STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24E150	A. Building B. Wing	09/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Grand Avenue Rest Home	3956 Grand Avenue S0uth Minneapolis, MN 55409

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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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed provide and document appropriate nonpharmacological interventions prior to administering as needed (PRN) psychotropic medication consumption for 3 of 5 residents (R16, R17, R1) reviewed for unnecessary medication use. Findings include: R16’s annual Minimum Data Set (MDS) dated [DATE], identified R16 with experiencing hallucinations (false perceptions that seem real but are not) and delusions (misconceptions or beliefs that are opposite of reality), and had psychiatric diagnoses of anxiety, depression, psychotic disorder, schizophrenia and post-traumatic stress disorder (PTSD). R16’s Pharmacist Consultant Report dated July 11, 2025-July 13, 2025, identified “[R16] receives frequent doses of diazepam prn (as needed psychotropic medication). Ensure staff document dangerous or distressful behavior, nonpharmacological interventions attempted before psychotropic administration, and effectiveness of the psychotropic and any adverse effects.” R16’s physician order dated 7/16/25, “diazePAM Oral Tablet 5 MG (Diazepam, also known as Valium) Give 1 tablet by mouth as needed for give 1 tab BID PRN related to ANXIETY DISORDER, UNSPECIFIED (F41.9) Document non pharmaceutical intervention before administering med. -Start Date07/16/2025 1700”. R16’s Medication Administration Report dated July, August, and September identified R16 was administered prn diazepam the following dates: July 17-31, 2025: Received one dose on 5 of the 15 days. Received two doses on 10 of the 15 days. August 1-31, 2025: Received one dose on 15 days. Received two doses on 16 days. September 1-10, 2025: Received one dose on 5 days. Received two doses on 4 days. R16's medical record lacked identification or documentation of non-pharmacological approaches prior to administration of diazepam. (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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview with licensed practical nurse (LPN)-A on 9/10/25 at 9:57 a.m., LPN-A stated expectation of nursing staff to document behaviors in a progress note including, “what worked and what happened” with psychotropic medication administration. LPN-A stated purpose of nonpharmacological interventions was “to reduce the need of taking [prn] psychotropics”. LPN-A reviewed R16’s electronic medical record (EMR) and stated she had documented administering the prn Valium but there was nothing in the EMR that identified what nonpharmacological interventions were used prior to administering the medication. During interview with assistant director of nursing (RN)-A on 9/10/25 at 10:14 a.m., RN-A identified purpose of assessing nonpharmacological medications prior to administering it was, to reduce anxiety meds”. RN-A reviewed R16’s EMR and verified the Pharmacist Consultant Report dated July 11, 2025-July 13, 2025, had instructed nursing staff to document nonpharmacological interventions attempted before administering prn Valium and that it was not done. R1 R1’s quarterly Minimum Data Set (MDS) assessment, dated 6/13/25, indicated R1 had intact cognition with hallucination, delusions with fluctuating disorganized thinking and was independent with all activities of daily living (ADLs). MDS-Section N indicated R1 was taking antipsychotic, antianxiety, antianxiety and antidepressant medications. R1’s diagnosis report, printed 9/11/25, included the following diagnosis: bipolar disorder with psychotic features (a severe form of bipolar disorder characterized by psychotic symptoms such as hallucinations and delusions during manic and depressive episodes), anxiety disorder, and schizoaffective disorder (a mental health disorder that combines symptoms of schizophrenia and a mood disorder). R1’s September 2025 Medication Administration Record (MAR), printed 9/11/25, included the following: -hydroxyzine (an antihistamine that helps with anxiety) 50 milligrams (mg) tablet – give one tablet by mouth as needed for anxiety/sleep for 30 days with a start date of 8/15/25 and end date of 9/9/25 which was administered eight (8) times from 9/1/25 to 9/9/25. Administrations were documented with an “e” indicating effective. There was no documentation on the MAR of nonpharmacological interventions prior to administration. -hydroxyzine 50 mg tablet – give one tablet by mouth as needed for anxiety/sleep starting 9/9/25 until 9/14/25 – nonpharmacological intervention attempted before psychotropic administration effectiveness / any adverse effects with a start date of 9/9/25 which was administered once on 9/10/25. Administrations were documented with an “e” indicating effective. There was no documentation on the MAR of nonpharmacological interventions prior to administration. The MAR lacked evidence of offering any nonpharmacological interventions prior to administration of administering PRN psychotropic medication. R1’s care plan, printed 9/8/25, indicated R1 received psychotropic medications. Care plan listed the following nonpharmacological interventions: (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-encourage (R1) to decrease TV watching late at night -encourage R1 to be up more during the day -attempt to re-direct and cue -offer psychotherapy bi-weekly -give her alone space/time to process emotions R1’s progress notes, dated 9/1/25 to 9/11/25, reviewed and lacked evidence of documentation of any nonpharmacological interventions offered prior to administration of psychotropic medication. During an interview on 9/10/25 at 11:23 a.m., assistant director of nursing (ADON) stated any nonpharmacological interventions offered prior to administration of PRN medications would be documented in the progress notes. ADON reviewed R1’s progress notes and electronic medical record (EMR) and verified there was no documentation of nonpharmacological interventions offered to R1 prior to administration of PRN psychotropic for the month of September. ADON stated nonpharmacological interventions should be offered and documented prior to administration of PRN medications. Surveyor attempted to reach consulting pharmacist. A voicemail was left for pharmacist on 9/11/25 at 8:08 a. m. without a return call. A facility titled Policy and Procedure for Administering PRN Psychotropic Medication, updated 5/5/25, indicated that the nurse attempts an intervention prior to administering a PRN psychotropic medication.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on interview and document review, the facility failed to ensure a comprehensive care plan was maintained to ensure appropriate care was provided for 1 of 2 residents (R1) reviewed for discharge planning. Findings include: R1's quarterly Minimum Data Set (MDS) assessment, dated 6/13/25, indicated R1 had intact cognition with hallucination, delusions with fluctuating disorganized thinking and was independent with all activities of daily living (ADLs). Section Q indicated there was no active discharge plan for resident to return to the community. During an interview on 9/8/25 at 2:44 p.m., R1 stated she was looking forward to moving to an assisted living. R1 stated she had an assessment and was told it might take 6 months to find a place which R1 was frustrated by. R1 stated again that she wants to move out of the facility.R1's care plan, printed 9/8/25, indicated the following: -Discharge plan: discharge plans reviewed with resident on 3/10/25 and R1 wants to remain in the facility and does not have any plans to discharge. Resident only want to be asked about discharge plans yearly which was last revised on 3/21/25. R1's progress notes, dated 5/6/25 to 9/8/25, were reviewed and identified the following:-5/6/25: R1 expressed her intention to give notice to move out of the facility. -5/12/25: R1 canceled meeting with care coordinator for assessment on 5/22/25.-5/27/25: R1 expressed a desire to move out of facility, obtain a part-time job and rent a hotel room. Social worker told her it was not an appropriate discharge and her worker would only assist her if she decided to move into an Assisted Living.-7/23/25: R1 had an assessment to assess what resident would qualify for housing services for an assisted living. R1 ended the assessment as R1 was told staff would enter her room to clean.-6/24/25: care conference note: DISCHARGE PLAN: Resident is appropriate for this facility; no discharge is planned. Resident has stated she would like to discharge to the community without services, but this goal may be unrealistic. Declined to be assessed for CADI Waiver. -6/9/25: Discharge Plans: Resident believes she can discharge to independent living. Resident declined to work with her Health Plan Coordinator to discharge to an ALF or Group Home. Resident only wants to be asked about her discharge plans yearly.re not.-9/3/25: R1 completed assessment with care coordinator and will be referred for further assistance for discharge planning for an Assisted Living Facility. -9/4/25: reviewed issues with resident regarding delusions related to wanting to discharge and doing a MN-Choice Assessment. This was completed with staff assistance yesterday. No further follow up needed. R1's care plan lacked evidence of being updated after R1 expressed desire to move out of the facility. During an interview on 9/10/25 at 10:57 a.m., nursing assistant (NA)-A stated they were not aware of any discharge plans for R1. NA-A stated R1 talked about a lot of things but were not sure if they could recall if R1 had talked about wanting to move out. During an interview on 9/10/25 at 11:15 a.m., assistant director of nursing (ADON) stated she was aware of R1 wanting to discharge as R1 mentioned it this week. R1 stated the social worker was assisting her with this. ADON stated a comprehensive care plan should be up to date and include residents' goals and preferences. ADON reviewed R1's care plan and verified it did not reflect R1's desire to move out of the facility. ADON verified discharge plans should be updated and on the care plan. During an interview on 9/11/25 at 10:35 a.m., social worker (SW)-A verified that R1 had expressed desire to move out of the facility. SW-A stated social services had assisted with setting up assessments for relocation services for R1. SW-A stated when a resident's discharge plans changed then the care plan needed to be updated. SW-A verified R1's care plan had not been updated to reflect her desire to move and should have been updated. A facility policy titled Comprehensive Care Plan Policy, updated 5/2025, indicated residents shall have a comprehensive care plan which include the following: reflects their assessed care needs, preferences, goals and values; identify risks to their safety, well-being, and quality of life; details planned interventions and strategies to meet their care needs; promote coordination across multidisciplinary teams; it will be regularly reviewed and updated to reflect changes in condition or preferences.

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to collaborate with a resident's external mental health provider to ensure adequate behavioral services were provided if needed for 1 of 2 residents (R4) reviewed for behavioral Health Services. Findings include: R4's quarterly minimum data set (MDS), dated [DATE], indicated R4 was admitted to the facility on [DATE] and was cognitively intact. R4's diagnoses list, printed 9/18/25, indicated R4 had several medical diagnoses including major depressive disorder, attention deficit hyperactivity disorder, generalized anxiety disorder, panic disorder, and post-traumatic stress disorder (PTSD). R4's care plan, revised 12/19/24, indicated R4 had a history of trauma and was classified high risk and in need for psychotherapy for PTSD. Interventions included ACP [Associated Clinic of Psychology] therapy with her provider. R4's electronic medical record (EMR) lacked evidence the facility was in collaboration with R4's outside therapy provider. During an interview on 9/9/25 at 11:46 a.m., the director of social services (DSS) confirmed the facility did not have a process for ensuring therapy notes for R4 were obtained and did not have a process for collaboration between the facility and outside provider. The DSS stated the facility rarely received notes from outside therapists, although if there was an issue she would try to collaborate. During an interview on 9/10/25 at 8:12 a.m., the director of nursing and the administrator stated it would be expected that the facility collaborate with outside therapy providers, stating social services would be expected to review the notes for any new information and upload them into the resident's EMR. During an interview on 9/10/25 at 12:58 p.m., R4 stated the facility had assessed if she had PTSD but did not assess specific triggers for her. R4 confirmed she went to therapy outside the facility. A facility policy on behavioral health was requested but not received.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review, the facility failed to ensure pharmacist recommendations were acted upon timely for 2 of 5 residents (R3, R1) reviewed for unnecessary medication use.Findings include: Findings include: R3’s quarterly Minimum Data Set (MDS) dated [DATE] identified R3 with diagnoses of hallucinations (false perceptions that seem real but are not) and delusions (misconceptions or beliefs that are opposite of reality), anxiety, schizophrenia, and was taking antipsychotics and antidepressants. R3’s physician orders dated 2/22/25 identified the following: Quetiapine Fumarate Oral Tablet 400mg, give 400mg by mouth at bedtime related to SCHIZOAFFECTIVE DISORDER, BIPOLAR TYPE (F25.0) with Medication Class: ANTIPSYCHOTICS/ANTIMANIC AGENTS, Quetiapine Fumarate Oral Tablet 100mg, give 100mg by mouth at bedtime related to SCHIZOAFFECTIVE DISORDER, BIPOLAR TYPE (F25.0) with Medication Class: ANTIPSYCHOTICS/ANTIMANIC AGENTS, and ARIPiprazole ER Intramuscular Prefilled Syringe 400MG, inject 1 syringe intramuscularly one time a day every 4 weeks on Friday for Schizophrenia related to SCHIZOAFFECTIVE DISORDER, BIPOLAR TYPE (F25.0). Review of R3’s electronic medical record (EMR) for medication review recommendations (MRR’s) from April to September of 2025, identified missing MRR for June 2025. During an interview on 9/11/25 at 10:40 a.m., administrator stated the facility did not have any more pharmacy reviews than what had been provided and verified the facility did not have the June pharmacy review for R3. R1’s quarterly Minimum Data Set (MDS) assessment, dated 6/13/25, indicated R1 had intact cognition with hallucination, delusions with fluctuating disorganized thinking and was independent with all activities of daily living (ADLs). R1’s Order Summary Report, printed 9/11/25, identified R1 had current physician orders for several psychotropic medications including: -hydroxyzine 50 milligram (mg) tablet - give one tablet by mouth as needed for anxiety twice a day as needed for anxiety/sleep for 30 days - nonpharmacological intervention attempt before psychotropic administration effectiveness/any adverse effects with a start date of 9/9/25 and end date of 9/14/25 -lurasidone 60 mg tablet – give one tablet by mouth in the evening for bipolar – give with dinner with a start date of 2/15/25. -melatonin 3 mg tablet – give one tablet by mouth at bedtime for insomnia with a start date of 12/26/23. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-trazodone 100 mg tablet – give 150 mg by mouth at bedtime for insomnia with a start date of 11/21/24. R1’s progress notes, dated 5/8/25 to 9/10/25, were reviewed for pharmacy recommendations and identified the following: -5/8/25: Medication regimen review: Based upon information available at time of review and assuming accuracy and completeness of such information, it is my professional judgment that the medication regimen contained no new irregularities. -6/10/25: Medication regimen review: see comments for recommendations. -7/13/25: Medication review: Based upon information available at time of review and assuming accuracy and completeness of such information, it is my professional judgment that the medication regimen contained no new irregularities. -8/8/25: Medication review: see recommendation -9/4/25: Medication review: see recommendation R1’s Consultant Pharmacist’s Medication Review, dated 6/10/25, identified the consulting pharmacist (CP) a recommendation: “Please attempt a gradual dose reduction (GDR) of Trazodone to 100mg QD. If contraindicated, please provide a detailed rationale.,” along with a section titled Rationale for Recommendation which outlined requirements for GDR. A Physician’s response section directed the physician to check if they accepted or rejected the recommendation. Furthermore, if the recommendation for a GDR was clinically contraindicated to mark either box 1 or 2 along with providing a patient-specific rationale. However, neither of the boxes were marked nor did the report have any signature from the physician to demonstrate it had been reviewed and/or addressed. A cover letter, dated 7/16/25, was provided. The cover letter was a “Fax Transmittal Sheet” with a note “please see attached pharmacy recommendation and address” with R1’s name and date of birth . However, the cover letter lacked confirmation of fax transmission. Surveyor attempted to reach consulting pharmacist. A voicemail was left for pharmacist on 9/11/25 at 8:08 a. m. without a return call. During an interview on 9/11/25 at 10:43 a.m., assistant director of nursing (ADON) stated the June pharmacy recommendation review was not signed by the provider. ADON stated the provider was sent the recommendation and the facility did not receive a response. ADON stated she was unsure if the facility attempted to follow up with provider and was going to investigate this as it should have been. No additional information was provided. A facility policy on pharmacy recommendations was requested; however, none was received.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. Based on observation and interview, the facility failed to ensure soiled linen was covered when transporting it through facility. This had the potential to impact all 19 residents of the facility. Findings include: During observation on 9/8/25 at 11:50 a.m., a staff member was observed walking through first floor living room and dining room with uncovered linen basket that also had no liner or bag. There were 4 residents sitting in the living room and 3 residents sitting in the dining room as he walked past. Staff transported uncovered linen outside of the building and around the corner to the back of the facility and then entered the facility to walk down the stairs to the laundry room.During interview with on 9/8/25 at 2:06 p.m., with trained medication aide (TMA)-A admitted he was the one that transported the uncovered soiled linen from upstairs of the facility (second floor) and walked it down the stairs, through the living room and dining room to outside the facility and around the back to the basement laundry area. TMA-A verified the dirty linen basket he transported had no liner and was not closed or cinched. TMA-A stated, I should have it all covered for infection control.During interview with infection control preventionist (ICP) on 9/10/25 at 10:38 a.m., ICP stated expectation of staff to ensure all linen is covered, in a plastic bag to prevent infection. ICP stated expectation of staff to should wrap the clothes in the liner or plastic bag and then cover it with the lid [of the laundry basket]. It should always be covered when transporting linen, whether it is clean or dirty.During interview with nursing assistant (NA)-A on 9/10/25 at 1:58 p.m., NA-A stated expectation of staff to cover all linen when transporting it through the facility. NA-A stated each laundry basket should have a plastic bag as a liner which will have to be cinched prior to transporting it. NA-A stated importance of covering dirty laundry during transport is important for infection control contamination.Facility policy titled Linen and Laundry, updated 5/2025 identified soiled linen is transported in covered containers only.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. Based on interview and document review, the facility failed to ensure recommended influenza, pneumococcal, and Covid-19 vaccinations, as outlined by the Centers for Disease Control (CDC), were offered and/or provided in a timely manner to reduce the risk of severe disease for 1 of 5 residents (R3) reviewed for immunizations.Findings include: R3's immunization tab and progress notes in electronic medical record (EMR) lacked evidence R3 was educated about, offered, and received or declined the influenza, pneumococcal and Covid-19 vaccine.During interview with infection control preventionist (ICP) on 9/10/25 at 11:36 a.m., ICP stated expectation of facility to offer and document vaccine status for all residents. ICP stated expectation of staff to document in a progress note of any vaccine education, what was offered, what was received or declined. ICP reviewed R3's EMR and stated R3 EMR lacked documentation of refusals and follow up for influenza, pneumococcal, and Covid vaccine status.Facility policy titled Influenza and Pneumococcal Immunizations and Covid, updated 05/14/2025 identified, all residents and their legal representative will be offered the opportunity to receive the Influenza [and Covid-19] Vaccine on a yearly basis and that the Pneumovax and Prevnar Vaccine will also be made available to each resident. In addition, the EMR will be documented with the following:Education provided, whether they received it and did not receive it including refusals.

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F 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to provide at least 80 square feet per resident in three resident bedrooms (room numbers 101,102,103) affecting 9 of 19 residents (R15, R8, R13, R4, R9, R17, R2, R3, R7) whose bedrooms had less than the required square footage.Findings include:During observation on room [ROOM NUMBER] had three residents residing in the room and measured approximately 197.83 square feet of useable space or 65.9 square feet for each resident.During observation on room [ROOM NUMBER] had three residents residing in the room and measured approximately 239 square feet of useable floor space or 79.6 square feet for each resident.During observation room [ROOM NUMBER] had three residents residing in the room and measured approximately 220.71 square feet of useable floor space or 73.6 square feet for each resident.The rooms were observed to pose no safety hazards and were furnished adequately. There was no observable evidence R15, R8, R13, R4, R9, R17, R2, R3, R7 were negatively impacted by their room size. During interview with R7 on 9/8/25 at 1:46 p.m., R7 stated she shared a bedroom with two other residents, and [there was] Not enough room in my room to get around. During an interview on 9/10/25 at 12:58 p.m., R4 stated she did not feel like she had enough space in her bedroom shared with two other residents. R4 stated she enjoyed doing a lot of crafting and did not have the space in her room for it. R4 stated she could use the tables in the dining room, but they were often taken up by group activities, mealtimes, or staff and residents lounging in the area. During interview on 9/11/25 at 12:33 p.m., the administrator indicated there had been no changes or updates to the rooms since the prior survey.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24E150	A. Building B. Wing	09/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Grand Avenue Rest Home	3956 Grand Avenue S0uth Minneapolis, MN 55409

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 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Based on observation, interview and record review the facility failed to ensure facility was kept sanitary and maintained in good repair which had the potential to affect all 19 residents, staff, and visitors of the facility. Findings include:Walls:During observation on 9/8/25 at 12:18 p.m., wallboard under the hand railing leading to second floor had several areas of missing wallboard and peeling paint showing underlayment. The dining room had curling vinyl tile on the floor along wall the with the window and old-style radiator. A window air conditioner unit was attached to the upper sash of window that had curled up blue masking tape surrounding it while it was wedged into the window on a board. Air space was observed on the bottom of the unit. On second floor, the shower room had broken vinyl wall board at the top of wall above the toilet. The second-floor lounge room had an alcove with exposed mechanical venting material, and the three walls were peeling and missing paint and part of baseboard. In addition, dark red carpet on the floor of second floor lounge area had area of 24 inches by 24 inches of bright white stains.During observation and interview on 9/8/25 at 1:46 p.m., R7 was lying in bed of their shared room with two other residents. The window ledge along the wall where R7's bed was aligned had peeling and flaking paint, the window was unable to close completely showing a small area of opening, and there was crumpled up clear plastic wrap hanging from the top half of the window attached by two-sided tape. R7 pointed to the window and said the condition of the window ledge and hanging plastic wrap has been on there since I have been here and did not like the look of the window and stated [I] just have to take what they give me.During observation and interview with infection control preventionist (ICP) on 9/10/25 at 10:38 a.m., ICP stated expectation of maintenance to visit facility daily and do their rounds to look at building including walls, floors [sic] and talk to staff about any concerns. ICP stated there was no formal process to request and perform repairs. ICP observed the holes in the wall below the hand railing leading up to the second floor and said, I do not know how long that has been there. It should be fixed because it is peeling and not attractive. Is should be repaired and painted to match the wall. During interview with R16 on 9/10/25 at 12:40 p.m., R16 pointed to wall below the hand railing leading to the second floor and stated she did not like the holes in the wall, looks awful like no one cares. R16 also stated the window air conditioner unit in the dining room should look better. It is barely in there and Looks like it is gonna fall out. The floor [pointing to the dining room floor] has old peeling tiles and it looks awful.During interview with R7 on 9/10/25 at 12:46 p.m., R7 pointed to the wall below the hand railing leading to the second floor and said, 'I don't like the hole in that wall there. Should be fixed.During interview with nursing assistant (NA)-A on 9/10/25 at 1:58 p.m., NA-A stated staff do not have to fill out any form or anything [for work orders]. NA-A stated the maintenance director (M-D) arrived every day and fixes what needs to be fixed. During observation on 9/11/25 at 8:01 a.m., first floor lounge with door to unit bathroom had white plumbing tubing extending out from the wall in an area taking up 18 inches long by 10 inches wide and extended beyond the wall by 6 inches. The patched area was never finished to match the wall.During observation on 9/11/25 at 8:18 a.m., an outside post railing at the bottom of the stairs had metal bracket that was attached to the front of the stairs and then formed around a loose and rotting post with no attachments noted. The area where the metal bracket could attach to outside of railing had no concrete to attach to due to cracked and missing concrete corner. The post was loose and was not secured causing anyone who held onto the railing to sway.During interview with R2 on 9/11/25 at 8:21 a.m., R2 stated, the stains [on second floor carpet] are nasty!! I don't like the looks of it. Should be replaced. Been there a long time. The wall there [second floor alcove] needs to get fixed. Should be covered.During interview with R1 on 9/11/25 at 8:26 a.m., R1 was walking up the stairs from first floor past the holes in the wall and stated, I hate the holes in the wall there. The carpet [on second floor lounge] should be fixed and replaced. Too many stains. It looks awful.During interview with M-D on 9/11/25 at 8:37 a.m., M-D stated the facility did not have a formal request system for work orders. M-D stated he had no evidence of what he worked on and what was repaired. M-D stated the staining on the second-floor lounge carpet, broken wallboard, cracked and peeling vinyl wall in the upstairs bathroom and the downstairs dining room, exposed plumbing into the first floor lounge, the air conditioner unit that was taped to a wallboard with blue masking tape with visible areas outside, and the unsecured post at the bottom of the stairs all posted a sanitary issue. M-D stated they were all in need of repair and finishing. M-D stated R7's bedroom window ledge which was covered with large bits of peeling paint and the crumpled-up plastic wrap hanging on her window needed attention. That [crumpled up plastic wrap] is winter window covering for insulation. It should be removed after winter. Looks bad. Should be thrown away. M-D