentioned a preference to use the term diaper in conversation. During an observation at 5/28/26 at 8:30 a.m., R50 was in the public hallway walking with physical therapist (PT)-A. PT-A stated to R50, it looks like your diaper is sagging. A visitor walked by at the same time. R50 stated he thought so also. During an interview on 5/28/26 at 9:53 a.m., R50 stated he walked with PT earlier in the morning today. and that his brief was bunched up. R50 verified PT-B called his brief a diaper, and that it had not really bothered him. R50 agreed that he would rather have discussions in privacy rather than in the hallway, especially about his undergarments.During an interview on 5/28/26 at 9:55 a.m., nursing assistant (NA)-A stated he worked with R50 often. R50 would sometimes call his own undergarments diapers however staff would respond using the term briefs because diaper could be a demeaning term to say to an adult. During an interview on 5/28/26 at 10:00 a.m., PT-A stated he worked with R50 this morning and verified he called R50's brief a diaper. PT-A stated R50 used the word diaper before so he thought it was okay. PT-B stated a more dignified term would be to call incontinence briefs a pad. During an interview on 5/28/26 at 10:32 a.m., NA-C stated she worked with R50 routinely. R50 would sometimes call a brief a diaper however staff should respond using the term briefs and would not talk about a resident's incontinence products in a public area. During an interview on 5/28/26 at 10:55 a.m., the director of rehabilitation services (DRS) stated she would not expect staff to talk about an adult's incontinence products in a publica area and the term diaper could be undignified.The facility's Promoting/Maintaining Resident Dignity policy dated 10/2022, identified the facility would protect and promote resident rights and treat each resident with respect and dignity as well as care for each resident in a manner and in an environment, that maintains or enhances resident's quality of life by recognizing each resident's individuality.

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	245632	A. Building B. Wing	05/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Therese of Woodbury LLC	7555 Bailey Road Woodbury, MN 55129

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 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 ensure provider orders were transcribed accurately into the electronic medical record (EMR) for 2 of 2 residents (R25,R61) and failed to ensure verbal orders were received accurately for 1 of 1 resident (R15), for residents reviewed for order accuracy.Findings include: R25 R25's admission Minimum Data Set, (MDS) dated [DATE], indicated R25 had intact cognition, required substantial to maximal assistance for toileting, and was frequently incontinent of bowel and bladder. R25's diagnoses included displaced intertrochanteric fracture (broken hip) of the left femur, muscle weakness, displaced fracture of shaft of fourth metacarpal (finger) bone of right hand, and diarrhea. R25's care plan dated 4/23/26, indicated R25 was incontinent with bowel and bladder and had an ADL (activities of daily living) deficit related to diagnoses including diarrhea. The care plan indicated R25 required substantial/maximal assistance of 1 staff with toileting tasks. R25's admission order dated 4/16/26, indicated, loperamide 2 milligram (mg) capsule Commonly known as: IMODIUM Used for: Chronic diarrhea.Dose: 2-4 mg Take 1-2 capsules [2-4mg] by mouth 4 times daily as need for diarrhea. Additionally, Continue taking all home meds. R25's pharmacist's recommendation to prescriber dated 4/27/26, identified loperamide was ordered with a dose range of 2-4mg QID [four times a day] PRN [as needed] and recommended Clarification of Imodium Give 1 tablet PO [by mouth] PRN QID. R25's provider order dated 4/30/26, indicated, Loperamide HCl Oral Tablet 2 MG.Give 1 tablet by mouth every 6 hours as needed for diarrhea. R25's May 2026, medication administration record (MAR) indicated R25 was given Imodium once on 5/7, 5/8, 5/12, and 5/25. The MAR indicated R25 was given Imodium twice on 5/23; once at 2:12 p.m., and once at 8:46 p.m. R25's progress notes (PN) dated 5/23/26 at 2:12 p.m., indicated Imodium was given for diarrhea. PN at 3:55 p.m. indicated the administration of Imodium was ineffective. PN at 5:35 p.m. indicated R25 was having loose stool x 4 today. PN at 8:46 p.m. indicated R25 was given a dose of Imodium. PN at 10:37 p.m. indicated the administration of Imodium was effective. R25's provider visit note dated 5/18/26, identified in a review of systems (ROS) R25 had chronic diarrhea and required PRN Imodium. During interview on 5/26/26 at 12:32 p.m., R25 stated she suffered from bowel issues, had frequent diarrhea, and used Imodium regularly at home. R25 stated the staff here were stingy with Imodium and would only give it to her after two to three loose stool. R25 further stated the staff would make her wait after an initial dose was ineffective and cause her to experience several more episodes of loose stool. R25 stated at home she took the medication per the instructions on the package which instructed to take two tablets after the first episode of diarrhea and then one tablet if ineffective with a maximum of four doses a day. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 5/27/26 at 10:10 a.m., nurse practitioner (NP)-A stated R25 was admitted with an order for a range dose for Imodium of 2-4 mg. NP-A stated dose ranges were not allowed in long term care facilities. NP-A further stated she wrote a new order for clarification for R25 to have one 2mg tablet as needed for diarrhea and that she could have that up to four times a day. During interview on 5/27/26 at 1:05 p.m., licensed practical nurse (LPN)-A stated if medication was ordered every six hours as needed, the resident would have to wait five to six hours in between doses. LPN-A stated if a medication was ordered four times a day. LPN-A stated that in the case a PRN medication was administered and was ineffective, a second dose could be given without waiting a specific amount of time. During follow up interview on 5/27/26 at 2:20 p.m., NP-A stated the Imodium was ordered as QID and should have been entered into R25's MAR accurately so that if the first dose was ineffective, a second dose could be given right away and not have to wait six hours. During interview on 5/27/26 at 2:31 p.m., registered nurse (RN)-A stated would expect orders would be entered as written. If the order was for QID should not have been entered as every six hours. During interview on 5/28/26 at 11:09 a.m., health unit coordinator (HUC) stated was initially taught to enter orders with a specific timeframe and was not aware that four times a day could be used. R61 R61's admission MDS was in progress. R61's hospital Discharge summary dated [DATE], identified on 5/20/26, R61 had an episode of shortness of breath, oxygen was required, and a chest x-ray was obtained to see if he aspirated. R61 would discharge to a transitional care unit (TCU) and discharge orders for swallowing instructions identified full supervision and assistance with all PO (by mouth). R61's hospital progress notes dated 5/22/26, identified the chest x-ray for questionable aspiration was negative for any infiltrate. R61's facility nursing admission assessment dated [DATE], identified a diagnosis of unstable fracture of the first cervical vertebra. R51 was alert and oriented to person, place, time and situation and always required an Aspen collar (rigid orthotic device worn around the neck to immobilize the cervical spine) on due to cervical fracture. No mealtime supervision was identified. R61's facility diet order dated 5/23/26, identified full supervision and assistance with all PO. R61's facility activities of daily living (ADL) care plan dated 5/23/26, identified set up and clean up assistance was required for eating. No mealtime supervision was identified. R61's Kardex (nursing assistant care guide with interventions pulled from the care plan) printed 5/26/26, identified set up and clean up assistance was required for eating. No mealtime supervision was identified. R61's facility diet order had not been pulled into the care plan or the Kardex for staff to be aware of the order. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R61's facility speech language pathologist (SLP) recommendations progress note dated 5/26/26 at 9:53 a.m., identified resident must be supervised during oral intake due to aspiration risk. R61's Point of Care (POC) charting dated 5/23/26 through 5/26/26, identified no mealtime supervision was provided. During an observation on 5/26/26 at 12:06 p.m., R61's was not in his room, and his lunch was on the tray table in his room. At 12:07 p.m., physical therapist (PT)-B brought R61 into his room, moved the bedside table in front of him and set up his meal. PT-B placed an instruction sheet in front of R61 which identified: Sit upright while eating and drinking Eat at a slow rate Take one small bite at a time and chew well Wash down every bite with a small drink Swallow multiple times for each bite drink Brush teeth after meals. No mealtime supervision was identified on the instruction sheet. During a continuous observation on 5/26/26 from 12:11 p.m. through 1:09 p.m., R61 ate his lunch in his room, and no staff had supervised his intake. During an interview on 5/27/26 at 10:57 a.m., RN-E stated she entered R61's admission orders. The root cause of staff not being aware of the mealtime supervision order from the hospital was because the way the order was entered, it did not pull through to the Kardex or care plan so staff could be aware. RN-E stated she would expect orders to be entered in a way that is visible to the staff caring for the residents. RN-E stated there could be a risk of choking because R61's order was not entered correctly. During an interview on 5/27/26 at 10:31 a.m., RN-A stated she was the manager and would review admission orders, history and physicals, and update the care plan within 72 hours and ensure accuracy. RN-A verified R61's hospital orders for mealtime supervision due to risk of aspiration. RN-A verified R61's facility admission assessment lacked indication for mealtime supervision, therefore that intervention had not pulled into the care plan or Kardex for staff to be aware. RN-A verified the order should have been entered in the computer in a way that the staff caring for the residents were aware of the mealtime supervision, the way the order was entered into the medical record was not initially correct. During an interview on 5/27/26 at 11:57 a.m., LPN-B stated she helped enter R61's admission orders. For residents that require mealtime supervision, that should pull through on the toe treatment administration record (TAR), care plan and Kardex. LPN-B was not aware of any issues with the order transcription yet. LPN-B stated she was not able to observe R61 at mealtimes when he was admitted , and that he ate his evening meal in his room without supervision. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/27/26 at 2:19 p.m., R61's nurse practitioner (NP)-A stated he was at moderate to high risk of aspiration since he had an order for full supervision at mealtimes. NP-A stated when she did her admission visit with R61 on 5/26/26, he had no respiratory concerns, and she noted he was eating 50-100% of his meals. NP-A stated his choking risk was related more so to the Aspen collar needing to be on at mealtimes. He has been eating 50-100%. NP-A stated she would expect admission orders to be entered accurately. R15 R15's admission MDS dated [DATE], indicated moderately impaired cognition, a diagnosis of atrial fibrillation (A-fib, irregular heartbeat), and received an anticoagulant (blood thinner) medication on a routine basis. R15's after visit summary (AVS) dated 3/24/26, indicated R15 was to start taking apixaban (anticoagulant medication) 5 milligram (mg) tablet for diagnosis of A-fib. Take 1 tablet by mouth 2 times daily. R15's physician's order (taken verbally by registered nurse (RN)-F and written in the physician's order book (white) at the nurse's station) dated 4/30/26, indicated apixaban oral tablet 2.5 mg by mouth two times a day with a diagnosis of weight loss. R15's physician's orders in the electronic medical record (EMR) indicated on: -4/30/25, apixaban oral tablet 2.5 mg. Give 2.5 mg by mouth two times a day for weight loss. -3/28/26, monitor R15's weight. If her weight falls below 60 kilograms (kg) or 132 pounds (lbs.), reduce apixaban to 2.5 mg twice a day, every shift (day) and notify the provider. R15's care plan dated 3/28/26, indicated R15 was receiving anticoagulant therapy related to A-fib with the following interventions: -staff will monitor for signs/symptoms of thromboembolism. Report if evident: pain or tenderness and swelling of arm/leg; increased warmth, edema and/or redness of affected extremity, unexplained shortness of breath; chest pain, or coughing, -hemoptysis (spitting up blood) -feeling of anxiety or dread. During interview on 5/27/26 at approximately 11:00 a.m., RN-D verified the original order for apixaban was prescribed on 3/24/26, for the diagnosis of A-fib and on 4/30/26, there was a new verbal order (from NP-A) to decrease the dose to 2.5 mg and that's when the diagnosis changed to weight loss. During interview on 5/27/26 at 12:58 p.m., RN-A stated when a resident was admitted or returned with new orders, the admissions coordinator would usually enter them and then a nurse was required to verify those orders. If there was a discrepancy, or clarification was needed, the NP would let the prescribing provider know and then the NP would make the changes to the order. RN-A stated apixaban was not used to treat weight loss and someone with nursing knowledge should know that would not be an appropriate diagnosis. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 5/28/26 at 8:50 a.m., NP-A stated R15 was prescribed apixaban for A-fib on 3/24/26, and then she reduced the dose on 4/30/26, due to her having weight loss. NP-A further stated, she wasn't sure if she had given the order verbally or if she had written it in the book herself and would need to check to see if it was her handwriting, but the indication shouldn't have changed stating Everyone knows you don't prescribe apixaban for weight loss. During interview on 5/28/26 at 11:00 a.m., RN-F stated the process for receiving verbal orders was to write the order in the white book in the nurse's station and then read the order back to the physician for clarification. Then the nurse should then enter the order into the EMR, and then it had to be verified by another nurse. During interview on 5/28/26 at 11:22 a.m., RN-G stated the process for receiving verbal orders from the physician was to write them in the book (white book in the nursing station). If the order was from the on-call physician, the nurses were also required to indicate who the resident's primary physician was, and the RN's name who was transcribing the order. If the order was something that needed to be addressed immediately, the nurse would enter the order and have another nurse verify it. If it was an order that didn't need to be addressed right away, the health unit coordinator (HUC) would enter the order and then a nurse was required to verify it. RN-G further stated all nurses who received verbal orders from the physician were required to read the order back to them for clarification. During an interview on 5/27/26 at 1:37 p.m., the director of nursing (DON) stated two nurses would check admission orders for accuracy. Mealtime supervision orders should be entered in a way they pull through to the care plan and Kardex so the staff caring for the residents would be aware. After the SLP noticed the order transcription error, she updated nursing and the order was corrected. The DON stated the way the order was initially entered, not all staff could see it clearly. The DON stated he expected all resident orders to be entered correctly and to reach the appropriate staff caring for the residents. Facility policy Medication Orders dated January 2026, indicated medication orders must have several elements including but not limited to, dose-strength, time or frequency of administration, diagnosis or indication for use, and condition for which being administered if PRN. The policy further indicated orders must be entered into the electronic health record orders must be transcribed on the MAR or treatment record and ensure the order was on the electronic MAR.