STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245635	A. Building B. Wing	12/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Johns on Fountain Lake	1771 Eagle View Circle Albert Lea, MN 56007

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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, interview and document review, the facility failed to ensure dishwasher water temperatures in 3 of 3 neighborhood kitchens were monitored to ensure proper sanitization of dishes. In addition, the facility failed to ensure metal pans in the main kitchen were dry before storing. This had the potential to affect all 77 resident who resided in the facility. Findings include:During the initial kitchen tour on 12/1/2025 at 10:55 a.m., dietary director (DD)-C, was asked to lift several metal pans and metal bowls of various sizes - all of which were stacked upside down on a wire shelving unit. Observed one wet 9 X 13-inch pan and three wet extra-large stainless bowls. DD-C stated staff were supposed to set wet dishes on a wire rack in clean side of the dish room to completely dry before storing. DD-C stated it was important to ensure no bacteria grew on the pans used to prepare and cook resident food. DD-C stated staff were trained to dry dishes completely before storing and did not know why that had not been done. During an observation and interview on 12/1/25 at 1:36 p.m., observed a dishwasher in operation in the neighborhood kitchen on third floor. Assistant cook (AC)-A and AC-B both stated there was no way to monitor the temperature of the water in the dishwasher - there was no temperature display on the outside of the dishwasher. During an interview and observation on 12/2/25 on 11:03 a.m., DD-C was in the neighborhood kitchen on third floor. DD-C stated the temperature of the water in the dishwasher was monitored by staff, who put an orange temperature strip in the dishwasher with each load. A small space on the orange strip turned from blue to orange when the water temperature reached 180 degrees. DD-C was informed some staff were not aware of that. DD-C provided a temperature log for November to show documentation of the results of the test strip. However, for November the temperature was documented 20 out of 60 potential times (morning and evening). Logs for September and October were blank. December had potential for logging the temperature on 12/1/25, but was blank.During an interview and observation on 12/2/25 at 11:07 a.m., with DD-C in the neighborhood kitchen on second floor, AC-C stated he was aware the orange strips should be used to verify temperature in the dishwasher and had a Ziploc bag of used strips, but strips were not dated to indicate verification. Neither AC-C nor DD-C could locate water temperature logs for September to December. During an observation and interview on 12/2/25 at 11:11 a.m., with DD-C in the neighborhood kitchen on first floor, AC-D provided a handwritten temperature log for November. Out of 60 possible temperature entries, only 23 temperatures were documented. For October, out of 62 possible temperature entries, 32 were documented. For September, out of 60 possible temperature entries, only 31 were documented. AC-D stated she utilized the orange strips and documented results on the log. At 11:15 a.m., DD-C stated she would need to re-educate staff, and that on 11/19/25, she had a training session with dietary staff called survey readiness and covered dishwasher temperatures. DD-C could not provide notes regarding specific training that had been covered (e.g., orange strips, documentation water temperatures, what do to if a strip doesn't change color). During an interview on 12/3/25 at 2:16, chief executive officer was informed of findings - wet pans and dish washer water temperatures not being monitored in the three neighborhood kitchens to ensure sanitization of dishes. No further information was offered or provided.Facility Cleaning Dishes/Dish Machine policy dated 2021, indicated all flatware, serving (continued on next page)

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

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

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	dishes, and cookware would be cleaned, rinsed and sanitized after each use. The dish machines would be checked prior to meals to assure proper function and appropriate temperatures for cleaning and sanitizing. Dishes should be air dried on the dish racks, not with towels. Inspect for cleanliness and dryness and put dishes away if clean. Dishes should not be nested unless completely dry. Facility Sanitation policy dated 2001, dishwashing machines were operated according to manufacturer's instructions. High temperature dishwashers wash temperature should be 150-160 degrees Fahrenheit (F), and rinse temperature 180 degrees F.

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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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review, the facility failed to ensure 1 of 1 resident (R19) who was observed to have medications in her room, had been appropriately assessed and deemed safe to self-administer medications.Findings include:R19's face sheet provided on 12/3/25, included diagnoses of fibromyalgia (chronic condition that involves widespread body pain), chronic pain syndrome, dry eye syndrome (chronic condition where eyes don't produce enough tears), irritable bowel syndrome (chronic disorder causing cramping, gas, constipation, diarrhea) with diarrhea, osteoporosis, bursitis (inflammation) of hips, and anxiety. R19's quarterly Minimum Data Set (MDS) assessment dated [DATE], indicated intact cognition, clear speech, could understand and be understood. R19 was independent with eating and oral care after set-up help. R19 required substantial assistance for mobility-related activities of daily living and did not walk.R19's physician orders that correlated to the over the counter (OTC) medications observed in R19's room included: --Order dated 5/15/25: Artificial Tears Ophthalmic Solution 1.4 % (used for dry eyes). Instill 1 drop in both eyes every 8 hours as needed for dry eyes. --Order dated 6/10/25: Imodium A-D, oral tablet 2 mg (used to treat diarrhea). Give 1 tablet by mouth as needed for loose stools, after each loose stool; use sparingly, can cause problems.--Order dated 7/8/25: Tucks External Pad (used to relieve discomfort of hemorrhoids). Apply to hemorrhoids topically every 4 hours as needed for hemorrhoid irritation.--Ordered dated 7/8/25: Anusol-HC External Cream 2.5 % (relieves pain associated with hemorrhoids). Apply to rectum/hemorrhoids topically as needed for hemorrhoid irritation QID (four times a day). Insert 1 application into rectum.R19's care plan dated 6/3/25, indicated R19 was not appropriate to self-administer medication. Care plan with revised date of 8/11/25, indicated R19 had acute and chronic pain and chronic pain syndrome. Staff were to evaluate the effectiveness of pain interventions, alleviating of symptoms, dosing schedules and resident satisfaction with results. Monitor/record/report to nurse resident complaints of pain or requests for pain treatment.During an observation on 12/1/25 at 1:30 p.m., observed various OTC medications on R19's overbed table, including:--Aspercreme, 2.7 oz (ounce) used for minor aches and pains.--Lidocaine 4% cream, 2.7 oz used to temporarily numb skin to relieve pain.--Preparation H, 2 oz, used to relieve pain and soreness of hemorrhoids.--Family Care brand eye drops 0.5 oz, used to relieve dry eyes.--Neosporin ointment, used to prevent minor skin infections.During an observation and interview on 12/3/25 at 11:00 a.m., medications remained present on overbed table. R19 stated she ordered the medications from Amazon. In addition to the OTC medications observed on 12/1/25, observed two Imodium Softgels in a blister pack, two Claritin (used to relieve allergy symptoms) tablets in blister packs, and one unidentified, small two-toned capsule not in packaging. R19 stated she used the Aspercreme and Lidocaine for pain by rubbing it on her skin; applied Neosporin to her outer right ear where she had a skin biopsy; used the eye drops for dry eyes - rarely; used the Imodium for diarrhea and Preparation H for comfort. R19 was unaware of the Claritin -- did not know why she had that and was unaware of what the small two-toned capsule was. During an interview on 12/3/25, at 11:04 a.m., licensed practical nurse (LPN)-A stated some residents could self-administer medications, but would first have to go through an assessment for safety and have a physician order. LPN-A looked in the electronic medical record (EMR) and stated R19 did not have an order for self-administration. LPN-A stated, The big thing is, a resident can't have medications in their room without a physician order. LPN-A stated R19's boyfriend brought her medications, and R19 didn't let us know about them. LPN-A stated it was important to let the physician know because he/she might not want the resident to take it. LPN-A stated she was unaware of OTC medications in R19's room. During an interview on 12/3/25 at 12:49 p.m., registered nurse (RN)-A, who was also the nurse manager on the unit in which R19 resided, stated R19's significant other was known to bring items into the facility for R19 without staff knowing. RN-A stated she would need to inform the physician and let him/her decide if it was safe for (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R19 to self-administer medication, adding they would need to look at potential medication interactions and allergies. RN-A stated nursing would need to conduct a self-administration assessment. RN-A looked in the EMR and verified R19 did not have a self-administration order. RN-A stated she did not know why staff had not noticed the medications on the overbed table. During an interview on 12/3/25 at 1:37 p.m., the director nursing (DON) stated nursing staff had informed her of these findings. The DON stated staff may be uncertain about residents bringing in their own medications versus prescription medications and would follow up with nursing staff to re-educate. The DON was aware residents could not have any medications in their room without a self-administration order and safety assessment. Facility Self-Administration of Medications policy with revised date of 12/25, indicated; Those residents who seek to self-administer medications will be assessed by a nurse using the Self Administration Assessment form. At that time, it will be determined whether the resident is qualified to safely self-administer. Self-administration will be allowed only for those residents who have expressed an interest to self-medicate, have demonstrated minimal cognitive, visual, and physical abilities as determined by the nurse, have a written nurse practitioner or physician's order allowing self-medication, have a secure area for storage of medication so that other residents do not have access. These medications were to be stored in the resident's locked cubby. All floor personnel (nursing assistants and nurses) should alert the nurse when they see a resident self-administer medications.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to ensure the care plan included management of CPAP (continuous positive airway pressure) for 1 of 3 residents (R24) reviewed for respiratory care. In addition, the facility failed to ensure a care plan was initiated after a trauma assessment identified history of Post Traumatic Stress Disorder for 1 of 1 resident (R27) who was reviewed for mood and behavior. Findings include: R24's face sheet provided on 12/3/25, included diagnoses of obstructive sleep apnea and dementia. R24's quarterly Minimum Data Set (MDS) assessment dated [DATE], indicated severe cognitive impairment, clear speech, was understood and could usually understand. R24 was dependent upon staff for most all activities of daily living and did not walk. R24's orders dated 3/5/25, indicated okay to use home settings on his CPAP machine every shift. Orders dated 3/8/25, indicated CPAP cleaning wash mask, nasal pillows, tubing and headgear, wipe off. Flow generator every day shift every Sunday. R24's orders did not include if or when to apply CPAP. R24's care plan did not indicate use of CPAP. During an interview and observation on 12/1/25 1:23 p.m., family member (FM)-B stated R24 wore CPAP at night, but it did not always stay on. FM-B was not aware if mask was cleaned. Observed only a small amount of water in bottom of CPAP reservoir. During an interview on 12/2/25 at 8:18 a.m., nursing assistant (NA)-G stated she did not know if R24 used his CPAP. NA-G stated nurses cleaned CPAP masks and filled the water reservoir, adding sometimes NAs would fill the reservoir. NA-G didn't know how often either was done. During an interview on 12/2/25 at 12:47 p.m., NA-E stated she did not think R24 wore his CPAP, adding his wife had said he did not. During an interview on 12/2/25 at 1:03 p.m., licensed practical nurse (LPN)-A stated she didn't know if R24 wore his CPAP. LPN-A stated either a nurse, or a NA cleaned the CPAP mask with soap and water once a week on Saturdays, and a nurse filled the reservoir with distilled water. LPN-A looked at R24's care plan and verified use of CPAP was not included on his care plan. During an interview on 12/2/25 at 1:23 p.m., registered nurse (RN)-A who was also the clinical care manager for the unit on which R24 resided, stated she wasn't sure if R24 wore his CPAP, adding she had heard at report he took it off. Looking in the electronic medical record (EMR), RN-A acknowledged there was not an actual order to assist R24 with applying CPAP at bedtime. RN-A acknowledged it would be important in order for nursing staff to be prompted to apply it and to document if R24 refused it. RN-A also acknowledged CPAP was not included on R24's care plan, stating it absolutely should have been. RN-A stated she had been responsible for adding CPAP to R24's care plan, stating she overlooked it. RN-A stated CPAP should have been care planned because it was an important part of R24's care. RN-A acknowledged not having CPAP on R24's care plan could lead to improper use of CPAP and improper cleaning of the equipment as there was no direction or guidance for staff, which (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	could result in a potential respiratory infection. During an observation on 12/3/25 at 7:00 a.m., R24 was supine in bed, eyes closed. Lights off. CPAP not on; mask and tubing draped over bedside table. During an observation and interview on 12/3/25 at 8:24 a.m., together with RN-A, went to R24's room and observed minimal water in bottom of both of the CPAP water reservoir. RN-A was not certain who was to monitor the level and add water. During an interview on 12/3/24, at 1:10 p.m., RN-A stated after doing some research, she learned CPAP masks should be cleaned daily (R24's was cleaned weekly), the remaining water in the reservoir should be emptied daily and the reservoir rinsed with warm water, which RN-A stated had not been done for R24. During an interview on 12/3/25 at 1:40 p.m., the director of nursing (DON) was informed CPAP had not been on R24's care plan, and while there had been some orders for maintaining the CPAP equipment, it did not cover all parts of the CPAP equipment. In addition, the DON was informed there had not been an actual order to apply CPAP to R24 at night. The DON was unaware of this, and unaware the CPAP mask was only being cleaned weekly. Facility Comprehensive Person-Centered Care Plan policy with revised date of March 2022, indicated a comprehensive, person-centered care plan that included measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs was developed and implemented for each resident. Care plan interventions were chosen only after data gathering, proper sequencing of events, careful consideration of the relationship between the resident's problem areas and their causes, and relevant clinical decision making. R27's face sheet received on 12/3/25, included diagnosis of dementia with other behavioral disturbance and agitation and repeated falls. R27's quarterly MDS assessment dated [DATE], indicated R27 understands and is understood. A Brief Interview for Mental Status (BIMS) indicated a score of 5 indicating severe cognitive impairment. R27 had behaviors that included verbal behavioral symptoms directed towards others 1 to 3 days, but less than daily. R27 had rejection of care 4 to 6 days. R27 required substantial/maximal assistance with transfers, toileting, bed mobility and transfers. R27 was taking antipsychotic and antidepressant medication. R27's Care Area Assessment (CAA) for cognitive loss/dementia dated 3/25/25, included psychiatric or mood disorder. The CAA for mood state included clinical issues that can cause or contribute to a mood problem including relapse of an underlying mental health problem, and psychiatric disorder. R27's care plan last revised 9/30/25, included R27 is/has potential to be verbally aggressive and has a history of threatening to hit staff and of striking staff. Interventions included: administer medications as ordered; analyze of key times, places, circumstances, triggers and what de-escalates behavior and document; assess and anticipate resident's needs for food, thirst toileting needs, comfort level, body positioning, pain etc ; assess R27's understanding of the situation. Allow time for the resident to express self and feelings towards the situation; give the resident as many choices as possible about care and activities; monitor behaviors every shift and document on observed behavior and attempted interventions; when the resident become agitated intervene before agitation escalates (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and guide away from source of distress. Engage calmly in conversation. If response is aggressive, staff to walk calmly away and approach later. R27's plan of care did not include a history of post traumatic stress disorder (PTSD). A Trauma Informed Care assessment dated [DATE], indicated R27 answered Yes to experiencing a traumatic event. A probable PTSD interview included R27 answered yes to having nightmares about events or thought about the events when he didn't want to. R27 answered yes to felt guilty or unable to stop blaming himself or others for the events or any problems the event(s) may have caused. On 12/1/25 at 3:10 p.m., R27 declined to speak with surveyor. On interview 12/2/25 at 1:42 p.m., social services (SS)-A indicated she had completed the Trauma Informed Assessment on R27 in February 2025. SS-A confirmed the plan of care did not include a plan to address potential PTSD but did include a behavioral plan of care addressing his refusals of care and behaviors. On interview 12/2/25 at 2:52 p.m., RN-C stated R27 sometimes talked about his time in war but has never stated he suffered from PTSD. RN-C indicated R27's family member had wondered if some of his behaviors are impacted from his history in the army. RN-C indicated a lot of his behaviors are during the night shift and could be related to nightmares but added R27 had never stated that to anyone. RN-C indicated R27 had a plan of care to address behaviors and mood but not for PTSD. On interview 12/2/25 at 3:27 p.m., NA-A stated R27 had verbal behaviors and on occasion will attempt to strike out. NA-A was unsure if R27 had a history of PTSD but did stated that sometimes if staff make too much noise he gets agitated and sometimes if they don't make enough noise when entering his room he will get startled. On interview 12/2/25 at 3:59 p.m., FM-A stated R27 was in army and when he returned home he struggled, was on edge and startled easily but thought that had resolved a few years after he returned. FM-A stated R27 does still get triggered by fireworks which can set off memories but otherwise does not show any signs of trauma. On interview 12/2/25 at 4:23 p.m., SS-B stated R27 had a terrible experience during war. SS-B stated R27 does have some triggers such as at night he doesn't want anyone in his room and will become verbally upset telling staff to get out of his room. SS-B was not aware of any other triggers except at night. SS-B confirmed there was no plan of care related to PTSD. On interview 12/3/25 at 10:01 a.m., the DON stated a further assessment should have been completed after the February 2025 assessment. The DON stated she would expect a plan of care to be initiated if confirmed PTSD history. Facility Trauma Informed Care and Culturally Competent Care policy dated 10/22, included: - Perform universal screening of residents, which includes a brief, non-specialized identification of possible exposure to traumatic events. - Use screening tools and methods that are facility-approved, competently delivered and culturally relevant and sensitive. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Use initial screening to identify the need for further assessment and care. - Develop individualized care plans that address past trauma in collaboration with the resident and family as appropriate - Identify and decrease exposure to triggers that may re-traumatize the resident.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review, the facility failed to ensure individualized activities were provided for 1 of 2 residents (R80) reviewed for activities. Findings include:R80's face sheet printed 12/3/25, indicated diagnoses of chronic kidney disease, adjustment disorder with depressed mood and anxiety, hearing loss, muscle weakness, and palliative care.R80's significant change Minimum Data Set (MDS) assessment dated [DATE], indicated R80 had no behaviors or rejection of care, intact cognition, considered it very important to have books, newspapers, and magazines to read, important to keep up with current news, and not important to do things with groups of people.R80's care plan dated 10/14/25, indicated R80 was alert and oriented and able to make needs known, enjoyed all types of music, reading, classic television shows and war movies. R80's care planned activity interventions included all staff conversing with the resident while providing cares, ensure activities are compatible with known interests and preferences, adapted as needed, compatible with individual needs, provide a program of activities that is of interest and empowers the resident, and a 1:1 activity program.During observation and interview on 12/1/25 at 3:48 p.m., R80 was awake in his bed and alone in his room. R80's television was on with no volume or captions. R80 stated he was not able to get out of bed anymore, was lonely in his room all day, bored, and wished more people would visit him throughout the day. R80 further stated his hearing was poor, and he couldn't read captions on his television, so could no longer enjoy that form of entertainment.During observation on 12/2/25 at 8:19 a.m., R80 was in bed in his room alone. R80's television was on with no volume, and he was staring at the ceiling. R80 stated he did not plan to attend any group activities today because he was unable to sit up in his wheelchair for more than 30 minutes due to back pain.During observation on 12/2/25 at 1:50 p.m., R80 remained in bed, was reading a book, and stated no activity staff had visited him so far that day.During observation on 12/3/25 at 8:53 a.m., R80 was in his bed, awake, starting to read a book. R80 stated he was bored in his room. R80 further stated activity staff bring him books and magazines but just drop them off and don't stay to visit with him or do an activity with him and he got very lonesome some days. R80 stated he would sure like to visit with activity staff sometime, but they are busy and can not spend the time with him.During interview on 12/2/25 at 8:30 a.m., nursing assistant (NA)-A stated R80 had declined over the last few weeks and did not get out of bed anymore. NA-A stated he stayed in his room all day, did not eat meals in the dining room, and did not attend any activities. NA-A was not aware of any individual activities for R80.During interview on 12/2/25 at 4:52 p.m., licensed practical nurse (LPN)-F stated R80 no longer got out of bed, and was in his room all the time. LPN-F stated he had declined and went on hospice, so he liked staying in bed.During interview on 12/3/25 at 8:19 a.m., activity assistant (AA)-A stated she was responsible for activity care plans and completing activities for R80. AA-A further stated she offered all group activities to R80 daily, delivered books and magazine to his room, and turned his television on to his preferred channel. AA-A stated she checked on R80 to make sure he had independent activities, but did not specifically do one-to-one activities with him because there was not enough time.During interview on 12/3/25 at 11:47 a.m., life enrichment director (O)-B stated she was not aware R80 was lonely and bored, and she was not sure if R80 had received individual one-to-one activities. O-B stated if R80's care plan indicated his program was for one-to one activity visits, then he should have been getting one-to-one visits. O-B further stated individual visits were for residents who did not attend group activities, and she would expect those visits to be completed. O-B stated dropping off books and magazines, and turning the television on did not qualify and individual activities.During interview on 12/3/25 at 2:05 p.m., administrator stated he would expect the activity care plan to be individualized and implemented as planned for each resident.A facility document titled The Woodlands Follow Up Question Report dated 11/1/25 through 11/30/25, indicated R80 was offered group activities and independent activities all days in November 2025 except for 11/2/25, 11/16/25, (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	11/23/25, and 11/27/25. It did not indicate R80 was offered any one-to-one activities.Facility Activity Programs policy dated 6/2018, indicated the activity programs are designed to encourage maximum individual participation and are geared to the individual resident's needs. Activity programs consist of individual, small group, and large group activities that are designed to meet the needs and interests of each resident. All activities are documented in the resident's medical record.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Johns on Fountain Lake	1771 Eagle View Circle Albert Lea, MN 56007

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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review, the facility failed to ensure weekly comprehensive skin assessments (including measurements and characteristics) were completed for 1 of 3 residents (R1) reviewed for pressure ulcers. Findings include:R1's face sheet received on 12/3/25, included diagnoses of pressure ulcer of sacral region, stage four (the most severe type, involving full-thickness tissue loss); diabetes, chronic kidney disease, hemiplegia (paralysis affecting one side of the body) and hemiparesis (muscle weakness on one side of the body) following stroke.R1's admission Minimum Data Set (MDS) assessment dated [DATE], indicated intact cognition, clear speech; R1 was understood and could understand. R1 required substantial assistance with toileting and bed mobility; was occasionally incontinent of bowel and bladder. R1 didn't walk and used an electric scooter. R1 was at risk for a pressure ulcer and had one, unhealed, stage four pressure ulcer present upon admission. R1's Skin CAA (care area assessment) dated 10/20/25, indicated R1 had been admitted with a stage four pressure ulcer to his sacrum. Treatments and interventions had been in place to promote healing and prevent further breakdown. R1's orders included:--10/16/25: Wound care coccyx: wash hands, remove old dressings, cleanse wound bases with Vashe (a solution used for cleaning, irrigating and debriding wounds), pack Vashe moistened dry gauze to wound base, cover with abdominal pad and secure with tape, every day shift and as needed for wound care.--10/29/25: Skin check on bath day. Document bruise, rash, open area. Complete N Adv.-Skin (Nurse Advantage; a skin assessment flow sheet in the electronic medical record [EMR]).R1's care plan dated 11/3/25, indicated R1 had potential/actual impairment to skin integrity of the coccyx related to stage four pressure injury. R1 was at risk related to fragile skin, type 2 diabetes, and impaired mobility. Weekly treatment documentation to include measurement of each area of skin breakdown's width, length, depth, type of tissue and exudate and any other notable changes or observations.R1's Braden score (standardized tool to assess risk of developing pressure ulcers) dated 10/14/25, indicated a score of 18 = mild or low risk for developing pressure ulcers.R1's skin assessments in the EMR indicated skin checks were documented each week on a flowsheet titled N Adv Skin Check, but not all of the skin checks included measurements of the coccyx wound or characteristics of the wound. Out of seven weekly skin checks since admission on [DATE], only one had all of the required documentation:10/15/25 (admission)***No staging. No characteristics such as tunneling, epithelial, granulation, slough, eschar, exudate amount and type, odor, condition of skin edges, surrounding tissue and induration had been documented.10/21/25*** All required documentation had been present.10/28/25 *** Required documentation had been present with the exception of characteristics. 11/4/25 ***No wound measurements or characteristics had been documented.11/11/25*** No characteristics had been documented. 11/19/25***No wound measurements or characteristics had been documented.11/25/25***No wound measurements or characteristics had been documented.12/2/25***No wound measurements or characteristics had been documented.R1's wound provider note dated 11/17/25, indicated a pressure ulcer on the coccyx, chronic, stage four measuring 2 cm x 2 cm x 1.5 cm. The pressure ulcer had moderate amount of drainage. The drainage was serous and serosanguineous. The pressure ulcer had exposed subcutaneous. Full thickness wound. No sign of epithelization. 50% granulation tissue. 50% nonviable material of slough/fibrin. R1's wound provider note dated 11/26/25, indicated sacral wound had reduced in size. There was healthy red granulation tissue to the wound base and no signs of infection. During an interview on 12/1/25 at 4:19 p.m., while in his room in his electric scooter, R1 stated he had one pressure ulcer on his coccyx, acquired in hospital before being admitted to the facility. R1 stated it was healing; nurses packed it and covered it. R1 stated he saw a wound provider at a clinic every four weeks. R1 stated he laid down frequently to get pressure off his bottom. During an interview on 12/2/25 at 12:53 p.m., licensed practice nurse (LPN)-A stated she had changed R1's coccyx dressing (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	that morning but had not assessed the wound. LPN-A stated assessments were completed by the evening shift nurse on his bath day. Together looked in the EMR at the electronic flowsheet titled N Adv Skin Check. Weekly documentation. LPN-A acknowledged the documentation was inconsistent and lacked measurements and characteristics. During an observation on 12/3/25 at 8:30 a.m., with LPN-A and registered nurse (RN)-A, who was also the clinical care manager, observed R1's coccyx wound. The wound was center of buttocks, proximal to the intergluteal cleft. Wound was star-burst shape, with an estimated outside diameter of 1.5 to 2 inches. LPN-B measured depth with a cotton swab at 0.5 cm., then measured outside of wound - just the opening without spreading open the starburst, at 1 x 1 cm. Skin was dry, color normal, no redness, no exudate. Wound was flushed, packed and covered with pad and taped. During an interview on 12/3/25 at 8:38 a.m., RN-A looked in the EMR for each week of skin checks for R1 since admission. RN-A verified documentation was inconsistent and lacked elements of a comprehensive wound assessment. RN-A stated she would have expected nursing staff to complete all fields of the electronic skin check tool. It was important to determine if the wound had worsened or became infected. RN-A stated she had been monitoring documentation of the weekly skin checks but had not looked at each section of the documentation tool and therefore had not been aware measurements and characteristics had not been documented. RN-A stated R1 saw a wound care provider outside of the facility each month and recently saw a provider in-house who indicated the wound had reduced in size, had healthy looking skin and no sign of infection.During an interview on 12/3/25 at 1:35 p.m., the director of nursing (DON) was informed of the lack of comprehensive assessments of R1's coccyx wound to include measurements and characteristics. The DON stated she would have expected a complete assessment of R1's wounds in order to know if it was improving or worsening. Facility Pressure Injury policy with revision date of 11/24, indicated the purpose was to provide appropriate assessment and prevention of pressure injuries, ensure the necessary treatment and services to promote healing, prevent infection and prevent any new pressure injuries from developing. Complete a new skin check weekly. Document weekly and PRN (as needed) in the Interdisciplinary Nursing notes on the size, drainage, odor, pain, surrounding tissue, and current treatment.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to assess safe smoking for 1 of 1 resident (R69) reviewed for smoking. In addition, the facility failed to provide a receptable for R69 to safely ash and dispose of cigarettes. Findings include:R69's face sheet provided on 12/3/25, included diagnoses of tobacco use and chronic obstructive pulmonary disease (a progressive lung disease that causes breathing difficulties).R69's quarterly Minimum Data Set (MDS) assessment dated [DATE], indicated R69 was cognitively intact, had clear speech, could understand and be understood. R69 was independent with most activities of daily living and used a motorized wheelchair for mobility. R69's orders did not include smoking. R69's care plan dated 7/30/25, indicated R69 was a smoker, would not suffer injury from unsafe smoking practices. R69 would be instructed about smoking risks and hazards and facility policy on smoking including locations, times and safety concerns. Progress note dated 7/11/25, indicated R69 asked about having a cigarette and was educated on the rules of smoke free campus.Progress note dated 10/19/25, indicated R69 went outside multiple times to smoke. During interview and observations on 12/1/25 at 2:41 p.m., R69 was sitting in a recliner in her room. R69 stated she had been in the facility for six months and had smoked the entire time. R69 stated she smoked three to four times a day and didn't smoke a whole cigarette - maybe three or four puffs. R69 stated she kept cigarettes and lighter in her room and both were currently in her coat pocket on her motorized wheelchair. R69 stated she went onto the sidewalk in the parking lot to smoke. Since it's cold and snowy now, R69 stated she stayed closer to the building. R69 did not recall having had a safe smoking assessment. R69 stated she did not know if it was a no smoking campus - couldn't recall if she was told that or not. R69 stated when she was done smoking outside, she put the cigarette out with her fingers, rolled up what was left in the front of her t-shirt, brought it into the building, wrapped it in a tissue and threw it in the wastebasket. R69 stated she had not been given an ash receptable. Observed a partially used cigarette setting on a piece of paper on her overbed table. Tobacco spilling out. R69 stated she had been smoking for more than 50 years and had never had an incident, such as a burn or fire. During an observation and interview on 12/2/25 at 12:27 p.m., R69 signed herself out of the facility to go with her boyfriend to run errands and stated, I will be smoking. R69 stated she had been going out to smoke despite the cold and snowy weather. During an interview on 12/2/25 at 1:05 p.m., licensed practical nurse (NA)-B stated the facility was smoke-free and residents had to go off property to smoke. LPN-B was aware R69 smoked but did not know if a safe smoking assessment had been done, or if one needed to be done - social services might know. LPN-B stated she assumed R69 was safe to smoke as she had not had any problems. During an interview on 12/2/2025 at 1:13 p.m., LPN-B approached to report she had asked the director of nursing (DON) about a smoking assessment for R69 and was told one had been completed on 12/1/25, and now social services would be doing it quarterly. During an interview on 12/2/25 at 1:20 p.m., registered nurse (RN)-A who was also the clinical care manager for the unit R69 resided, stated the facility was smoke free and if a resident wanted to smoke, he/she had to go off campus and would not be escorted by staff. RN-A stated she was not aware the facility had a smoking risk assessment tool. Looking in the electronic medical record, RN-A stated she did not see a safe smoking assessment for R69.During an interview on 12/2/25 at 2:51 p.m., DON was asked how a smoking assessment happened to be completed for R69 on 12/1/25. The DON stated when their smoking policy had been requested, she reviewed it and realized they had not been following it, so therefore a safe smoking assessment had been completed on R69 on 12/1/25. The DON stated the facility was a smoke free campus but was aware R69 smoked in the parking lot. The DON was informed of interview with R69 on 12/1/25, specifically about R69 rolling up a used cigarette in her t-shirt, bringing it into the building, rolling it in a tissue and throwing it in the wastebasket. The DON was aware R69 had used a (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	small can in the summer to ash her cigarettes but did not know how R69 had been disposing of ashes and cigarettes currently. The DON provided a copy of R69's smoking assessment dated [DATE], and signed by R69, the social worker and the DON which indicated R69 was safe to smoke independently. Facility Smoking policy dated 7/8/21, indicated the facility was a smoke free facility effective April 1, 2015. Residents admitted after July 1, 2011, would not be permitted to smoke on campus. All residents who wished to smoke (admitted prior to July 1, 2011) or use e-cigarettes, would be assessed at least quarterly to ensure the resident continued to be in compliance with the smoking policy. The use of e-cigarettes was only permitted outside the building on campus grounds. Social Services and nursing would assess quarterly at care conferences if a resident was safe to smoke/use e-cigarettes and keep smoking materials in their possession. Smoking materials included cigarettes, cigars, pipes, chewing tobacco, matches, lighters, and e-cigarettes.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review, the facility failed to ensure 1 of 1 resident (R8) reviewed for hydration and who was dependent upon staff for fluid intake, was offered water/fluids on a consistent basis.Findings include:R8's face sheet printed on 12/3/25, included diagnoses of Alzheimer's disease and severe dementia.R8's quarterly Minimum Data Set (MDS) assessment dated [DATE], indicated severe cognitive impairment, unclear speech, was usually understood, and sometimes was able to understand. R8 required substantial/maximal assistance with eating and drinking. R8 was dependent on staff for activities of daily living and did not walk. R8's orders dated 8/12/24, indicated regular diet, minced and moist texture, regular/thin consistency, required assist with all meals.R8's care plan dated 8/23/24, indicated R8 had the potential for hydration problems related to dementia and Alzheimer's disease.R8's Kardex (a quick reference tool used by nursing assistants summarizing essential resident cares) printed on 12/3/25, indicated staff were to offer fluids with all cares/meals and at least every three hours while awake. Assist with drinking.R8's fluid intake record indicated that for seven days (11/25/25, to 12/1/25), R8 averaged 660 milliliters (ml) of fluid each day.R8's urine output record indicated that for seven days (11/25/25, to 12/1/25), R8 averaged 787 ml of urine output each day. During a telephone interview on 12/1/25 at 4:56 p.m., family member (FM)-C stated staff didn't offer R8 anything to drink, adding it would be good if they were more in tune to giving him a drink every couple of hours or so. FM-C stated she had never seen staff offer R8 beverages unless it was at mealtime. FM-C stated, I think he gets dry and should be drinking more than he does. During a continuous observation on 12/2/25, from 8:28 a.m. to 10:59 a.m., R8 was not offered water:--8:28 a.m., lying in bed supine. Eyes open. Room dim.--9:14 a.m., no change. Observed arms in the air from time to time. -- 9:38 a.m., small navy thermal mug with straw on bedside table was full of water. R8 lacked ability to reach it and help himself. Urinary drainage bag appeared to have about 200 ml dark gold urine in bag.--9:54 a.m., no staff had been in R8's room.--10:13 a.m., nursing assistant (NA)-E entered room. NA-E emptied contents of the urinary drainage bag into a graduate. Urine was dark gold in color and had a pungent odor. NA-E stated the urine smelled strong and she would report that to the nurse and push fluids. A total of 150 ml of urine was emptied from the urinary drainage bag. NA-E stated R8 could not drink fluids on his own in bed. --10:38 a.m., up in wheelchair.--10:53 a.m., NA-E shaving R8. --10:59 a.m., in dining room. --11:21 a.m., eating scrambled eggs, yogurt and Carnation instant milk in a mug with straw with NA-F assisting. No water on the table.During an observation and interview on 12/3/25 at 9:58 a.m., R8 was at a table in the dining room being assisted with breakfast by NA-E, which included Carnation instant milk in a mug with straw. No water on the table. NA-E stated she offered R8 water when he was in his room, adding, We should before we lay him down. NA-E stated R8 was a good drinker. NA-E stated R8's urine output for the day shift yesterday 12/2/25, was only 200 milliliters (ml) and had a strong smell. NA-E stated she had informed licensed practical nurse (LPN)-A of this on 12/2/25. During an interview on 12/3/25 at 10:08 a.m., LPN-A acknowledged that NA-E had informed her yesterday that R8's urine was yellow and smelled strong. NA-E stated she would typically encourage fluids by offering a resident water and cranberry juice. LPN-A admitted she did not go to R8's room to assess skin turgor, mucous membranes, color, clarity and odor of urine. LPN-A stated she reported what NA-E had told her at shift change but admitted she had not communicated to NA staff to push fluids, nor did she document anything about characteristics of his urine, nor inform the clinical care manager. During an interview on 12/3/25 at 12:52 p.m., registered nurse (RN)-A, who was also the clinical care manager for the unit on which R8 resided, was informed of R8's urine - amount, color and odor and observations of R8 not being offered water. RN-A stated she would have expected LPN-A to lay eyes on R8 and report findings to her so they could determine if he was dehydrated, if he had possible urinary tract infection symptoms, notify the physician if necessary and to communicate to all NA staff to encourage fluids. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	RN-A stated she expected residents to receive fresh water and for staff to offer R8 fluids before laying him down and at mealtimes, adding it was especially important for residents who can't drink fluids without assistance. During an interview on 12/3/2025 at 1:46 p.m., the director of nursing (DON) was informed of R8 and potential for hydration concerns. The DON stated after being informed of the amount, color and odor of R8's urine, the nurse should have gone to look at R8 herself and reported it to RN-A so she could update the provider. Facility Resident Hydration and Prevention of Dehydration policy dated October 2017, indicated the facility would strive to provide adequate hydration and prevent and treat dehydration. Nurses' aides would provide and encourage intake of bedside, snack and meal fluids, on a daily and routine basis as part of daily care. If potential inadequate intake and/or signs and symptoms of dehydration were observed, intake and output monitoring would be initiated. The physician would be notified.

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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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review, the facility failed to ensure staff were following manufacturer's guidelines with continuous positive airway pressure (CPAP) machine with daily maintenance for 1 of 3 resident (R33) reviewed for respiratory care and treatments.Reviewed-LS-done Findings include: R33's face sheet received on 12/3/25, included diagnoses of epilepsy (seizures), cerebral infarction (stroke) and obstructive sleep apnea (breathing repeatedly stops or become significantly reduced during sleep often due to collapse of the upper airway). R33's admission Minimum Data Set (MDS) assessment dated [DATE], indicated R33 had moderate cognitive impairment, and was dependent on staff for all activities of daily living. Special treatments included CPAP. R33's plan of care dated 10/28/25, included a sleep disturbance using a CPAP at baseline. Interventions included CPAP auto set at night pressure settings at auto set home settings. Wipe off mask, nasal pillows and tubing. CPAP cleaning included wash mask, nasal pillows, tubing and headgear. Wipe of flow generator. R33's physician order dated 10/11/25 included CPAP cleaning every shift every Saturday to clean and wash mask, nasal pillows tubing, headgear and wipe of flow generator. An order dated 10/30/25, included CPAP auto set at night. Pressure setting at auto set home settings; wipe off mask, nasal pillows and tubing every shift. ResMed AirSense 10 manual, undated, included empty the humidifier tub daily and wipe it thoroughly with a clean disposable cloth and allow to dry out of direct sunlight. Mask cushion should be cleaned daily in a sink or tub using mild liquid detergent and warm, drinking-quality water. Weekly cleaning includes clean the humidifier tub, mask cushion and headgear, air tubing and outlet connector in warm water using mild liquid detergent and water. Rinse each component thoroughly in water and place on a flat surface, on top of a towel, to dry. Avoid placing them in direct sunlight. Wipe the exterior of the device with a dry cloth. On observation and interview on 12/2/25 at 8:32 a.m., R33 was lying in bed with his CPAP mask on and machine running. Nursing assistant (NA)-A turned off the CPAP machine, removed face mask and laid it over the machine. NA-A and NA-B stated the nurse is responsible for cleaning the mask, the CPAP machine and reservoir. On observation 12/2/25 at 10:48 a.m., R33's CPAP mask remained sitting on top of CPAP machine and moisture remained in the water reservoir. On observation 12/2/25 at 12:52 p.m., R33 was assisted to his bed by NA-A and NA-B. CPAP mask remained on bedside table on top of machine. Moisture was present in the water reservoir. On observation 12/2/25 at 3:36 p.m., R33 was assisted to his wheelchair. Water reservoir of CPAP machine remained with moisture present. CPAP tubing and mask remained sitting on top of CPAP machine. On observation and interview 12/3/25 at 7:30 a.m., R33 was lying in bed with his CPAP mask on, machine running with a noise coming from the CPAP mask. Licensed practical nurse (LPN)-C entered R33's room and readjusted his mask and the noise stopped briefly but then returned. LPN-C stated he hasn't noticed a face mask leak prior and thinks it is positional. On observation and interview 12/3/25 at 7:52 a.m., R33 was lying in bed with CPAP mask on which continued to make noise from around the mask. NA-A and NA-B entered R33's room, and NA-A turned off CPAP machine and removed the face mask. NA-A placed hose and mask over top of the machine. NA-A indicated they aren't responsible for cleaning the CPAP machine or supplies but are allowed to turn it off and remove the mask. NA-B stated LPN-C had told them R33's CPAP mask was leaking so it was time to get R33 up for the day. On observation and interview 12/3/25 at 8:24 a.m., LPN-C stated the CPAP machine, mask and tubing in cleaned once a week. LPN-C was unsure how often the mask is changed but stated they clean the mask, tubing, and water reservoir weekly with soap and water. LPN-B stated they refill the water chamber before applying the mask at bedtime and empty and clean it weekly. On interview 12/3/25 at 8:40 a.m., LPN-D stated the CPAP mask should be wiped every morning and evening using soap and water. LPN-D stated the water reservoir is cleaned every Saturday with soap and water along with the face mask and tubing. On interview 12/3/25 at 8:36 a.m., LPN-E stated the CPAP mask and tubing is (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	cleaned weekly on Saturday's. The mask is wiped out daily. LPN-E stated the water reservoir is emptied and cleaned on Saturday's also using either vinegar with water or soap and water. On interview 12/3/25 at 8:37 a.m., registered nurse (RN)-C stated tubing, mask and reservoir should be cleaned weekly. RN-C stated a discussion was held with other team members this morning and it was noted the orders lack instructions on how to clean the machine, mask and reservoir and plan to review the templates so staff have more detailed instructions. On interview 12/3/25 at 9:56 a.m., the director of nursing (DON) confirmed the CPAP policy and instructions was lacking guidance on the cleaning of the CPAP machine, supplies and reservoir with how often and what to use to clean it with. The DON confirmed there was a variance in how the supplies were cleaned and how often. Facility CPAP-BIPAP cleaning policy last revised 3/15 included: General Guidelines for Cleaning: - These are general guidelines for cleaning. Specific cleaning instructions are obtained from the manufacturer/supplies of the CPAP device. - To clean machine wipe with warm, soapy water and rinse at least once a week and as needed. - Humidifier: Use clean, distilled water only in the humidifier chamber. Clean humidifier weekly and air dry. To disinfect, place vinegar-water solution (1:3) in clean humidifier. Soak for 30 minutes and rinse thoroughly. - Masks, nasal pillows and tubing cleaning is done daily by placing in warm, soapy water and soaking/agitating for 5 minutes. Mild dish detergent is recommended. Rinse with warm water and allow to air dry between uses. - Headgear strap is to be washed with warm water and mild detergent as needed. Allow to dry.

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview,, and document review, the facility failed to comprehensively assess and reassess past trauma and implement care plan interventions utilizing a trauma-informed approach for 1 of 1 resident (R27), reviewed who was evaluated for mood and behavior. Findings include: R27's face sheet received 12/3/25, included diagnosis of dementia with other behavioral disturbance and agitation and repeated falls. R27's quarterly Minimum Data Set (MDS) assessment dated [DATE], indicated R27 understands and is understood. A Brief Interview for Mental Status (BIMS) indicated a score of 5 indicating severe cognitive impairment. R27 had behaviors that included verbal behavioral symptoms directed towards others 1 to 3 days, but less than daily. R27 had rejection of care 4 to 6 days. R27 required substantial/maximal assistance with transfers, toileting, bed mobility and transfers. R27 was taking antipsychotic and antidepressant medication. R27's Care Area Assessment (CAA) for cognitive loss/dementia dated 3/25/25, included psychiatric or mood disorder. The CAA for mood state included clinical issues that can cause or contribute to a mood problem including relapse of an underlying mental health problem, and psychiatric disorder. R27's care plan last revised 9/30/25, included R27 is/has potential to be verbally aggressive and has a history of threatening to hit staff and of striking staff. Interventions included: administer medications as ordered; analyze of key times, places, circumstances, triggers and what de-escalates behavior and document; assess and anticipate resident's needs for food, thirst toileting needs, comfort level, body positioning, pain etc ; assess R27's understanding of the situation. Allow time for the resident to express self and feelings towards the situation; give the resident as many choices as possible about care and activities; monitor behaviors every shift and document on observed behavior and attempted interventions; when the resident become agitated intervene before agitation escalates and guide away from source of distress. Engage calmly in conversation. If response is aggressive, staff to walk calmly away and approach later. R27's plan of care did not include a history of post-traumatic stress disorder (PTSD). A Trauma Informed Care assessment dated [DATE], indicated R27 answered Yes to experiencing a traumatic event. A probable PTSD interview included R27 answered yes to having nightmares about events or thought about the events when he didn't want to. R27 answered yes to felt guilty or unable to stop blaming himself or others for the events or any problems the event(s) may have caused. On 12/1/25 at 3:10 p.m., R27 declined to speak with surveyor. On interview 12/2/25 at 1:42 p.m., social services (SS)-A indicated she had completed the Trauma Informed Assessment on R27 in February 2025. SS-A does not believe the facility had a further Trauma assessment to complete if the initial assessment shows positive indicators possible of PTSD. SS-A reviewed the trauma assessment and indicated R27 would likely with his dementia answer the same assessment differently if completed, but confirmed another trauma assessment or further assessment had not been completed. SS-A confirmed the plan of care did not include a plan to address potential PTSD but did include a behavioral plan of care addressing his refusals of care and behaviors. On interview 12/2/25 at 2:52 p.m., registered nurse (RN)-C stated R27 sometimes talked about his time in war but has never stated he suffered from PTSD. RN-C indicated R27's family member had wondered if some of his behaviors are impacted from his history in the army. RN-C indicated a lot of his behaviors are during the night shift and could be related to nightmares but added R27 has never stated that to anyone. RN-C indicated R27 had a plan of care to address behaviors and mood but not for PTSD. On interview 12/2/25 at 2:53 p.m., licensed practical nurse (LPN)-F stated R27 occasionally talks about his time in the service but has never mentioned issues with PTSD. LPN-F stated he does have behaviors which increase at night with refusals of care and yelling at staff. On interview 12/2/25 at 3:27 p.m., nursing assistant (NA)-A stated R27 had verbal behaviors and on occasion will attempt to strike out. NA-A was unsure if R27 had a history of PTSD but did state sometimes if staff make to much noise he gets agitated and sometimes if we don't make enough noise when we enter his room he will get startled. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245635	A. Building B. Wing	12/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Johns on Fountain Lake	1771 Eagle View Circle Albert Lea, MN 56007

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On interview 12/2/25 at 3:59 p.m., family member (FM)-A stated R27 was in army and when he returned home he struggled, was on edge and startled easily but that had resolved a few years after he returned. FM-A stated R27 does still get triggered by fire works which can set off memories but otherwise does not show any signs of trauma. On interview 12/2/25 at 4:23 p.m., SS-B stated a brief assessment is completed for trauma informed care with the intent of filling out a more complete assessment on all residents. SS-B stated R27 had a terrible experience during war. SS-B stated R27 does have some triggers such as at night he doesn't want anyone in his room and will become verbally upset telling staff to get out of his room. SS-B was not aware of any other triggers except at night. SS-B confirmed there was no plan of care related to PTSD and indicated further assessment should have been completed after the initial assessment in February 2025. On interview 12/3/25 at 10:01 a.m., the director of nursing (DON) stated further assessment should have been completed after the February 2025 assessment. The DON stated she would expect a plan of care to be initiated if confirmed PTSD history. Facility Trauma Informed Care and Culturally Competent Care policy dated 10/22, included: - Perform universal screening of residents, which includes a brief, non-specialized identification of possible exposure to traumatic events. - Use screening tools and methods that are facility-approved, competently delivered and culturally relevant and sensitive. - Use initial screening to identify the need for further assessment and care. - Develop individualized care plans that address past trauma in collaboration with the resident and family as appropriate- Identify and decrease exposure to triggers that may re-traumatize the resident.