STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24E355	A. Building B. Wing	03/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aftenro Home	510 West College Street Duluth, MN 55811

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on observation, interview and document review, the facility failed to ensure the narcotic emergency kit was tracked to prevent potential theft and diversion of medications. This had the potential to affect all residents residing on the nursing unit.Findings include:On 3/18/26 at 1:05 p.m., a tour of the locked medication room was conducted with registered nurse (RN)-D. The medication room had one emergency kit that contained controlled substances, was locked in a cupboard and had a plastic numbered lock on it. RN-D stated the emergency kit containing narcotics was swapped out weekly by pharmacy. If the emergency kit was used they would fill out a slip identifying what was used and for which resident. RN-D stated the emergency kit containing narcotics was not part of the shift change narcotic count.The emergency kit contained the following controlled substances:hydrocodone/APAP (acetaminophen) 5/325 milligrams (mg) quantity of sixhydromorphone 2 mg quantity of twooxycodone 5 mg quantity of sixtramadol 50 mg quantity of sixmorphine oral solution 20 mg per milliliter quantity of sixoxycodone/APAP 5-325 mg quantity of sixlorazepam 0.5 mg quantity of sixDuring an interview on 3/19/26 at 2:40 p.m., the assistant director of nursing (ADON) verified they had an emergency kit that contained controlled substances and that it was not part of the controlled substance count at each change of shift. The ADON stated there was potential for diversion by not accounting for the emergency kit at each shift change.Narcotic (Controlled Substance) Control Policy dated 10/25/25, identified all narcotics would be securely stored, accurately documented, and reconciled at each shift change.

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 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. Based on interview and document review, in the absence of a full-time registered dietician the facility failed to designate a qualified person to serve as the director of food and nutrition services. This deficient practice had the potential to affect any resident in the facility.Findings include:During an interview on 3/16/26 at 8:22 a.m., the dietary manager (DM) stated she didn't have a certified dietary manager (CDM) certificate, and didn't think anyone here did, but the dietician was here several times a month. During an interview on 3/18/26 at 2:27 p.m., the administrator stated the DM didn't have a CDM certificate and wasn't enrolled in the program yet but had been at a previous employment. The administrator offered the DM did have a food safety manager training certificate of completion from 2/26/24.During an interview on 3/19/26 at 11:24 a.m., the registered dietician (RD) stated she was aware the RD didn't have a CDM and that she handled the quarterly reviews for residents.A policy regarding dietary management qualifications was requested but not received.

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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 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review the facility failed to ensure a reliable system for identifying ingredients containing food allergens, and to ensure residents were not served items they were allergic to. In addition, the facility failed to have pre-planned menus for therapeutic diet types for 2 of 2 residents (R5, R35) reviewed for nutrition and food concerns.Findings include:R5's quarterly minimum data set (MDS) dated [DATE], identified R5 had intact cognition, a diagnosis of diabetes mellitus (DM), unplanned weight loss and needed set-up assistance with eating.R5's care plan dated 1/8/25, identified a focus statement related to DM and included interventions to have a dietary consult for nutritional regimen and ongoing monitoring, to discuss mealtimes, portion sizes, dietary restrictions, snacks allowed in daily nutritional plan, and compliance with nutritional regimen. Offer substitutes for foods not eaten. The care plan was updated on 1/30/26, the registered dietician (RD) added interventions for monitoring for signs of dysphagia, to monitor and report signs of malnutrition including weight loss of three pounds (lbs.) in a week, more than five percent in a month, or more than 7.5 percent in three months, or more than 10% in 6 months.R35's quarterly MDS dated [DATE], identified intact cognition and diagnoses of hypertensive heart failure, chronic kidney disease with kidney failure, and congestive heart failure (CHF). R35 needed set-up assistance with eating.R35's provider order dated 9/9/25, identified a two-gram sodium restricted diet.R35's care plan was created and last revised on 9/18/25, identified the need for set-up assistance with eating. A focus statement for nutrition identified interventions of serving a two-gram sodium diet as ordered.During an interview on 3/16/26 at 12:01 p.m., R35 stated there were no options if you didn't like the main course, and added she was sensitive to salt. R35 stated frustration at not being able to choose anything, and when you get an alternative, they give you want they want.During an interview on 3/16/26 at 12:26 p.m., R5 stated he was allergic to fish and they kept sending it to him, he demonstrated date and time-stamped pictures on his phone of a lettuce salad with dressing on it. R5 stated that was Cesear salad and he can't have it because of the dressing, and once last fall he was served tuna fish. R5 stated he normally called the kitchen on a day fish will be served to ask for a burger. R5 stated the facility didn't have an alternate menu.During an observation on 3/17/26 at 11:49 a.m., the current week's menu was posted on the dietary door on the first floor. At the bottom of the sign, it indicated alternative meal options were available and to call the kitchen two hours before the meal to allow staff to prepare your request.During an interview on 3/17/26 at 12:45 p.m., R35 stated she sent back her tray because it was sausage and peppers, which she stated she couldn't eat because of the sodium. R35 wasn't sure what she would eat, she didn't feel like going to her refrigerator, and staff didn't offer an alternative this time. R35 stated she had talked to the dietician right after she moved here, and they told her she could cross off the menu items she didn't want, and she made a list of everything she couldn't have. During an interview on 3/18/26 at 2:27 p.m., the administrator stated they had a huge action plan for resident satisfaction in dining, including a new ticket system. Their new food distributor will come to the facility and provide training, they have talked with dining consultants to come in and work with the DM on getting kitchen operations down, but first they were working on getting some consistency with staffing. The administrator stated the always-available menu hadn't been published yet, so there currently wasn't one. During an interview on 3/19/26 at 9:10 a.m., the DM stated they didn't have specific menus for things like diabetic and low sodium menus. They used a diet spreadsheet, so if there was a replacement needed they could make the adjustment, for example it could be a portion size change for them so they weren't completely devoid of a meal they would enjoy. The DM demonstrated a list written by R35 of food items she didn't want, including no salt or seasoning added. For R35, if she had asked for something different, they would have brought it up for her. For residents with food allergies typically the resident assistant (RA) will come (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	down and let them know what the resident would like in place of the item. For R5, it was just common knowledge he couldn't have fish products, and he would call down for a burger. Their current ticket system didn't recognize ingredients in the recipe as potential allergens. The DA stated she depended on staff to look at the allergy and make an informed decision, and she wasn't aware if the Caesar dressing they used had anchovy paste in it and they didn't have any right now to check. It was noted Caesar salad was on the current four-week menu rotation.During an interview on 3/19/26 at 11:24 a.m., the registered dietician (RD) stated the menus were written and approved by a dietician at the food distributor, the current 4-week rotation was for a general diet. They didn't have separate menus for therapeutic diets, they had a spreadsheet with the diet types and what the substation for a particular item would be, and the cook must check the tray ticket to see the resident's diet type and what the substituted item would be when they are dishing up the plate. The RD stated she would expect preplanning to be sure you had what you needed. For R35, with a sodium-restricted diet, she wouldn't want her to receive sausage and peppers for dinner on a day she had sausage for breakfast. And for R5, he would say ahead of time what he wanted instead of fish.During an interview on 3/19/26 at 12:53 p.m., the director of nursing (DON) stated it was important to follow a provider-ordered diet, but the resident could dictate their own diet, they could refuse an item or get something else they wanted. The DON would expect the kitchen to send the therapeutic diet, and for products containing fish not to be served to a resident with a fish allergy.

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure meals and snacks are served at times in accordance with resident?s needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure no more than 14 hours between the dinner and breakfast meals without offering a substantial snack.Findings include:A document, Dining Room Meal Service, listed breakfast as 7:30 a.m. to 8:15 a.m., lunch at 11:30 a.m. to 12:15 a.m., and dinner at 5 p.m. to 5:45 p.m. To ensure you receive your meal, please be in the dining room during the scheduled service time. Otherwise, a tray will be sent to your room.Food committee minutes dated 10/23/25, identified the administrator and dietary manager were in attendance. Concerns included the transition to more nutritious snack options with plans to phase out less healthy snack items. Residents mentioned staff members were witnessed helping themselves to resident snacks. Additionally, residents raised concerns about diabetic snacks and snack requests being unmet, after witnessing staff eating snacks.Food committee minutes dated November 2025, identified the dietary manager was in attendance. Residents requested snacks, egg salad to have for midnight snacks. A decision was identified, the nutrition director will coordinate with dietary cooks to prepare egg salad to be stored in a container on each floor along with a loaf of bread, residents can request assistance from on-duty staff to ensure optimal freshness.Resident council minutes dated 11/24/25, identified new business included a statement about snacks and soda, Aftenro is not going to supply everyone with soda and unhealthy snacks on a regular basis, only at special events such as bingo or happy hour. To do so would be outside the budget and mission. The facility will look at putting soda for sale in the country store for those residents who didn't leave the building. Residents requested [NAME] cookies and [NAME] Krispie treats and were informed these suggestions could go to the dietary manager. Sandwiches, fruit, vegetables are snacks that Aftenro can provide to residents. Items listed under the topic of kitchen included too many carbs at meals, 4-week menu cycle very repetitive, meat is too stringy, not many homemade meals, many things come out of a package, green beans and carrots are often undercooked and difficult to eat, diabetics need a more substantial snack between dinner and breakfast, snack situation still needs to be remedied, residents requested the administrators presence at the next food committee citing nothing gets done otherwise. There were noted discrepancies to the time, temperature and order correctness of items delivered to the floors.Food committee meeting minutes dated December 2025, identified the administrator and dietary manager were in attendance. Noted was a follow up on snacks, including a decision by the nutrition director to make the following snacks available at the nurse's station on each floor: microwave popcorn, crackers with peanut butter, granola bars, fig newtons, fresh fruit, pudding, Jello, popsicles, cheesy crackers, crackers with cheese. Noted for the next meeting was a discussion with residents about potential scheduled snack pass.During an interview on 3/16/26 at 8:22 a.m., the dietary manager (DM) stated the meals were delivered to the second and third floors prior to starting service in the dining room.During an interview on 3/16/26 at 12:26 p.m., R5 stated he was diabetic and needed a bedtime snack and there weren't snacks out anymore. During an interview on 3/17/26 at 7:23 p.m., trained medication aid (TMA)-A stated they didn't specifically offer snacks, but the residents all knew they could ask for them. At dinnertime a couple of the diabetics will get an extra sandwich.During an interview on 3/18/26 2:13 p.m., R35 stated never once had anyone gone around offering snacks. Even when you were to ask, it would take them a long time to go check and see if there was a snack. During an interview on 3/18/26 at 2:27 p.m., the administrator stated he had removed the big bowl of candy, snacks and pop because they were here to provide healthy snacks for the residents. The administrator stated they were not currently doing a snack pass where they go resident to resident and offer something, but they were in the process of changing the mealtimes so they could be within the 14 hours.During an interview on 3/19/26 at 11 a.m., registered nurse (RN)-A (continued on next page)

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	stated snacks were offered as needed; they used to have a snack cart out in the dining room for residents to help themselves, but they had issues with residents taking more than they should or not the right diet type. RN-A stated they did recently stop having soda, which was a cost savings. Almost every single resident had complained about this. During an interview on 3/19/26 at 11:24 a.m., the RD stated she was just recently made aware of the dissatisfaction of snacks here, when they used to have a very nice snack situation, she didn't know what changed and when this change had occurred. The RD stated there needed to be snacks residents wanted, and she would suggest something with protein and some milk would be helpful snacks in the event of low blood sugars, and as far as juice from concentrate being any healthier than soda, the RD felt it was a perception and the juice may be fortified with vitamins. A policy regarding timing of meals and snacks was requested but not received.Food Committee meeting minutes from January 2026 to present were requested but not received.An undated policy, Aftenro Home Snack and Beverage Availability Policy, described the purpose of the policy was to promote resident autonomy and access to snacks between meals. The policy defined the snack availability process as a designated area where residents may obtain food or beverages from staff or by requesting them from the nursing station. General requirements identified snacks, including whole fresh fruit such as bananas and oranges, may be provided by staff or available upon request at the nursing station. Only appropriate foods shall be provided by staff or made available upon request. Snack items must be stored in clean, designated areas and provided to residents by staff or upon request. For resident safety, staff must monitor and redirect residents who attempt to obtain food inconsistent with their care plan. For supervision and monitoring, staff are responsible for controlling access to snacks and ensuring safe distribution.

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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 record review, the facility failed to ensure potentially hazardous food (PHF) was dated when opened and held at safe temperatures when served to residents. In addition, the facility failed to ensure expired PHF was removed from circulation, that temperature logs were complete, and that medical equipment wasn't stored with resident food. These deficient practices had the potential to affect anyone consuming food and beverages at the facility.Findings include:During an observation and interview on 3/16/26 at 8:22 a.m., the walk-in cooler in the main kitchen contained an open and undated, partially full container of Prairie Farms heavy cream. The dietary manager (DM) stated she would expect milk to be dated when it was opened.During an observation on 3/17/26 at 11:57 a.m., the beverage station near the second-floor nursing station had a small refrigerator and freezer. There was an ice pack in the freezer with individual cups of ice cream. A sign on the refrigerator door indicated it was for labeled food only, no ice packs. Ice packs were in the freezer in the conference room.During an observation on 3/17/26 at 4:28 p.m., an unidentified dietary aid (DA) brought a cart of milk and juice cartons, not on ice, to the area where plated food was going into the hot carts for delivery to the floors. The DA proceeded to place milk cartons on the trays inside of the hot cart as plated food is being loaded. The tables already had place settings and milk containers at several of them. At 4:40 p.m., the DA brought the whole cart with juice and milk back into the walk-in cooler. At 5:07 p.m., the hot cart for third floor left the dining room. At 5:12 p.m., the DM temped a container of milk which had been on a table at a place setting, the temperature was 50.7 degrees Fahrenheit (F). At 5:18 p.m., the DA temped a carton of milk from the hot cart for the second floor. The temperature was 53.6 degrees F. The DM stated she wasn't sure what an unsafe temperature for milk was, but she thought it had to be sustained at a certain temperature for it to be un-servable. At 5:21 p.m., the DA temped a carton of milk from the hot cart on the third floor, the temperature was 55 degrees F. The DA stated milk had to be out for two to four hours above 40 degrees to be dangerous.During an observation and interview on 3/18/26 at 1:31 p.m., the second-floor beverage station refrigerator had resident food dated and labeled, individual containers of juice, and a multiple-serving container of open and undated, partially full orange juice. The temperature log was taped to the wall nearby and had no entries for 3/7, 3/8 and 3/14, 3/15/26.During an interview on 3/18/26 at 1:36 p.m., the assistant director of nursing (ADON) stated either nursing or housekeeping documented the refrigerator temperature, and dietary would be in charge of making sure things were labeled and dated. During an observation and interview on 3/19/26 at 9:27 a.m., a refrigerator behind the third-floor nurse's station contained food for residents and a temperature recording log was taped to front of it. The log had no entries for 3/7, 3/8 and 3/14, 3/15/26. The DA stated housekeeping was responsible for recording the temperatures and they were not there on the weekends, so that would be the empty spots. The DA added she had hoped nursing would do those.During an observation and interview on 3/19/26 at 9:32 a.m., on the second floor behind the locked nurse's station, there was a room with a refrigerator with resident food and beverages. The temperature log was missing the same dates as the other two. There was one-percent chocolate milk expired on 3/15/26, and four open, undated partially full containers of juice. The DA stated she would expect expired items to be removed.An undated policy, Aftenro Home Snack and Beverage Availability Policy, identified all food must be stored and handled in accordance with Minnesota Food Code requirements, perishable or temperature-controlled foods shall not be left out for self-service. Dietary staff are responsible for ensuring proper rotation and freshness of items.

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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, interview, and record review the facility failed to ensure proper measures were in place for the handling of resident and facility laundry. In addition, the facility failed to ensure residents were offered an opportunity to clean their hands prior to meals and that staff properly sanitized hands during dining services. These deficient practices had the potential to impact all residents who resided at the facility.Findings include: During an interview on 3/18/26 at 2:13 p.m., housekeeper HK-A gave a tour of the laundry area. HK-A explained dirty resident and facility laundry entered the laundry area via the laundry chute and then got sorted by color and type. They had been trained to wear eye protection if they had to rinse laundry, to wear gloves when they sorted laundry, and proper times that required hand sanitizing. HK-A stated they had not been told to wear a personal protective gown when sorting laundry, but they thought staff could if they wanted to, but it wasn't required. During an interview on 3/19/26 at 9:30 a.m., HK-B stated when they sorted laundry, they always wore gloves. HK-B opened the cabinet door next to the laundry scute and pointed to a single rolled up PPE gown and stated sometimes they wore the PPE gown in addition to gloves to protect themselves from things like urine-soaked linen. During an interview on 3/19/26 at 11:52 a.m., the director of nursing (DON) stated staff should always wear a PPE gown and gloves when they sorted laundry. This was important for personal safety and infection prevention reasons. During an interview on 3/19/26 at 1:17 p.m., the house keeping supervisor HKS stated for infection prevention reasons, staff were required to wear gloves when they sorted laundry. Staff were also required to wear a PPE gown when they sorted laundry bags marked with a biohazard sticker because those bags contained items that were soiled with substances like urine/BM (bowel movement), or blood. They believed once staff were done sorting the biohazardous laundry, they should then remove the gown and put it in the wash. It should not be reused. It would be optional for staff to wear a gown to sort general dirty laundry, but they were not required to do so. HKS did not identify any concerns with staff not wearing a gown to sort general laundry. The Facility policy In-House Laundry Services Policy & Procedure dated 10/25/25, directed all resident linen and personal laundry was to be handled and processed in adherence with infection prevention standards. The policy referenced F880, F584, and F550. The policy did not clearly state stand precautions including PPE gown should be utilized for soiled linen handling. During an observation and interview on 3/17/26 at 12:28 p.m., NA-A was pushing a cart with meal trays, there was no hand sanitizer or hand cleaning wipes on the cart or the resident meal trays. NA-A delivered meal trays to R23 and R36's rooms, entering their rooms setting the trays down. NA-A stated she didn't offer to clean their hands, and she didn't sanitize her own hands in between resident rooms. NA-A explained she hadn't really seen anyone else do that either. At 12:35 p.m., NA-B delivered room trays to R2, R24, R37 without providing cleaning wipes or other opportunities for residents to clean their hands before eating. NA-B stated they could offer wipes, but she hadn't seen any around here.

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to organize and participate in resident/family groups in the facility. Based on interview and record review, the facility failed to provide timely follow up to resident suggestions from the resident council. This deficient practice had the potential to affect any resident whose requests were brought forth at resident council.Findings include:Resident council minutes 10/27/25: ongoing challenges were noted regarding wheelchair cleanliness. Aftenro will explore implementing a suggestion box to encourage resident feedback and ideas.11/24/25: kitchen issues brought up by resident council included too many carbohydrates at meals, a 4-week menu cycle was too repetitive, not many homemade meals as many things are pre-packaged, diabetics needed a more substantial snack between dinner and breakfast, residents requested administrators presence at the next meeting, discrepancies in timing of meals delivered to the floors, food not kept warm, and wrong orders.12/29/25: resident council suggested cleaning wheelchairs and walkers, the administrator and dietary manager will follow up, residents suggested they could make a list of residents and cross one off a day. The dietary manager will follow up on a suggestion box and find a great location for it.1/28/26: old minutes reviewed including administrator following up with wheelchair cleaning and a suggestion box. Request for an agenda and minutes of past meetings to be present at all resident council meetings.2/25/26: Follow up on old topics, wheelchair cleaning and suggestion box, the administrator will continue to follow up.During an interview on 3/18/26 at 10 a.m., the resident council stated there were certain things that were brought up every month, but they keep getting put off, like the suggestion box, wheelchair washing, and food issues. The resident council explained the suggestion box wasn't for complaints but for people who want to have input into resident council but didn't come to the meetings. They also explained they asked about wheelchair washing because they appeared dirty, and they thought the facility could make a schedule and do them routinely. The resident council stated food has been an issue they talk about, for example too many carbs, too much chicken and processed food, but not all the residents were willing to say anything about it. The resident council stated they didn't feel like they got answers and weren't sure what the holdup was.During an interview on 3/19/26 at 3:40 p.m., social worker (SW)-A stated she thought progress had been made with the suggestion box as one has been ordered. For the wheelchair washing, she knew maintenance and housekeeping had been working on clearing the area for washing wheelchairs. SW-A stated they have offered to wash wheelchairs when requested.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to revise the care plan for skin and wound care interventions for a resident at risk for and having actual pressure ulcers for 1 of 6 (R8) reviewed for pressure ulcers. The facility also failed to include interventions related to high-risk medication use for 2 of 5 residents (R4, R12) reviewed for unnecessary medications. In addition, the facility to ensure care conferences were scheduled quarterly and/or for significant changes for 1 of 1 resident (R6) reviewed for care planning. Findings include: R8: R8's admission minimum data set (MDS) dated [DATE], identified impaired cognition and diagnoses of hypertension (HTN), hemiplegia, protein-calorie malnutrition, general weakness, and reduced mobility. R8 had limited range of motion upper and lower on both sides, was dependent for all activities of daily living (ADL)s, transfers, and locomotion. R8 was at risk for, and had an actual stage two, pressure ulcer. R8 needed hearing aids and glasses. A care area assessment (CAA) worksheet dated 4/1/25, identified R8 was at risk for impaired skin integrity due to urinary incontinence, impaired mobility, ambulatory dysfunction, impaired cognition, and chronic disease process. Braden score of 15 indicating at risk for pressure ulcer injuries. Proceed to plan of care. R8's significant change in condition (SCSA) MDS dated [DATE], identified R8 was at risk for and had an actual stage three pressure ulcer. A CAA worksheet dated 11/24/25, identified a stage three pressure on R8's left buttock area. R8 was resistive to turning and repositioning and declines to lie in his bed at any time, preferring to sit in his recliner most of the day and throughout the night. R8 was encouraged to allow staff to assist him with reposition, toileting, perineal hygiene and brief changes as necessary. He receives wound care from staff daily for existing pressure injury and monitored for any changes in skin integrity or development of new injury. Encourage and assist with repositioning or changing every two hours. Encourage and assist with repositioning or changing every two hours. Wound care and skin integrity was monitored and provided two times a day and as needed for R8. Staff will continue to follow his current plan of care. R8's care plan, created and last updated on 4/3/25, identified a focus statement for self-care deficit including the need for two staff to move his legs, turn, reposition or boost in bed. R8 also required the assist of two staff to transfer to the toilet, provide incontinent care and clothing adjustment. The care plan didn't indicate a frequency for incontinent care or repositioning. The care plan didn't include intervention for routine skin monitoring by a licensed nurse. Didn't include monitoring for the area under the glasses and hearing aid wires. Didn't include managing refusals of care or interventions, when to remove the hearing aid, or glasses. A progress note dated 10/14/25, identified the appearance of a sore on the top of R8's ear. A provider order dated 11/10/25, identified to encourage R8 to reposition every two hours. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aftenro Home	510 West College Street Duluth, MN 55811

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A progress note dated 11/21/25, identified an order to place Band-Aids on top of right ear before placing hearing aids. An order on 3/3/26, leave hearing aids out until directed by hospice RN. During an observation and interview on 3/16/26 at 10:52 a.m., R8 wasn't wearing hearing aids and was having difficulty hearing. R8's spouse stated she thought the nursing staff had the hearing aids because of the sore on his right ear from his glasses and hearing aid wire rubbing. During an interview on 3/19/26 at 10:30 a.m., registered nurse (RN)-A stated R8's hearing aids were not being placed due to a sore on his ear. RN-A stated R8 was someone who wouldn't remove them at night, and he had a sore on his ear from it. On scheduled bath day the NA has a skin assessment on their POC charting. The aids can then call the nurse and they come and do the assessment. During an interview on 3/19/26 at 1:28 p.m., the director of nursing (DON) explained hospice had made the decision to remove R8's hearing aids to help his ears heal. The DON added R8 had been wearing them for years without removing them, so his ear canals had been in bad shape too. The DON stated this was probably something they had missed with their care planning process. Care plans were reviewed at care conferences. R4: R4's quarterly Minimum Data Set (MDS) dated [DATE], identified R4 had diagnoses which included depression, chronic pain, adjustment disorder, adult physical abuse, alcohol dependence, anemia, iron deficiency, migraines, and convulsions. In addition, R4's MDS identified R4 was cognitively intact and took antipsychotic medications, antidepressant medications, antianxiety medications, and opioids. R4's Order Summary Report dated 3/19/26, identified the following orders: -monitor for potential side effects from opioid analgesics dated 7/2/25 -monitor/document/report as needed any risk for harm to self-dated 7/2/25 -psychotropic medication side effect monitoring dated 2/13/26 -resident will need to be monitored for over sedations due to increased suboxone and gabapentin dated 1/25/26 -buspirone 10 milligrams (mg) twice a day used for anxiety disorder -duloxetine 20 mg in the morning for chronic pain -gabapentin 600 mg three times a day for chronic pain -mirtazapine 30 mg at bedtime for depressive disorder -quetiapine 100 mg at bedtime related to post traumatic stress disorder -risperidone 0.25 mg twice a day for depressive disorder (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-suboxone 2 mg three times a day for chronic pain -trazadone 50 mg at bedtime for sleep disorder R4's care area assessment (CAA) dated 7/8/25, revealed the following: Section 7. Psychosocial Well-Being identified depression, the care plan consideration was checked as yes. Section 17. Psychotropic Drug Use, the classes of medications checked were antipsychotic, antidepressant, antianxiety, sedative/hypnotic. The care plan consideration was checked as yes. R4's care plan identified the following: Activities of daily living related to self-care dated 8/21/25 Diagnosis of stress bladder incontinence dated 7/10/25 At risk for falls dated 6/21/25 Nutritional problem dated 7/8/25 Shortness of breath dated 7/10/25 Fall dated 7/29/25 R4's care plan did not have any care plan considerations related to high-risk medications and/or interventions. R12: R12's annual MDS dated [DATE], identified R12 had diagnoses which included insomnia, fibromyalgia (chronic long-term condition characterized by widespread musculoskeletal pain, fatigue, and sleep disturbances), osteoarthritis (chronic degenerative joint disease where cartilage breakdown causes pain, stiffness and reduced mobility), and trigeminal neuralgia (chronic pain condition affecting the trigeminal nerve in the face causing sudden, intense, electric shock-like pain). In addition, R12 was cognitively intact, and took antianxiety, antidepressant, diuretic, opioid, and anticonvulsant medications. R12's Order Summary Report dated 3/19/26, identified the following orders: -monitor for potential side effects from opioid analgesics -psychotropic medication side effect monitoring -amitriptyline 25 mg daily for depressive disorder -buspirone 10 mg three times daily for anxiety disorder (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-duloxetine 60 mg twice a day for depressive disorder -gabapentin 100 mg three times daily for trigeminal nerve pain -oxycodone 2.5 mg every 12 hours as needed for moderate to severe pain -prednisone 5 mg every 24 hours as needed for trigeminal nerve pain -Wellbutrin 150 mg daily for depressive disorder R12's CAA dated 2/6/26, revealed the following: Section 17. Psychotropic Drug Use, the classes of medications checked were antidepressant, antianxiety, sedative/hypnotic. Care plan considerations were checked as yes. R12's care plan revealed the following: Falls dated 12/4/25 Vulnerable adult dated 5/2/25 Activities dated 3/17/26 ADL self-care performance deficit dated 11/8/24 Urge incontinence dated 5/27/23 Depression dated 2/13/23 Nutritional problem dated 2/10/23 Skin integrity dated 8/12/25 Diabetes Mellitus dated 5/27/23 Asthma dated 4/6/23 R12's care plan did not have any care plan considerations related to psychotropic, opioid or antianxiety medications and/or interventions. During an interview on 3/19/26 at 8:27 a.m., registered nurse (RN)-B reviewed R4 and R12's care plans and identified their care plans were missing information on high-risk medications. RN-B stated the care plan alerts staff to be aware of potential concerns and to monitor those concerns. During an interview on 3/19/26 at 10:18 a.m., the director of nursing (DON) stated the care plans should be updated quarterly with every care conference. The DON stated it was important to keep the resident care plans updated because they drive the resident's care. Comprehensive Person-Centered Care Policy dated 10/25/25, identified the purpose of the care plan (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	was to ensure each resident had an individualized, person-centered care plan that reflected their needs, preferences, and goals. In addition, the policy identified the care plan would be updated routinely and with changes in condition. The policy identified the care plan guides daily care delivery. R6: R6'6 significant change Minimum Data Set (MDS) dated [DATE], indicated R6 was cognitively intact with the diagnoses of diabetes, atherosclerotic heart disease, chronic kidney disease stage 4, major depression, and hypertension. Review of R6's electronic medical record (EMR) lacked evidence to show a care conference had been held in conjunction with R6's significant change MDS dated [DATE]. R6's most recent care conference documented in the EMR was documented as 11/26/25. During an interview on 3/16/26 at 10:06 a.m., R6 stated they could not recall attending or being invited to a meeting about their care or their care plan. During an interview on 3/19/26 at 1:09 p.m., the social worker (SW) stated they scheduled resident care conferences. Conferences were scheduled quarterly, for significant changes and then as needed or requested by residents/family. SW looked in the computer and stated R6 did not have a care conference scheduled. R6's last care conference was held on 11/26/25. The social worker confirmed R6 had not had a care conference when they had a significant change, R6 was overdue for a care conference. During an interview on 3/19/26 at 11:32 a.m., the director of nursing (DON) stated care conferences were required with quarterly and/or significant changes. The facility policy Care Conference (Interdisciplinary Team) dated 10/25/25 directed care conferences were to be conducted, if possible, quarterly, in conjunction with annual MDS assessments, within 14 days of a significant change, and within seven days of admission. Failure to adhere to the policy could result in citations.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure all sections of the minimum data set (MDS) were completed for 2 of 4 residents (R5, R8) reviewed for MDS accuracy.Findings include:Section C of the MDS focuses on cognitive patterns and includes a staff assessment for mental status and signs and symptoms of delirium. It assesses the resident's ability to make decisions, orientation and ability to register and recall new information.R5's quarterly MDS dated [DATE], identified section C was not assessed.R5's electronic medical record (EMR) didn't contain a progress note regarding the incomplete section C.R8's quarterly MDS dated [DATE], identified section C was not assessed.R8's electronic medical record (EMR) didn't contain a progress note regarding the incomplete section C.During an interview on 3/19/26 at 8:35 a.m., registered nurse (RN)-B looked at section C for R5 and R8 and confirmed they were not assessed. RN-B stated a note should be made in the chart as to why something wasn't assessed.

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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 observation, interview, and record review the facility failed to develop and implement a comprehensive care plan for a resident's sensory losses and devices, including the potential for skin impairment related to devices for 1 of 3 residents (R8) reviewed for pressure ulcers. In addition the facility failed to update and incorporate significant change Minimum Data Set (MDS) triggered care areas into the comprehensive care plan for 1 of 3 residents (R6) reviewed for comprehensive care planning. Findings include: R8: R8's admission minimum data set MDS dated [DATE], identified moderately impaired cognition, ability to hear with hearing aids, clear speech, the ability to make himself understood, and R8 wore corrective lenses. R8's care plan dated 4/3/25, didn't contain a focus statement for communication, hearing, vision, hearing aids, or glasses. The care plan identified R8 was at risk for skin impairment but didn't contain interventions for routine skin inspections by a licensed nurse or to provide guidance for assisting with the routine removal, or to address R8's refusal of removal of devices. During an interview on 3/19/26 at 1:28 p.m., the director of nursing (DON) stated R8 did have hearing aids, and confirmed hearing wasn't included in R8's care plan and it was probably something they missed with their process. R6: R6'6 significant change Minimum Data Set (MDS) dated [DATE], indicated R6 was cognitively intact with the diagnoses of diabetes, atherosclerotic heart disease, chronic kidney disease stage 4, major depression, and hypertension. Section V. indicated the following care areas had been triggered on the 1/21/26 MDS. The associated care area worksheets indicated the following care areas were to be addressed on the care plan as well. Mood state Psychosocial wellbeing – functional status psychotropic drug use functional abilities self-care nutritional status urinary incontinence pressure ulcer/injury at risk for developing (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R6's care plan at time of facility entrance on 3/18/26, identified target goal dates in the month of May and August 2025 for all focus areas with the exception of nutrition which had the goal date of 4/16/26. The care plan did not address the following care areas identified by the facility for care planning: pressure wound prevention, mood, psychotropic meds, or psychosocial wellbeing. In addition, the care plan had not been updated to reflect appropriate care interventions related to the changes in R6's lower extremities and resulting changes in abilities. During an interview on 3/19/26 at 11:32 a.m., the director of nursing (DON) stated care plans were updated as needed and with required quarterly or significant change care conferences. The DON stated they primarily updated the care plans. The DON stated triggered care areas like pressure ulcers did not always get updated in the care plan. Things like psychosocial and mental health should be incorporated into the care plan. The status of R6's lower extremities, and mental health should also be reflected in the care plan. The DON confirmed they had updated the goal dates on R6's care plan during the survey period but indicated they had not yet updated the content of the care plan. The facility policy Comprehensive Person-Centered Care Plan dated 10/25/25, instructed the facility will develop and maintain a comprehensive, interdisciplinary, person-centered care plan that will be initiated upon admit, is based on MDS/RAI assessment findings, reflects resident preferences and goals, is reviewed and updated routinely and with changes in condition and guides daily care delivery.

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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 observation, interview and document review, the facility failed to ensure a safe smoking area, safe extinguishing of cigarettes in designated container, and monitoring of designated smoking area for 1 of 3 residents (R46) reviewed for smoking.Findings include:R46's quarterly Minimum Data Set (MDS) dated [DATE], identified R46 had diagnoses which included heart disease, low back pain, left knee pain, heart failure (a disease in which the heart muscle doesn't pump blood as well as it should), anticoagulant use, hyperlipidemia, and nicotine dependence. In addition, R46's MDS identified that she was cognitively intact.R46's care plan dated 5/13/24, identified R46 had chosen to smoke cigarettes despite the risks to her health. Interventions included the following:-licensed staff had educated R46 on the risk versus benefit of smoking-licensed staff would educate R46 that smoking was only allowed outside in the designated smoking area- a smoking assessment would be completed quarterly to include the ability to light the cigarette safely, smoke it and discard it in the appropriate receptacle-any time the resident had a condition change they would be re-assessed for safe smokingDuring an observation on 3/17/26 at 5:48 p.m., R46 stated she was going out to smoke.On 3/17/26 at 5:52 p.m., R46 was returning from having a cigarette, she stated the door was coded but she knew the code so she could always get back in.During an interview on 3/18/26 at 10:37 a.m., the maintenance director (MD)-A stated residents who smoked had the code to the employee entrance. MD-A stated there were random items in the garage. MD-A stated there was lots of stuff in the garage that needed to go to the reclamation center. Inside the garage door there was a semi-circle of chairs, a stool with a number ten can that had several cigarette butts in it. Outside of the garage there was an official receptacle for cigarette butts.On 3/19/26, a continuous observation of the smoking area was started at 8:58 a.m. the continuous observation ended at 9:51 a.m.-8:58 a.m. R46 was seated on the bench seat of her wheeled walker in the open garage. There were five chairs in a semi-circle with a step stool in the middle with a rusted number ten can on top of the stool with cigarette butts in the can. There were two employees seated in the area (they were not smoking) one was seated in a cloth armchair. The garage had a large car door that was open to the outside. Outside of the garage there was an official butt disposal receptacle. Inside the garage there were wheelchairs, machinery, stacks of air conditioners, cardboard boxes on a shelf, computer stands, a full-sized chest of drawers and a smaller chest of drawers, a cloth covered recliner, folding chairs, plastic wheeled carts, stackable chairs, Christmas lights, shovels, and some type of wooden spinning game. The area was too crowded with items to list all and was too crowded to walk past the semi-circle of chairs. To the right of the garage door there was also a staircase going to an upper level. The garage was too crowded with items to get to the stairs to see if there was anything stored in the upper area. R46 was using the number ten can to put her cigarette ashes in. There was a lighter for lighting candles on the stool next to the number ten can. No evidence of a fire extinguisher or a fire blanket.-9:12 a.m., R46 remained seated in the garage, she appeared to put her hand into the number ten can, her hand went into her pocket.-9:19 a.m., R46 lit another cigarette and smoked again.-9:25 a.m., R46 lit another cigarette and continued to smoke.-9:30 a.m., R46 knocked ashes from her cigarette into the number ten can.-9:37 a.m., R46 put her cigarette out in the number ten can.-9:38 a.m., R46 lit another cigarette.-9:47 a.m. R46 stood up used and used her walker to leave the area, she did not put her cigarette butt into the receptacle outside of the garage.During an interview on 3/19/26 at 9:53 a.m., the administrator stated the smoking area was currently in the garage area. The administrator stated staff had been permitted to smoke in the area and then residents started to use the area too. The administrator stated he was unsure if there were any items in the garage that were combustible, if there was a fire extinguisher, or if there was a fire blanket in the smoking area. The administrator stated there would be a risk of fire if residents were smoking in an area with combustible materials.During an interview on 3/19/26 (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	at 10:38 a.m., the administrator volunteered he had looked at the area where residents were smoking and decided to close the area as there were too many items that were flammable. He also verified there was not a fire extinguisher or fire blanket in the area.The Tobacco and Nicotine Product Restrictions dated 3/10/26, identified they were a Tobacco-Free Campus with the exception of residents who were permitted to smoke prior to the implementation of the Tobacco-Free Campus free policy would be grandfathered under a Smoking and Nicotine Device Safety Agreement.Resident Smoking and Nicotine Device Safety Agreement signed by R46 on 3/5/26, identified smoking or vaping would need to be outside and in the designated smoking area (identified by Aftenro Home). Cigarette butts would be fully extinguished and disposed of in the designated receptacle. A lighter would be maintained by nursing staff and would be returned immediately after use.

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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 interview and record review, the facility failed to ensure a resident maintained acceptable nutritional status when they experienced significant unplanned weight loss, despite known dissatisfaction with meals, dietary restrictions, and repeated complaints impacting intake. The facility failed to implement and revise interventions to address their nutritional needs resulting in continued weight loss and psychosocial distress for 1 of 3 residents (R5) reviewed for nutrition. Findings include:The Resident Assessment Instrument (RAI) manual at chapter three identified Section K of the minimum data set (MDS) considered weight loss or gain significant if there was a change of 5-percent or more in a month, or 10-percent or more in six months.R5's quarterly MDS dated [DATE], identified intact cognition, a diagnosis of diabetes mellitus (DM) and unplanned weight loss. R5 needed set-up assistance with eating.R5's quarterly MDS dated [DATE], identified R5 had unplanned weight loss and needed set-up assistance with eating.R5's care plan dated 1/8/25, identified a focus statement related to DM and included interventions to:have a dietary consult for nutritional regimen and ongoing monitoring, anddiscuss mealtimes, portion sizes, dietary restrictions, snacks allowed in daily nutritional plan, and compliance with nutritional regimen, andoffer substitutes for foods not eaten.On 1/30/26, the registered dietician (RD) added interventions for:monitoring for signs of dysphagia, andmonitoring and reporting signs of malnutrition including weight loss of three pounds (lbs.) in a week, more than five percent in a month, or more than 7.5 percent in three months, or more than 10% in six months.Review of R5's electronic medical record (EMR), identified the following:5/2/24, a provider order for magic cups (a calorie-dense frozen snack) as needed and if blood sugar was less than 80 milligrams per deciliter.5/2/24, weight 273 lbs.5/4/24 for a regular diet, regular texture, thin liquids, and low potassium.8/21/26, weight 263 lbs.9/30/25, a progress note, R5 reported, I haven't had anything to eat in over a week. When asked why he wasn't eating, he stated Cuz the food here is terrible. They give me tuna fish when I'm allergic to fish! I don't have any appetite, and they aren't giving me as much of the juice I like either. Encouraged R5 to speak with kitchen manager and or the administrator, however he refused, stating It doesn't do any good. Reported this information to assistant director of nursing (ADON) and Clinical Coordinator.10/23/25, weight 246.7 lbs.11/11/25, a progress note R5 stated I think I'm getting sick. He reports eating poorly because he hated the food. Writer will report this information to R5's provider and to the next shift as well.11/20/25, weight 236 lbs.A dietary review couldn't be found in R5's EMR from 9/30/25 until 11/24/25.On 11/24/25, a registered dietician (RD) progress note for a quarterly review. R5 was served a regular, low potassium diet and was independent at meals. Recorded meal intakes have been 50 to 100 percent. Despite good oral intake, weight has trended downward. Net weight loss of 37 pounds or 13.5 percent in the past six months. Significant loss. Nursing staff, provider aware. Additional work-up planned. RD attempted to meet with R5 during round visit this date. R5 was out of his room. Will ask dietary manager to follow up with resident to discuss food preferences. Proceed with diet per order. Resident remains obese; however, rate of weight loss is a concern.11/24/25, a progress note R5 was extremely upset tonight. He stated he was very unhappy with the administrator. Took a clonidine. Tried to calm him down with talk therapy with very little results.11/27/25, a progress note, R5s' level of anxiety seems to be increasing over the past week. He states that This place is trying to kill me!, and I'm dying, and it's all the administrator's fault. Why is he punishing us all?. Resident was referring to his strong dislike of the food and that he is losing a lot of weight. He might benefit from another psychiatric evaluation and medication change. Writer will place a note in provider rounding book.11/27/25 at 5:45 p.m., a progress note, R5 was very agitated and yelling at kitchen staff, using inappropriate language. He stated that they did not send any milk with his supper tray and did not include his special silverware.11/27/25 at 6:10 p.m., a progress note, R5 was sent to emergency room (ER) at 6 p.m. per his request. He stated, ?I am having a panic attack; I need to go in right away.' Writer called for an (continued on next page)

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	24E355	A. Building B. Wing	03/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aftenro Home	510 West College Street Duluth, MN 55811

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	emergency ambulance, and the paramedics transported him to the ER.11/28/25 at 11:50 p.m., a progress note, R5 returned via transportation with ER discharge paperwork, resident has hypomagnesemia (low blood magnesium levels) and an order for magnesium chloride 64 milligrams (mg) sent to the pharmacy. Also stated he received Clonidine and Trazadone in the ER. Staff assisted R5 to his chair, he was still frustrated regarding previously noted issues of administration, therapy, food, cost. No behavior towards staff.11/28/25 at 10:00 a.m., a progress note, R5 came to writer and yelled at writer that the kitchen had sent the wrong silverware and threw his silverware roll down the hallway causing silverware to separate from the roll and land scattered on the floor. Writer educated R8 that it was not appropriate to throw objects, and if he received the wrong silverware to put his call light on and staff would get him the correct silverware. R5 then yelled I need to get out of here and left the area. Writer called the kitchen to request the correct silverware. After five minutes writer went to kitchen to collect the correct silverware. Writer then saw R5 on first floor in the entry way and let R5 know writer had the correct silverware and was going to put it in his room. R5 stated I don't need it anymore!.11/28/25, a progress note, at approximately 1:30 p.m., R5 came to writer and apologized for yelling earlier. Writer accepted apology and validated R5's feelings of frustration. While discussing lunch writer explained that hot dogs were the alternate for fish today. R5 stated he has been eating hot dogs all week because I am allergic to fish, writer told R5 writer was not aware of any other lunch meals this week being fish and R5 didn't reply. R5 allowed writer to reheat his lunch and bring it to his room. R5 stated don't they have any milk here? and I never get any milk. Writer showed R5 his meal ticket and milk was not listed, writer explained since it was not on the ticket it is not being put on his tray, and writer would go get milk now, and alert the kitchen that he would like milk with all meals. R5 was pleasant throughout the interaction and thanked writer. Dietary Department Communication Form was completed and given to the kitchen.11/29/25, a progress note, R5 requested as-needed (PRN) Clonidine, I need it. I'm having anxiety because of him (administrator). He's playing head games! That's what it is, he's playing head games with everyone here. I can't sleep because of him and this whole place. They don't know what the f*ck they're doing! They've taken everything! I'm going to get every one of you guys fired! Resident hyper and frustrated, he was speeding up and down hall in his power chair. Allowed CNA to help him back into bed.12/9/25, an RD progress note, identified R5 was served a regular, low potassium diet. R5 was independent at meals, with recorded meal intakes at 50 to 100 percent. R5's weights, in pounds, 12/4/25 235, 11/6/25 240, 9/19/25 257.2, 6/1/25 271. R5's net weight loss was 36 pounds or 13 percent in the past 6 months. Significant weight loss despite relatively good recorded meal intakes. Has colonoscopy scheduled. Proceed with diet per order. Update provider and responsible party of continued weight loss.During an interview on 3/16/26 at 12:26 p.m., R5 stated his frustration with the removal of the snacks from resident areas, R5 was also frustrated with the removal of soda pop from resident access, and stated the administrator removed them due to costs and then opened a country store for one hour a week where residents can purchase pop. R5 stated he was a diabetic and needed a bedtime snack, sometimes he would ask for an extra hamburger and then eat that later. Also, R5 stated he was tired of the rotating menu, they had the same things, like chicken, all the time and it was processed chicken. R5 demonstrated his lunch tray, there was processed and breaded chicken meat, vegetables and about half the plate full of rice. R5 shared he hid a clothing cover in his room because they didn't' ever send it up. R5 also stated he was allergic to fish and they kept sending it to him, he demonstrated date and time-stamped pictures on his phone of a lettuce salad with dressing on it. He stated that was Cesear salad and he can't have it because of the dressing. He stated one time last fall he was served fish, he normally calls the kitchen on a day fish will be served to ask for a burger. R5 stated the facility didn't have an alternate menu. Furthermore, depending on the cook R5 stated his burger patties were often burned and demonstrated several different pictures of blackened patties. R5 admitted he had gotten frustrated with asking for substitutes. During an interview on 3/17/26 at 1:37 p.m., R5 reported he got two spoiled milk this morning, their expiration date was for today and it (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	tasted sour. R5 stated he told everyone who would listen about the milk. Also today, R5 received small spoons with built-up handles and not the larger one for eating soup at lunch. Most people can't get to the little fridge by the nursing station. He doesn't go there anymore because there is no soda. He had emailed the dietician about the food but never got a response. R5 stated one of his concerns was the processed chicken not real chicken, like yesterday's chicken at lunch was processed. R5 stated this was often the case, they didn't get real chicken, and they had it a few times a week. R5 demonstrated the freezer in his room had several frozen dinners, the refrigerator had naan bread, condiments, and protein supplement drinks. R5 stated he had his friend start buying him the shakes, so he had something when he didn't want the food here.During an interview on 3/19/26 at 9:10 a.m., the dietary manager (DM) stated she was aware R5 had weight loss, but he could have magic cups if he wanted and they did try to accommodate his preferences. The DM explained R5 would call down during the meal to say he didn't like what he got and then they would make him something on the fly and he may or may not like it, and R5 didn't eat breakfast at the regular times because he slept in. The DM stated they worked with him, and it ended up he wanted his tray to go up on the cart and sit there in the hot cart while staff served everyone else and then put the tray in his room before they took the hot cart back downstairs. The DM stated the RD had seen him several times, and R5 visited with the administrator and assistant administrator. The DM added R5 was upset the V8 juice he liked was no longer available from their new distributor, but they weren't able to go out and purchase individual things for each resident. During an interview on 3/19/26 at 11:00 a.m., registered nurse (RN)-A stated R5 complained about the food all the time; he complained about repetitiveness, portion sizes, or he just doesn't like the taste. RN-A stated R5 could get a cheeseburger whenever he wanted, they could call down to the kitchen and ask. Regarding R5's behaviors, RN-A stated nothing was that frequent or all the time, most of the time for him it was understandable because it was out of frustration, he would use a stronger tone, but never physical. Didn't know him to be delusional. During an interview on 3/19/26 at 11:24 a.m., the RD stated she would pull weight reports around the middle of the month and identified weights that needed to be taken or retaken, and then she did her monthly charting on those residents with weight loss and email it to nursing leadership. The RD stated she would consider R5 nutritionally at risk and she did try meet with him in December when he met criteria for significant weight loss, despite having good recorded intakes which didn't match weight loss, but she wasn't sure meeting with him would help so she did discuss concerns with the DM. The RD hadn't considered the intake recordings may not be accurate. The RD stated she wasn't aware if his medical work-up had any findings and was just recently made aware of the dissatisfaction of snacks here, when they used to have a very nice snack situation, she didn't know what changed and when this change had occurred. The RD stated there needed to be snacks residents wanted, and she would suggest something with protein and some milk would be helpful snacks in the event of low blood sugars, and as far as juice from concentrate being any healthier than soda, the RD felt it was a perception and the juice may be fortified with vitamins. During an interview on 3/19/26 at 12:44 p.m., R5 demonstrated the pictures of Cesar salad on his phone, the most recent was dated 2/14/26 with the dressing already on it, and again on 1/13/26. During an interview on 3/19/26 at 12:53 p.m., the director of nursing (DON) stated R5's provider had ordered a diagnostic work-up for his weight loss, and it had been negative for findings. The DON stated his expectations would be for the kitchen to send the modified diet to residents, but R5 had always been mad about the food and he can request something else if he would like.Food committee minutes dated 10/23/25, identified the administrator and dietary manager were in attendance. Concerns included the transition to more nutritious snack options with plans to phase out less healthy snack items. Residents mentioned staff members were witnessed helping themselves to resident snacks. Additionally, residents raised concerns about diabetic snacks and snack requests being unmet, after witnessing staff eating snacks.Resident council minutes dated 11/24/25, identified new business included a statement about snacks and soda, Aftenro is not going to supply everyone with soda and unhealthy snacks on a regular basis, only (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	at special events such as bingo or happy hour. To do so would be outside the budget and mission. The facility will look at putting soda for sale in the country store for those residents who didn't leave the building. Residents requested [NAME] cookies and [NAME] Krispie treats and were informed these suggestions could go to the dietary manager. Sandwiches, fruit, vegetables are snacks that Aftenro can provide to residents. Items listed under the topic of kitchen included too many carbs at meals, 4-week menu cycle very repetitive, meat is too stringy, not many homemade meals, many things come out of a package, green beans and carrots are often undercooked and difficult to eat, diabetics need a more substantial snack between dinner and breakfast, snack situation still needs to be remedied, residents requested the administrators presence at the next food committee citing nothing gets done otherwise. There were noted discrepancies to the time, temperature and order correctness of items delivered to the floors.A document, Resident Problem/Concern Form dated submitted 11/28/25, identified R5 made a complaint regarding the food, mentioned he kept getting turkey which upsets his stomach, that he didn't receive the correct silverware when he needed his adapted silverware. R5 stated he had gotten raw food over the weekend and kept it to show it wasn't cooked. R5 also shared he didn't think all the cooks were very nice and that he hated this place and wanted to leave and has been trying very hard to do that. R5 felt dietary had not gotten better and that in his words, he and other residents are being subjected to abuse. The abuse was in the form of removing their snacks. R5's dietary ticket information identified as regular, allergy-shellfish, low potassium, seafood allergy, soup, no fish wants hamburger instead, fresh fruit, prefers grapes. Under the resolution or action taken, identified R5 met with the administrator to discuss dietary changes, that R5 was appreciative of the conversation and he encouraged R5 to keep filling out concern forms. Food Committee minutes dated November 2025, identified the dietary manager was in attendance. Residents requested snacks and egg salad to have for midnight snacks. The decision was identified, the nutrition director will coordinate with dietary cooks to prepare egg salad to be stored in a container on each floor along with a loaf of bread, and residents can request assistance from on-duty staff to ensure optimal freshness.Food committee meeting minutes dated December 2025, identified the administrator and dietary manager were in attendance. Noted was a follow up on snacks, including a decision by the nutrition director to make the following snacks available at the nurse's station on each floor: microwave popcorn, crackers with peanut butter, granola bars, fig newtons, fresh fruit, pudding, Jello, popsicles, cheesy crackers, crackers with cheese. Noted for the next meeting was a discussion with residents about potential scheduled snack pass.Review of the four-week rotating fall and winter 2025 menu revealed Caesar salad on one Tuesday lunch on the menu labeled week four.Additional Food Committee minutes were requested for January and February 2026 but were not received.Policies on specialty diets, alternative foods were requested but not received.

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F 0572 Level of Harm - Potential for minimal harm Residents Affected - Many	Give residents a notice of rights, rules, services and charges. Based on observation, interview and document review, the facility failed to ensure resident rights provided to residents on admission and posted in the facility were up to date. In addition, the facility failed to ensure residents were provided with resident rights during their stay. This deficient practice had the potential to affect any resident in the facility.Findings include:The Combined Federal and State [NAME] of Rights for residents in nursing facilities or skilled nursing facilities was updated effective 1/1/26.During an interview on 3/18/26 at 10:00 a.m., the resident council noted staff didn't review the resident rights at resident council meetings and hadn't for about a year, but they did note the rights were posted on the wall by the elevator.During an observation on 3/18/26 at 11:13 a.m., a resident rights poster, dated December 2015, was posted by first floor elevator. During an interview on 3/18/26 at 1:48 p.m., social worker (SW)-A stated they gave new residents the bill of rights at admission and demonstrated a form, Combined Federal and State [NAME] of Rights dated December 2017, as the form currently in their admission packet. SW-A stated they hadn't been reviewing resident rights at resident council but were going to be restarting that as they have done in the past.

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F 0567 Level of Harm - Potential for minimal harm Residents Affected - Some	Honor the resident's right to manage his or her financial affairs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review the facility failed to have the appropriate funds available for Medicare/Medicaid residents on the evening shift and weekends for 7 of 8 residents (R42, R24, R36, R1, R21, R46, R13) reviewed for personal funds. This had the potential to affect 39 residents who had funds held by the facility in a trust account.Findings include:Aftenro's Trust Transaction History report dated 3/18/26, identified there were 39 residents who had accounts including R42, R24, R36, R1, R21, R46, and R13.R42's quarterly Minimum Data Set (MDS) dated [DATE], identified R42 was cognitively intact.During an interview on 3/16/26 at 2:09 p.m., R42 stated they could not get their money at the weekend because the money was kept in the business office and the business office was not open on the weekends.R24's quarterly MDS dated [DATE], identified R24 was cognitively intact.During an interview on 3/18/26 at 2:18 p.m., R24 stated she had money in an account that the facility managed but stated she had no idea how to get any of the money.R36's quarterly MDS dated [DATE], identified R36 was cognitively intact.During an interview on 3/18/26 at 2:23 p.m., R36 stated if she wanted money from her account she would need to go to the business office. R36 stated she was not sure what she would do if she wanted money on an afternoon shift or a weekend.R1's quarterly MDS dated [DATE], identified R1 was cognitively intact.During an interview on 3/18/26 at 2:31 p.m., R1 stated she would have to wait for the business office to open to take money out of her account.R21's comprehensive MDS dated [DATE], identified R21 was cognitively intact.During an interview on 3/18/26 at 2:39 p.m., R21 stated her kids had put money into an account. R21 stated if she wanted money she would go to the business office and ask for money. R21 stated she had never tried to get money on an evening shift or the weekend.R46's quarterly MDS dated [DATE], identified R46 was cognitively intact.R13's quarterly MDS dated [DATE], identified R13 was cognitively intact.During an interview on 3/18/26 at 2:45 p.m., R46 and R13 both stated they needed to go to the business office to get money out of their accounts Monday through Friday during the day shift. Both stated if they needed money for the weekend, they would need to get it out during business hours before the weekend.During an interview on 3/18/26 at 10:13 a.m., business office manager (BOM)-E stated residents needed to come and see her in the business office Monday through Friday between 8:00 a.m. and 4:30 p.m., to remove money from their personal accounts. BOM-E stated if residents wanted money after hours or on the weekend they would tell the staff on the floor and the staff would leave her a note and she would get them their money when she was back. BOM-E stated money from the personal accounts was available Monday through Friday during business hours.On 3/18/26 at 11:33 a.m., BOM-E stated there was a process for residents to get money from their personal accounts after hours and weekends, she had just been made aware of this process. BOM-E stated there was a cash box in the medication room with $80.00 in the box. BOM-E stated the charge nurse had the key, the process was for staff to sign out the money requested and to fill out the transaction in a receipt book.During an interview on 3/18/26 at 1:40 p.m., registered nurse (RN)-C stated she learned about the cash box in the medication room for resident's who wanted money from their accounts today. RN-C opened the box which was locked in the medication room and checked the receipt book, the last time money had been signed out was on 7/2/22. During an interview on 3/18/26 at 1:44 p.m., trained medication aide (TMA)-B stated he was unaware there was money for residents available when the business office was closed.During an interview on 3/18/26 at 1:47 p.m., TMA-C stated they were unsure if there was money available for residents' requesting money after hours but would ask the charge nurse.During an interview on 3/19/26 at 10:25 a.m., the director of nursing (DON) stated there was money available after the business office was closed. He thought maybe residents knew about the money from resident council meetings and from the admission process.During an interview on 3/19/26 at 1:33 p.m., the social worker (SW)-A stated the trust account/personal account was discussed with resident's verbally prior to admission, the day of (continued on next page)

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F 0567 Level of Harm - Potential for minimal harm Residents Affected - Some	admission and at the first care conference. SW-A stated all of this information was verbal. SW-A reviewed the resident admission folder and verified there was no information regarding the trust account and how to access the money in the admission folder. A review of the Resident Trust (Personal Funds) & Procedure no date, identified residents would have access to their funds upon request. In addition, residents would have same-day access to small amounts (petty cash best practice).