| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 355129 | A. Building<br>B. Wing | 04/01/2026 |

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| Fargo Elim Health Care Center | 3534 University Drive S<br>Fargo, ND 58104 |

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| F 0684<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Provide appropriate treatment and care according to orders, resident?s preferences and goals.<br><br>1. Based on observation, record review, review of facility policies, and staff and hospice staff interviews, the facility failed to provide the necessary care and services to attain the highest practicable physical, mental, and psychosocial well-being for 1 of 1 supplemental resident (Resident #62) with uncontrolled pain under hospice care. Failure of staff to effectively assess and treat Resident #62's pain resulted in unnecessary pain and discomfort.<br><br>Findings include:Review of the facility policy titled Hospice occurred on 03/12/26. This policy, dated 03/18/24, stated, . The facility retains primary responsibility for implementing aspects of care .<br><br>Review of the facility policy titled Pain management occurred on 03/12/26. This policy, dated 02/18/26, stated, . Pain management is an interdisciplinary care process that includes . Assessing the potential for pain . Effectively recognizing the presence of pain . Identifying the characteristics of pain . Reports of pain are handled as high priority and handled as such.<br><br>During an interview on 03/11/26 at 3:45 p.m., Resident #62's family member (BB) voiced concerns regarding Resident #62's pain not assessed on a regular basis and the timeliness of administering prn (as needed) pain medications. The family member stated when he arrived this morning around 8:30 a.m., the resident was moaning, and when he asked the nurse when she last received a prn pain medication, the nurse stated, 4:00 or 4:15 this morning.<br><br>Review of Resident #62's medical record occurred on March 11-12, 2026. The current care plan stated, . Monitor level of comfort. Medicate per orders . Resident will maintain the highest possible level of comfort .<br><br>Resident #62's current physician's orders included:* 11/17/25 - Admit to hospice with primary diagnosis of hypertensive heart disease with congestive heart failure.* 03/11/26 - Hydromorphone (a pain medication) 2 milligrams (mg) every four hours. Can give as needed (prn) dose one hour after scheduled dose.* 03/11/26 - Hydromorphone 2 mg every two hours prn. Can give one hour after scheduled dose.* 03/09/26 - Lorazepam (an antianxiety medication) 0.5 mg every four hours prn. Can give two hours after scheduled dose.* 03/10/26 - Lorazepam 0.5 mg every four hours.<br><br>Review of the electronic medication administration record (emar) showed facility staff administered prn hydromorphone on 03/10/26 at 5:18 p.m. (22.5 hours before the interview with family member (BB) and not 4:00 a.m. or 4:15 a.m. the morning of 03/11/26 as identified by the nurse) and prn lorazepam on 03/10/26 at 5:19 p.m. Observation on 03/11/26 at 5:20 p.m. showed Resident #62 in bed and restless with family and the hospice nurse (#20) at the bedside. The hospice nurse stated she had requested the facility staff nurse administer prn hydromorphone and prn lorazepam related to signs of pain and restlessness. The hospice nurse also stated staff should use prn pain and anxiety medications more frequently. The hospice nurse educated the facility nurse (#17) on administering prn<br>(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 0684<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | medications more frequently and timely related to Resident #62's increased pain and restlessness.Observation on 03/12/26 at 7:21 a.m. showed Resident #62 leaned to the right of the bed, used accessory muscles to breathe, moaned, was restless, and fidgeted with the blankets and call light. After approximately 2-3 minutes the resident started grunting louder and attempted to move her upper body with no success. At 7:41 a.m., the resident's moaning and grunting became louder, and she stated, Help, help and continued to fidget in the bed. At 7:43 a.m., a nurse (#17) entered the room and administered the scheduled hydromorphone, lasix (to treat fluid retention) and lorazepam by the oral mucosa route. Resident #62 stopped moaning, grunting, fidgeting and appeared comfortable about 4-5 minutes after receiving the medications.<br><br>The EMAR showed the facility staff administered the last prn hydromorphone on 03/12/26 at 1:10 a.m. (over six hours prior) and administered the last prn lorazepam on 03/11/26 at 5:21 p.m. (over 14 hours prior).<br><br>During an interview on 03/12/26 at 8:01 a.m. a nurse (#17) confirmed Resident #62 received the last prn dose of hydromorphone at 1:10 a.m.<br><br>Resident #62's hospice progress notes included the following:* 03/10/26 at 12:16 p.m. This writer spoke with . staff nurse (#21) to encourage use of PRN hydromorphone and lorazepam for symptoms of non verbal signs of pain and restlessness/moaning.* 03/10/26 at 10:30 p.m. Visit made to patient per request of daughter for concerns of restlessness. Patient grimace and groans with touch/movement. Encouraged staff to check on patient QH2 (every two hours) through the night, utilize PRNs if warranted and [Hospice agency's name] hospice nurse could increase dose based on PRN use tomorrow.* 03/11/26 at 5:37 p.m. Had facility nurse give prn doses of hydromorphone and lorazepam while I was here for signs of pain restless with relief noted. Patient is now resting very comfortable at this time since the prn medications. Facility to continue to use prn medications as needed and to call [Hospice agency's name] hospice at any time if prn medications are not effective.<br><br>Review of Resident #62's electronic medication administration record (EMAR) from March 9th to March 12th at 9:00 a.m. showed the following prn medications:* 03/09/26 - Lorazepam prn administered one time at 3:53 p.m.* 03/10/26 - Hydromorphone prn administered at 5:18 p.m. Lorazepam prn administered one time at 5:19 p.m. The emar showed the resident's scheduled 12:00 p.m. dose of hydromorphone administered at 1:25 p.m. (1.25 hours later than scheduled). * 03/11/26 - Hydromorphone prn administered one time. Follow up on Resident #62's pain identified the medication as not effective. Lorazepam prn administered one time at 5:21 p.m. Follow up identified the medications as somewhat effective.<br><br>* 03/12/26 - Hydromorphone prn administered one time at 1:10 a.m.<br><br>Per observation and hospice nurse's notes, the hospice nurse requested the facility nurse administer both medications due to Resident #62 experiencing pain and restlessness.<br><br>The facility failed to appropriately monitor, assess, document, and treat Resident #62's continued pain.<br><br>2. Based on observation, record review, review of facility policy, review of professional reference, and staff interview, the facility failed to follow professional standards of practice for 1 of 1 sampled resident (Resident #27) observed during insulin administration. Failure to properly administer medications may result in residents receiving an ineffective dose and experiencing adverse reactions. (continued on next page) |

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| F 0684<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Findings include:<br><br>Review of manufacturer's instructions for Fiasp insulin aspart occurred on 3/12/26. These instructions, dated June 2023, stated, . Inject FIASP at the start of a meal or within 20 minutes after starting a meal .Observation on 03/11/26 at 5:00 p.m., showed a nurse (#9) administered Fiasp (rapid-acting insulin) to Resident #27. The resident received the evening meal meal at 6:15 p.m. (1 hour and 15 minutes after insulin administration). During an interview 03/11/26 at 6:13 p.m., a nurse (#9) stated, He should have his meal tray by now, normally I would offer juice or snack, but I did not today.During an interview on 3/12/26 at 2:55 p.m., an administrative nurse (#1) confirmed the nurse failed to administer the insulin as per manufacturer instructions.<br><br>3. Based on observation, record review, and staff interviews, the facility failed to provide the necessary care and services for 1 of 1 sampled resident (Resident #58) reviewed for wheelchair positioning. Failure to ensure correct positioning may result in pain and physical discomfort.<br><br>Random observations conducted throughout survey showed Resident #58 seated and reclined in a Broda chair (a specialized geriatric tilt-in-space seating device) leaning forward and to the right.<br><br>Review of Resident #58's medical record occurred on all days of survey identified diagnoses of Parkinson's disease, dementia with behavioral disturbance, osteoarthritis, pain, and restlessness/agitation. The record identified a wheelchair/positioning assessment completed by the Veteran's Administration (VA) on 05/13/23.<br><br>The current care plan stated, . Skin integrity . Resident noted to sleep in Broda instead of bed . FALL INTERVENTIONS . Recline Broda for positioning. The care plan failed to include interventions for proper head positioning while in the Broda chair.<br><br>Resident #58's care conference notes, dated 01/13/26, stated, . Education provided to family risk of skin breakdown d/t extended time in Broda . Staff do attempt repositioning (reclining) when in Broda to help protect skin integrity.<br><br>During an interview on 03/10/26 at 10:05 a.m., an unidentified nurse stated staff used a blanket to support Resident #58's head sometimes and indicated the blanket frequently fell out of place.<br><br>During an interview on the afternoon of 03/11/26, an occupational therapist (#22) stated she/he expected nursing staff to send a seating and positioning screening referral to therapy department. The therapist confirmed a positioning assessment had been completed since 2023 by the VA. |

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| F 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.<br><br>Based on observation, record review, review of facility policies, confidential resident interviews, family, visitor and staff interview, the facility failed to provide necessary care in a manner that promotes, maintains, or enhances their quality of life for 16 of 35 sampled residents (Resident #67, A, B, D, E, F, G, H, I, J, L, M, N, O, P, and Q) requiring assistance with activities of daily living. Failure to assist dependent residents with toileting, answer call lights timely, and speak to residents in a dignified manner does not enhance the resident's quality of life and has the potential to affect the resident's psychosocial and personal dignity.<br><br>Findings include:<br><br>Review of the facility policy titled Resident dignity, choices and preferences occurred on 03/12/26. This policy, dated 11/20/25, stated, . It is the expectation that all . employees will treat residents with dignity and respect at all times. Residents will be encouraged to voice their concerns and needs at all times to ensure their care needs, choices and preferences are honored.<br><br>Review of the facility policy titled Resident Rights occurred on 03/12/26. This policy, dated 11/20/25, stated, . facilities recognize they must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of the resident's quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident.'<br><br>-Review of Resident #67's medical record occurred on all days of survey. The current care plan stated, . COGNITION-strength: [Resident #67's name] does not have any cognitive diagnoses. He is alert and oriented and is able to make needs known to staff.TOILETING: Staff to provide assist x2 [times two] with toileting. Offer toileting upon arising, after meals, before bed and as resident requests.During an interview on 03/09/26 at 1:42 p.m. Resident #67 stated, At nights I put the light on and they [facility staff] don't come in. They turn it off out there [nurses' station] and I have had to wet my pants, and I hate to say it, but I've crapped my pants too before because of it. At night when I flip the switch to go to the bathroom, I get an argument from the night aide. They tell me that they just took me an hour earlier. They [facility staff] are telling fibs, they judge how often I should pee, and I tell them my body tells me when I need to pee. Just Friday I wet my pants. One night a few weeks ago, they [facility staff] put me to bed without my call button. Well, it was my fault because I should have checked that I had it before they [facility staff] left. That really scares me because otherwise I have no way to communicate with them [facility staff]. They [facility staff] wouldn't hear me if I yelled. So, I got my reacher and pulled my wheelchair over to me and transferred myself into the wheelchair and I went to hallway, and they [facility staff] gave me hell for getting up myself. They {facility staff] couldn't find it either right away, and I don't know where she [staff] found it.<br><br>During an interview on 03/10/26 at 1:25 p.m., Resident #67 stated, During the night shift, closer to the morning, I put my call light on to use the bathroom. A CNA [certified nurse aide] popped her head in the door and asked what I needed, and I said: 'I gotta pee bad.' She [the CNA] said, 'It's not your time to pee now, you're going to have to wait.' I said I can't wait, and then she turned my call light off and left the room. The night staff are rude and disrespectful to me. I've told [CNA #13's name] about the night shift not helping me to the bathroom when I need to pee. And [he/she] shakes [his/her] head.<br><br>During an interview on 03/10/26 at 1:55 p.m. with the CNA (#13), when asked if Resident #67 has told<br>(continued on next page) |

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| F 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | him about the night shift not assisting him to the bathroom, the CNA (#13) stated, [Resident #67's name] has told me that a couple of times in the last couple weeks. When asked what he does with that information, the CNA stated, I report it to the nurse, and I think she lets the case manager know, but that I am not sure about.<br><br>During an observation on 03/10/26 at 8:22 p.m., two CNAs (#11 and #12) assisted Resident #67 with evening cares and toileting. When the wheelchair was positioned in front of the toilet, the CNA (#11) told the resident to lock his wheelchair brakes. The resident did not hear the CNA (#11). The CNA (#12) started to lock the brakes on the wheelchair and the CNA (#11) stated, He can lock it. While sitting on the toilet the resident stated, My diaper is clean. The CNA (#11) stated, You've had this diaper on all day and we're going to change it. When the resident stood beside the bed, the CNA (#11) stated in a raised voice, SIT to the resident.<br><br>-During an interview on 03/09/26 at 4:29 p.m., Resident A stated the night shift CNAs are rude, and I've had some not nice interactions.<br><br>-During an interview on the evening of 03/10/26, Resident B stated, I am having trouble with the care here. They [staff] treat me like I am nothing. They make me do things that I do not want to do. I do not appreciate them giving me [explicative] all of the time when I ask for help. It is at night. It is the nurses that are on at night. It takes them more than 20 minutes to answer my call button. When I tell them it took so long for them to come, they disagree and tell me it did not take them that long. Sometimes they do not come at all.<br><br>-During an interview on 03/10/26 at approximately 9:00 p.m., Resident D stated, Some of the night shift staff have attitude and are not as nice as they should be.<br><br>-During an interview on 03/09/26 at 3:26 p.m., Resident E stated, I need to use the bathroom. Sometimes it takes a long time for them to come help me to the bathroom if they come at all. The surveyor noted a strong bowel movement odor in the room.<br><br>-During an interview on 03/10/26 at 11:20 a.m., Resident F stated, The night shift CNAs are not nice and they are rude. They could do better.<br><br>-During an interview on 03/09/26 at 1:42 p.m., Resident G identified the night crew as rude. Resident G stated one night he/she pressed the call button to ask help due to diarrhea. When a staff member came into the room, he/she told the resident to take care of it him/herself.<br><br>-During an interview on 03/09/26 at 3:00 p.m., Resident H stated the night shift grumble about helping me.<br><br>-During an interview on 03/09/26 at 12:55 p.m., Resident I stated, They [staff] have no manners. I get bruises from the way they handle me. I wish they would leave my stuff alone; It's my home.<br><br>-During an interview on 03/10/26 at 8:54 p.m., Resident J stated, The night shift CNAs [the CNAs from last night and tonight] are rude, they [staff] do not talk to me when they are in my room, unless they are upset with me then they talk back. I know I can be picky where I want things placed, but I need to be able to reach things. Sometimes they answer my call light and say they will come back but they never do. I do not have this problem with other shifts.<br>(continued on next page) |

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| F 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | -During an interview on 03/10/26 at 9:26 p.m., Resident L stated, I pressed my call button for help at 1:30 a.m. My call button fell on the floor after I pressed it. I needed staff to pick up my call button and readjust the pillow at my feet. I was very uncomfortable. Staff never came, and I finally fell back to sleep.<br><br>-During an interview on 03/09/26 at 4:44 p.m. Resident M stated, One of the attendants on the night shift is really mean. Resident M's family member (EE) stated, A CNA was really mean, it was a couple weeks ago. She was getting her ready to go to breakfast and the CNA told her, 'You need to hurry. I got another person to take care of.' During an interview on 03/10/26 at 8:18 a.m., Resident M cried and said he/she was upset. Resident M stated, They [the night shift] got mad at me because I wet the bed. They said, 'Why did you wet the bed. See that call light?' I had pushed the call light, and no one ever came. What was I supposed to do. They speak rough and are mean to me. I don't know what I did. Could you hide in the bathroom so you could hear the way they talk to me, I'd certainly give you permission.<br><br>-During an observation on 03/10/26 at 9:35 p.m., Resident N sat on the edge of his/her bed threading the catheter bag through his/her pants. The resident stated, I have to do all of this by myself, because the night ones [staff] are rude. It takes forever for them [staff] to answer my call light.<br><br>-During an interview on 03/10/26 at 8:37 p.m., Resident O stated, night shift CNAs are still making me use the bed pan to have a bowel movement. I have told them it is difficult for me to go on the bed pan; I can only go a little and I end up needing to use it several times in a row. Physical therapy does not want me using a slide board with staff yet, so I feel like the CNAs do not want to deal with me since it requires a hoyer lift to transfer me to the bathroom, and The night CNAs [like the two who are on tonight] have attitude.<br><br>-During an interview on 03/10/26 at 9:37 p.m. regarding Resident P, a visitor (DD) stated staff do not answer the call button at night and are not friendly and they leave Resident P on the toilet for long periods of time. Visitor DD stated Resident P has cried and yelled for staff to transfer him/her off the toilet.<br><br>-During an interview on 03/10/26 at 9:45 p.m., Resident Q stated, Staff speak in their native tongue and laugh with each other during cares. Staff do not talk to me. Staff are rough when they put me to bed even when I tell them to be careful, and it is painful. Staff have left me sitting on the toilet for long periods of time. My feet fall asleep and then I cannot walk. I lost my balance and fell one time trying to get up from the toilet myself. I screamed for help and staff came.<br><br>During an interview on 3/12/26 at 2:55 p.m., an administrative staff member (#1) stated, It is my expectation that residents are treated with respect and dignity, like you would treat your own family. |

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| F 0657<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, review of facility policy, and family and staff interview, the facility failed to review and revise care plans to reflect the residents' current status for 5 of 20 sampled residents (Residents #5, #11, #27, #38, and #58) care plans reviewed. Failure to update care plans limited the staff's ability to communicate needs and ensure continuity of care.<br><br>Findings include:<br><br>Review of the facility policy titled Care plan and baseline care plan occurred on 03/11/26. This policy, dated 02/18/26, stated, . Care plans are update with MDS [Minimum Data Set]/care conference schedule and as needed to assure that they are an accurate reflection of the resident and their care needs. - Review of Resident #5's medical record occurred on all days of survey. Physician's orders included spironolactone (a diuretic) once a day for chronic combined systolic and diastolic heart failure. A quarterly MDS, dated [DATE], identified diuretics as a high-risk drug/medication. The care plan lacked a problem, goal, and interventions related to Resident #5's diuretic use. - Review of Resident #11's medical record occurred on all days of survey and identified a supra-pubic catheter (a tube inserted into the lower abdomen to drain urine) . The care plan stated, . indwelling urethral catheter [a tube inserted into the urethra]. Requires Suprapubic Catheter.<br><br>Observation on the morning of 03/11/26 showed Resident #11 with a suprapubic catheter.<br><br>During an interview on 03/11/26 at 3:24 p.m., an administrative staff member (#1) confirmed Resident #11 had a suprapubic catheter and not an indwelling urethral catheter.<br><br>-Review of Resident #27's medical record occurred on all days of survey. The care plan stated, . [Resident name] is currently smoking on a regular basis. Smoking materials are kept in the nurse's med [medication] cart. [Resident name] will remain safe when smoking and will follow facility policy regarding smoking . Shared Risk Agreement in place for [name] and smoking. Fire safety education has been provided to [name] so he is aware or how to respond in the event of a fire. Staff to continually monitor clothing for any burn holes to ensure safe smoking habits. Encourage [name] to utilize the portable ash tray attached to his wheelchair. Empty the portable ashtray when he comes back inside and dispose of cigarette butts in garbage located in locked med room or he may empty the portable ash tray into the garbage can outside. [name] instructed on smoking policy and appropriate location(s) to smoke. [name] is to have personal cell phone when he goes out to smoke. [name] is to sign out and obtain cigarettes and lighter from nurse. [name] is to sign back in when done smoking and return cigarettes and lighter to nurse. Staff to monitor for safe smoking practices and will report concerns to nursing supervisor.<br><br>A smoking risk assessment, dated 02/20/26, identified Resident #27 as not safe to smoke under any circumstances.<br><br>During an interview on the afternoon of 03/12/26, two administrative staff members (#1 and #2) stated the facility is aware of the risks and continue to monitor Resident #27. Staff member (#1) stated, It's the wording of the assessment.<br><br>Resident #27's medical record showed a discrepancy between the smoking risk assessment and care<br>(continued on next page) |

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| F 0657<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | plan.<br><br>-During an interview on 03/10/26 at 9:07 a.m., a family member of Resident #38 stated, One day mom, got over to dad's apartment and the facility was not aware of it. Dad is confused and cannot care for mom right now, and the facility put an alert on her now. Now the facility will be notified if dad attempts to take her to the apartment.<br><br>Review of Resident #38's medical record occurred on all days of survey. Diagnoses include legal blindness and mild cognitive impairment of uncertain/unknown etiology. An admission MDS, dated [DATE], identified severe problems with thinking and memory. The medical recorded lack documentation of the incident mentioned by the family member.<br><br>An electronic message, dated 02/05/26 at 12:30 p.m., sent by administrative staff member (#3) to facility staff, stated, . now has a wanderguard [alarm system] in place effective 02/05/26. her husband . has been bringing her over to their apartment without alerting staff.The care plan lacked a problem, goals, or interventions related to Resident #38's possible elopement incident and application of the wanderguard. -Review of Resident #58's medical record occurred on all days of survey. The current care plan stated, . Problem: Hearing is impaired and utilizes bilateral amplifiers per his & [and] families request . Approach: Resident prefers to keep bilateral amplifiers at bedside when not in use.<br><br>During an interview on 03/12/26 at 8:45 a.m., a nurse (#10) stated the resident's amplifiers are kept in the top drawer of the nightstand and are no longer utilized per family's request.<br><br>The facility failed to revise Resident #58's care plan related to the amplifiers. |

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| F 0641<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure each resident receives an accurate assessment.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, review of the Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual (Version 1.20.1), and resident and staff interview, the facility failed to ensure accurate coding of the Minimum Data Set (MDS) for 2 of 34 sampled residents (Resident #6 and #64). Failure to accurately complete the MDS does not allow each resident's assessment to reflect their current status and may affect the accurate development of a comprehensive care plan and the care provided to the residents.Findings include:SECTION I: ACTIVE DIAGNOSESThe Long-Term Care Facility RAI User's Manual, revised October 2025, pages I-9 and I-12, stated, . Active Diagnoses . Coding Instructions: Code diseases that have a documented diagnosis in the last 60 days and have a direct relationship to the resident's current functional status . mood or behavior status, medical treatments, nursing monitoring. during the 7-day look-back period . Psychiatric/Mood Disorder . I6100, post-traumatic stress disorder (PTSD) . - Review of Resident #6's medical record occurred on all days of survey. A quarterly MDS, dated [DATE], showed the facility coded Post Traumatic Stress Disorder (PTSD) as an active diagnosis.During an interview on 03/11/26 at 10:54 a.m., Resident #6 stated he has never been diagnosed with PTSD.The medical record lacked documentation of PTSD diagnosis, behaviors, medical treatments, or nursing monitoring for PTSD.During an interview on 03/11/26 at 11:17 a.m., an administrative staff member (#3) confirmed facility staff coded Resident #6's MDS incorrectly. Section H: BLADDER AND BOWELThe Long-Term Care Facility RAI User's Manual, revised October 2025, pages H-1 to H-2, stated, . H0100: Appliances check all that apply . c. ostomy (including . ileostomy .) .Coding Instructions check next to each appliance that was used any time in the past 7 days. - During an interview on 3/10/26 at 11:20 a.m., Resident #64 confirmed the presence of an ileostomy. Review of Resident #64's medical record occurred on all days of survey. The current care plan stated, . Resident has an alteration in bowel status related to presence of ileostomy. An admission MDS, dated [DATE], showed facility staff failed to code an ileostomy. During an interview on 03/12/26 at 2:55 p.m., an administrative staff member (#1) stated it is an expectation that the MDS reflect a resident's current status. |

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| F 0690<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.<br><br>Based on record review, review of facility policy, and resident and staff interviews, the facility failed to provide appropriate toileting for 2 of 6 sampled residents (Resident #4 and #67) who required staff assistance with toileting. Failure to provide toileting may result in a loss of dignity and placed the resident at risk for skin breakdown, decreased self-esteem, urinary tract infections, and falls and/or injuries. Findings include:Review of the facility policy titled Nursing assistant standard care occurred on 03/12/26. This policy, dated 02/18/26, stated, . Assist with toileting needs per resident request. Refer to care plan for individualized toileting needs.- Review of Resident #67's medical record occurred on all days of survey. Diagnosis included fecal urgency. The current care plan stated, . COGNITION-strength: [Resident #67's name] does not have any cognitive diagnoses. He is alert and oriented and is able to make needs known to staff. TOILETING: Staff to provide assist x2 [assistance of two staff] with toileting. Per resident he has no control of bowels. Offer toileting upon arising, after meals, before bed and as resident requests.During an interview on 03/09/26 at 1:42 p.m. Resident #67 stated, At nights I put the light on and they don't come in, they turn it off out there and I have had to wet my pants, and I hate to say it, but I've crapped my pants too before because of it. At night when I flip the switch to go to the bathroom, I get an argument from the night aide. They tell me that they just took me an hour earlier. They are telling fibs, they judge how often I should pee, and I tell them my body tells me when I need to pee. Just Friday I wet my pants. During an interview on 03/10/26 at 1:25 p.m. Resident #67 stated, During the night shift, closer to the morning I put my call light on to use the bathroom. A CNA [certified nurse aide] popped her head in the door and asked what I needed and I said: I gotta pee bad. She (the CNA) said, 'It's not your time to pee now, you're going to have to wait.' I said I can't wait, and then she turned my call light off and left the room. The night staff are rude and disrespectful to me. I've told [CNA #13's name] about the night shift not helping me to the bathroom when I need to pee. And he shakes his head. During an interview on 03/10/26 at 1:55 p.m. with a CNA (#13), when asked if Resident #67 has told him about the night shift not assisting him to bathroom, the CNA (#13) stated, [Resident #67's name] has told me that a couple of times in the last couple weeks. When asked what she/he does with that information, the CNA stated. I reported it to the nurse, and I think she lets the case manager know, but that I am not sure about.Review of Resident #67's toileting record, dated February 15th, 2026 through March 10th, 2026, showed 72 occasions facility staff failed to assist the resident with toileting as care planned. The log showed gaps of approximately 5 to 16 hours between staff assistance with toileting.During an interview on 03/12/26 at 10:25 a.m., an administrative staff member (#1) verified several gaps in Resident #67's toileting task, and stated, He might have been offered, but didn't need to go. When asked if he/she expected staff to document if the resident refused, the nurse manager stated, Yes, they [the staff] should definitely be documenting refused if the resident was offered and refused.- During an interview on 03/09/26 at 3:26 p.m., Resident #4 stated, I need to use the bathroom. Sometimes it takes a long time for them to come help me to the bathroom if they come at all. The surveyor noted a strong bowel movement odor in the room.Review of Resident #4's medical record occurred on all days of survey. The current care plan stated, . Resident prefers to call for toileting at night and not to be awoken on rounds. TOILETING: Staff to provide assist . Offer toileting in the AM [Morning], after every meal, HS [hour of sleep], and as resident requests.Review of Resident #4's toileting record, dated February 15th, 2026 through March 10th, 2026, showed 94 occasions facility staff failed to assist the resident with toileting per the care plan. The record showed gaps of approximately 4 to 24 hours between staff assistance with toileting.The facility staff failed to provide toileting assistance consistent with Resident #4 and #67's needs/requests, which may result in decreased self-esteem, decreased dignity, and avoidable incontinence. |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.<br><br>Based on observation, review of professional reference, and staff interview, the facility failed to label medications in accordance with professional standards for 1 of 1 sampled resident (#46) observed for eye drop administration. Failure to ensure appropriate labeling of medications placed resident(s) at risk for medication errors.Findings include: Kozier & Erb's Fundamentals of Nursing, Concepts, Process and Practice, 11th Edition eText, 2021, Pearson, Boston, Massachusetts, page 834, stated, . administer the drug. Read the MAR [medication administration record] carefully and perform three checks with the labeled medications. Box 35.5 Check Three Times for Safe Medication Administration . First Check . Read the MAR and remove the medication(s) from the client's drawer. Verify that the client's name and room number match the MAR. Compare the label of the medication against the MAR. Second Check While preparing the medication . look at the medication label and check against the MAR. Third Check Recheck the label on the container . against the MAR .Observation on 03/11/26 at 1:03 p.m. showed a medication assistant (MA) (#8) prepared medications for Resident #46. The MA (#8) removed a bottle of lubricating eye drops from the drawer of the medication cart and administered it to the resident. The bottle identified a room number but lacked a label with the resident's name and instructions for administration. During an interview on 03/12/26 at 2:55 p.m., an administrative nurse (#1) confirmed all medications should have labels. |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.<br><br>Based on observation, review of facility policy, and staff interview, the facility failed to maintain a clean and sanitary kitchen environment for 1 of 1 kitchen. Failure to ensure cleanliness of the ventilation system above the grill and removal of ice buildup in the walk-in freezer has the potential for contamination of food and may result in a foodborne illness. Findings Include: Review of the facility policy titled Food service areas shall be maintained in a clean and sanitary manner occurred on 03/12/26. This policy, dated 01/09/26, stated . Kitchen . surfaces not in contact with food shall be cleaned . enough to prevent the accumulation of grime.The initial observation of the kitchen, occurred on 03/09/26 at 12:35 p.m. with two dietary supervisors (#18 and #19) and showed the following: * An accumulation of grease and grime on the ventilation system above the grill. * An accumulation of ice/condensation on the ceiling above and beside the fan of the walk-in freezer and an accumulation of ice on boxes of food under the fan.During interviews on the afternoon of 03/09/26 and 03/11/26, two dietary supervisors (#18 and #19) stated the vents above the grill and the walk-in freezer ceiling were not on a regular cleaning schedule but cleaned as needed. |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide and implement an infection prevention and control program.<br><br>Based on observation, record review, review of facility policy, and staff interview, the facility failed to follow standards of infection control and prevention for 2 of 8 sampled residents (Resident #64 and #86) observed during cares. Failure to practice infection control standards related to enhanced barrier precautions (EBP), catheters, glove use, and hand hygiene has the potential to spread infection throughout the facility. Findings include:<br><br>Review of the facility policy titled Transmission-based precautions, enhanced barrier precautions and empiric precautions occurred on 03/12/26. This policy, dated 09/29/25, stated, . Residents with an indwelling medical device, even if the resident is not known to be infected or colonized with an MDRO [multi-drug resistant organism] . Examples of high contact resident care activities requiring gown and glove use for enhanced barrier precautions include . Device care . urinary catheter .<br><br>Review of the facility policy titled Hand Hygiene occurred on 03/12/26. This policy, dated 07/02/25, stated, . Hand washing/sanitizing is necessary . 1. Before and after providing care to resident . 6. After removing gloves . 11. After handling dressings, catheters, bed pans, specimens or urine .-Review of Resident #64's medical record occurred on all days of survey. The current care plan stated, . requires enhanced barrier precautions . related to ileostomy and indwelling catheter .Observation on 03/11/26 at 11:21 a.m. showed an EBP sign on the outside of Resident #64's room. A nurse (#7) completed hand hygiene, applied a gown and gloves, and entered the room. The nurse removed two dressings from Resident #64's buttocks, discarded them in the trash, and cleansed the areas with a damp cloth. The nurse removed the soiled gloves, and without performing hand hygiene applied clean gloves, reached into his uniform pocket, retrieved a pen, and dated the new dressings. The nurse applied the new dressings, applied barrier cream to the left upper buttocks area, removed the soiled gloves, and without performing hand hygiene, applied new gloves. The nurse (#7) then cleaned the supplies off of the resident's bed, placed a pull up brief around the resident's legs, threaded the catheter bag and tubing through the brief and pant leg, and assisted the resident in pulling up the brief and pants. The nurse removed the soiled gloves and performed hand hygiene and exited the resident's room.<br><br>The nurse failed to perform hand hygiene after removing soiled gloves and before applying clean gloves.-Review of Resident #86's medical record occurred on all days of survey. A current physician's order stated EBP due to indwelling catheter. The current care plan stated, . requires Enhanced Barrier Precautions . R/T [related to] indwelling catheter .<br><br>Observation on the afternoon of 03/10/26 showed an EBP sign located inside Resident #86's room. A certified nurse aide (CNA) (#4) entered the room, performed hand hygiene, and applied gloves and a gown. The CNA (#4) drained the urine from the catheter bag into a clear plastic container. Wearing the same gloves, the CNA transported the resident from the bathroom to the bedroom via wheelchair.<br><br>The CNA (#4) failed to remove the soiled gloves and perform hand hygiene before transporting the resident out of the bathroom.During an interview on 03/12/26 at 2:55 p.m., an administrative nurse (#1) stated, staff should follow policy and procedure and always complete hand hygiene after removing gloves. |