STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435068	A. Building B. Wing	04/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avantara Watertown	415 Fourth Ave NE Watertown, SD 57201

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	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** A. Based on observation, interview, record review, and policy review, the provider failed to ensure resident safety regarding the side rails/grab bars and mattresses on the resident's beds were assessed for entrapment (trapped between the rail, mattress, or bedframe spaces) risk for three of three sampled residents (23, 35, and 48) who had loose side rails/grab bars on their beds and three of three sampled residents (23, 32, and 35) who had an unsecured mattress on their bed. Those failures put the identified residents at risk for entrapment injury or harm. Findings include: 1. Observation and interview on 4/22/26 at 10:31 a.m. with resident 35 in his room revealed his bilateral side rails could move away from his bed one to two inches. He stated they had been like that since he admitted to the facility. 2. Observation on 4/22/26 at 3:27 p.m. of resident 35's bed revealed there was a gap of five inches between the top of his mattress and the headboard. The top opening of his bilateral side rails measured four and three-quarter inches in width by five and one-half inches in height. The bottom opening measured four and three-quarters inches in width by four and one-half inches in height. 3. Observation and interview on 4/22/26 at 10:16 a.m. with resident 48 in his room revealed he had bilateral side rails on his bed. He used the left side rail to get in and out of bed, but it was loose. He did not use the right-side rail because it was against the wall. He thought the side rails were on his bed because he had nightmares which made him move around in bed and he had fallen out of his bed due to the nightmares. His left side rail could move away from the mattress three inches when pulled. He denied that he had gotten a body part stuck in the either side rail. He had told a certified nursing assistant (CNA) and his daughter that his left side rail was loose but did not know when he told them. He thought it was a week or so. 4. Review of resident 48's electronic medical record (EMR) revealed he was admitted to the facility on [DATE]. He had a 3/13/26 Brief Interview of Mental Status (BIMS) assessment score of 15, which indicated his cognition was intact. His diagnoses included that he was legally blind. On 8/15/25 resident 48 had a dream and fell out of his bed. He was sent to the emergency room after this fall and was diagnosed with a brain bleed. 5. Observation and interview on 4/22/26 at 10:36 a.m. with resident 23 in her room revealed she used the bilateral side rails to roll over in bed. The right-side rail could move away from the bed two to three inches when pulled. Resident 23 did not know how long her side rail had been loose. The opening within the bilateral side rails measured three and one-half inches wide by 13 inches in height. The space between the foot of her mattress and the footboard was seven inches. (continued on next page)

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

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

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	6. Observation and interview on 4/22/26 at 6:25 p.m. with licensed practical nurse (LPN) N in resident 32's room revealed resident 32 had a side rail on the right side of her bed. LPN N determined if a side rail or mattress was a risk for entrapment for a resident if there was a gap that a body part could be trapped in. LPN N measured the space at the top of the mattress to the side rail and the bottom of the mattress to the side rail when she assessed for an entrapment. She centered the mattress on the bed when she took the measurement even if the mattress could be slid over. Resident 32's mattress was able to slide to the wall leaving an eight-inch gap between the mattress and the side rail. 7. Review of the maintenance logbook for side rail inspections for January 2026 through April 2026 revealed that in January the side rail audits indicated that zone 1 (the opening within the side rail) was the only entrapment zone assessed. The other six zones of entrapment were documented as not applicable. In February all seven zones of entrapment were documented as having passed the audit on every bed assessed. In March only zone 1 was documented as being assessed, all the other six zones were documented as not applicable. In April six side rail assessments were documented as passed for zone one with not applicable for the other 6 zones. Twenty-one side rail audits were documented as not applicable for all seven zones. Those residents documented as not applicable for all seven entrapment zones in April 2026 included residents 2, 3, 4, 12, 14, 16, 17, 22, 23, 31, 33, 35, 36, 37, 45, 47, and 48. Residents who were identified as having side rails that were not included on the April 2026 side rail audit included residents 8, 27, and 32. There were no entrapment assessments for zone 7 (the space between a mattress and headboard or footboard) from January 2026 through April 2026 documented for residents without a bed rail. 8. Interview on 4/22/26 at 6:06 p.m. with director of nursing (DON) B revealed she was unsure if the provider had a policy related to entrapment assessments. She thought maintenance did the entrapment assessments on the residents' beds. The side rail assessments were to be completed by the nurse on the resident's admission if the resident or the resident's representative wanted a side rail and quarterly by the Minimum Data Set (MDS) nurse. DON B completed the consent for side rails with the resident or the resident representative and that consent had the risks versus benefits of having a side rail on it. 9. Notice of immediate jeopardy (IJ) of F689 was given verbally and in writing on 4/22/26 at 7:00 p.m. to administrator A regarding the resident's side rails not being securely attached and the mattresses on residents' beds not being assessed for entrapment. Observations made throughout the survey and throughout the entire building on 4/22/26 revealed there were several safety concerns related to side rail installation, maintenance, and bed zone assessments. Residents 23, 35, and 48 had side rails that were not securely attached to their bed, which created a risk for resident entrapment and injury. Resident 23's side rail openings measured three and one-quarter inches in width by 13 inches in height, was loose and separated from the mattress with over two inches of a gap which created a risk for entrapment and injury. Resident 48's side rail opening measured three and one-quarter inches in width by 11 inches in height, was loose, and separated from the mattress with over two inches of a gap which created a risk for entrapment and injury. Resident 35 had a five-inch gap between the top of his mattress and his headboard which created a (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	rails and mattresses, and when the side rails were loose. 15. Review of the provider's 11/18/25 Bed Rail policy revealed, These cbars [side rails] pose safety hazards and must be evaluated for appropriate placement for the sole purpose of transfer and bed mobility assistance for the resident. The Entrapment Zone Review Form (or electrical format in TELS) is completed upon placement of rails, quarterly and with a resident change of condition. Entrapment zones should be assessed with any changes of mattress. B. Based on South Dakota Department of Health (SD DOH) facility-reported incident (FRI), observation, interview, record review, and policy review, the provider failed to ensure the safety of: *One of one sampled resident (58) who fell from his bed that was left in an elevated position by CNA Z and required further evaluation in the emergency department (ED) due to a possible head injury. *One of one sampled resident (22) who was assisted by CNA NN with a sit to stand (a mechanical lift used to assist from a seated to a standing position) lift transfer done incorrectly which caused the resident to have pain. *One of one sampled resident (56) identified as at risk for elopement (leaving the facility without staff knowledge) who eloped through an unsecured door and was outside for approximately 15 minutes. *One of one sampled resident (59) who fell while transferring herself to the bathroom and hit her head which required an ED evaluation, when the provider failed to implement review and revise interventions to reduce the risk of falls when she fell 11 times in 30 days. Findings include: 1. Review of the provider's 1/8/26 SD DOH FRI revealed on 1/8/26 at 11:15 p.m. resident 58 fell out of his bed. When the staff responded to resident 58 they noted that his bed was not in its lowest position. Registered nurse (RN) OO thought resident 58 hit his head during the fall and due to him being on an anticoagulant (blood thinning) medication he was transported by ambulance to the ED for evaluation. He returned to the facility from the ED after a few hours with a diagnosis of a minor closed head injury and abrasions to his left forearm, wrist, and knee. Resident 58 was trying to take off his socks while he was in bed and due to his left-sided weakness from a prior stroke (blood supply to the brain is blocked or reduced), he fell sideways and out of bed. Resident 58's bed was left in an elevated waist high position by CNA Z at 9:30 p.m. 2. Review of CNA Z's 1/9/26 fall witness statement revealed she had assisted resident 58 to bed at approximately 9:30 p.m. She did not have a pocket care plan (a document that identifies residents' care needs and interventions) to reference because the system was not working so she left his bed at waist height. 3. Review of resident 58's EMR revealed he was admitted to the facility on [DATE] and passed away on 2/4/26. His diagnoses included a stroke with left sided weakness or paralysis. His care plan (personalized plan that addresses a resident's care needs, goals, and interventions) did not identify a specific height at which his bed was to be positioned before he fell from his bed on 1/9/26. After he fell out of bed on 1/9/26 his care plan indicated he had a high risk for falling, and his bed was to be left in the lowest position for his safety. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	4. Interview on 4/29/26 at 9:10 a.m. with CNA HH revealed that if a resident was not care planned for a specific bed height the resident's bed was to be positioned at a height that when that resident sat up on the side of the bed their feet would rest flat on the floor. 5. Interview on 4/29/26 at 10:09 a.m. with DON B revealed she was notified when resident 58 fell out of bed. When she completed her investigation, she found out he was trying to remove his socks while he was in bed and due to his left-sided weakness because of his stroke he fell to the side and out of bed. His bed was not in the lowest position after the staff had assisted him to bed. She expected the staff to leave the residents' beds in the lowest position after they had completed cares for that resident. 6. Review of the 2025 CNA competency checklist that was used upon hire and annually revealed that the bed mobility competency required the resident's bed to be left in the low position after the staff assisted the resident. 7. Review of the provider's 4/25/26 SD DOH FRI revealed that resident 22 had sustained a back injury when contracted travel CNA NN transferred him using a sit-to-stand lift with a sling that was too small. Contracted travel CNA NN transferred the resident without another staff member's assistance when resident 22's care plan indicated he required two staff members to assist him to transfer. Resident 22 needed further outside medical evaluation for the injury. His care plan was updated to reflect that he should no longer receive care from contracted travel staff, only the provider's staff. 8. Interview on 4/22/26 at 10:06 a.m. with resident 22's family member revealed that although his care plan indicated he needed two staff members to assist him with transfers, she said, there's usually just one person transferring him. 9. Interview on 4/22/26 at 3:04 p.m. with social services designee (SSD) J revealed that updates to the resident's care plans were added to a communication book that the staff were to read each day before their next shift. 10. Interview on 4/27/26 at 2:16 p.m. with CNA U revealed that she determined how to transfer a resident by referencing the resident's care plan or Kardex (a report of the resident's care needs and interventions). 11. Interview on 4/27/26 at 3:53 p.m. with resident 22 revealed that he was aware that two staff members were supposed to help him transfer. He stated, Just one person comes to get me for my bath. I'm supposed to have two people [transfer me] at all times. He stated that he thought the contracted travel staff were not always aware that he was to be transferred by two staff members. He informed DON B when only one staff member transferred him. 12. Interview on 4/28/26 at 11:35 a.m. with resident 22's family member revealed that on 4/24/26, she had to show a contracted travel CNA how to use a mechanical lift in resident 22's room. Resident 22's family member stated, I asked her if she knew how to use the lift and she said, 'No, but I can look it up.' A nurse called [me] the next morning [to report the 4/25/26 incident], and she apologized and said a CNA transferred him [resident 22] by herself and he got hurt. 13. Interview on 4/28/26 at 12:15 p.m. with LPN KK revealed that as a contracted travel nurse, she was expected to arrive early on her first day at a facility to complete training on how to operate the mechanical lift equipment. She said the training only occurred the first time she was hired for a (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	and repeated the monthly elopement drill to reinforce the importance of always knowing the location of assigned residents and promptly locating anyone whose whereabouts are unknown. Door audits are being performed regularly. 23. Review of resident 56's EMR revealed he was admitted to the facility on [DATE]. His 6/18/25 facility care plan indicated he had a potential for elopement and was revised on 1/9/26 and 1/26/26 addressing his history of elopement's. The 9/18/25 care plan interventions instructed the staff to ensure that the resident wore an identification bracelet, to have the resident follow a familiar routine, keep photographs of the resident's family and/or their significant other to help provide one to one care, maintain a calm environment, avoid stimulation by other physically aggressive residents, to place the resident on a therapeutic unit, provide the resident with his robotic dog, and to provide activities that resembled the residents prior lifestyle. On 1/25/26, a wander guard was added to the care plan and instructed staff to check the placement since the resident would remove it and place it on his ankle. The 1/26/26 initiated care plan interventions included the resident's family suggesting referrals be sent out to memory care locked units, the staff to check on the resident every 30 minutes, to maintain the elopement binder, and to have his family/friends sign the resident in and out of the facility. 24. Interview and record review on 4/29/26 at 11:45 a.m. with DON B revealed on 1/24/26, the door alarms were deactivated at the time of resident 56's elopement. The facility tried to redirect resident 56's wandering and agitation by having his significant other come and visit with him. Resident 56 would attend activities and would sit with management at times. He received a physician's order for a wander guard on 1/24/26 after his elopement. 25. Review of the provider's revised 5/14/25 Elopement policy revealed The facility must take steps to keep the resident safe and assess residents to identify those who are risk for elopement. Facility personnel must investigate all reports of missing residents. Elopement drills should be conducted monthly. 26. Review of the provider's 1/31/26 SD DOH FRI revealed on 1/31/26 at approximately 12:00 a.m., resident 59 was found sitting on the floor between her bed and the bathroom. RN QQ conducted a full body assessment. Resident 59 stated she hit the left side of her head and was transferred to the hospital for further evaluation because she was taking a blood t

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and policy review, the provider failed to protect the resident's right to be free from sexual abuse for one of one sampled resident (21) who reported he was touched in a private area without his consent by one of one contracted travel certified nursing assistant (CNA) (E). Immediate Jeopardy (IJ) at F600, with a scope and severity of J, began on 4/21/26 at 9:17 a.m. upon observation of resident 21 in the hallway when he reported to registered nurse (RN) D that he had a concern of being touched by a staff member on 4/21/26. Resident 21 reported that contracted travel CNA E had touched him in a private area without his consent, which upset the resident. The provider failed to report and investigate the allegation of abuse to other entities, provide education to all staff, interview any further residents and staff regarding the allegation, and provide safety to resident 21 and all the residents to prevent similar situations from occurring. Administrator A was notified of the IJ on 4/21/26 at 3:28 p.m. and a removal plan was requested. The removal plan was received on 4/21/26 at 6:38 p.m. by email. The edited removal plan was received on 4/21/26 at 6:55 p.m., and it was accepted on 4/21/26 at 7:01 p.m. The IJ was removed on 4/21/26 at 10:00 a.m. as confirmed by onsite verification by the survey team. After the IJ removal, the scope and severity of the noncompliance remained at a G. The resident census was 45. Findings include: 1. Observation on 4/21/26 at 9:17 a.m. of resident 21 in the hallway revealed he reported to RN D that contracted travel CNA E had touched him in a private area without his consent, which upset him (resident 21). RN D told the resident they had handled that situation. 2. Interview on 4/21/26 at 10:02 a.m. with resident 21 revealed that he was touched in a private area without his consent by one of one contracted travel certified nursing assistant (CNA) (E). At 6:00 a.m. on 4/21/26, he woke up with a quick startle when someone had their hands in my pants. I said, what the hell are you doing? He said that contracted travel CNA E replied, I am trying to see if you are wet. Resident 21 then stated to CNA E, I said you get the hell out of here, and per resident 21, CNA E left his room. The resident said that CNA E did not stop to explain anything to him. He stated that CNA E groped him with her hands down his pants and it made him feel cheap. He said he does not normally get checked for incontinence (involuntary urine or bowel leakage) at night. He was awake for an early morning blood sugar checks or blood lab draws, but not for going to the bathroom, because he used a urinal at night. 3. Interview on 4/21/26 at 11:18 a.m. with RN D revealed resident 21 had stopped her in the hallway and said that he was woken up at 6:00 a.m. that morning by a lady's hands down his pants. There was a contracted travel CNA working on the 4/20/26 night shift and RN D stated that we did speak with the traveler and normally he [resident 21] is able to take himself to the bathroom and put his call light on if he needs help to go to the bathroom. RN D knew resident 21 reported the allegation to RN F, who then had the conversation with the contracted travel CNA. RN D did not report this allegation to director of nursing (DON) B, but RN D was aware of the provider's process to inform the DON of the situation. The DON would then visit with the resident and contact the resident's family about the incident. RN D was aware that facilities had two hours to report allegations of abuse to the South Dakota Department of Health (SD DOH). The failure to report and investigate the allegation of abuse to the DON regarding the allegation, and provide safety to resident 21 and all the residents to prevent similar situations from occurring. 4. Interview on 4/21/26 at 11:47 a.m. with assistant director of nursing (ADON) G and DON B revealed (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	investigating, to ensure all residents remain free from abuse and/or neglect prior to their next shift worked. DON or designee will ensure new staff, including contract staff, receive education on the Abuse and Neglect policy, including immediate reporting requirements, prior to their first shift worked. DON or designee will interview 5 random residents each week to ensure they remain free from abuse and/or neglect and feel safe in the facility. Additionally, the DON or designee will observe 5 CNAs each week on random shifts to ensure residents are approached and touched appropriately when assisting them with incontinence care. These interviews and audits will continue for four weeks and then monthly for three months. Results of audits will be reviewed by the Administrator, DON or designee with IDT [interdisciplinary team] and Medical Director at monthly Quality Assurance Performance Improvement (QAPI) for analysis and recommendation for continuation/discontinuation/revision of audits based on findings. The immediacy was removed by onsite verification through observations, interviews, and documentation review on 4/22/26 at 10:00 a.m. After the IJ removal, the scope and severity of the noncompliance remained at a G. 8. Review of the provider's 5/14/25 Abuse and Neglect policy revealed the policy statement read, It is the policy of the facility to provide professional care and services in an environment that is free from any type of abuse, corporal punishment, misappropriation of property, exploitation, neglect, or mistreatment. The facility follows the federal guidelines dedicated to prevention of abuse and timely and thorough investigations of allegations. These guidelines include compliance with the seven (7) federal components of prevention and investigation. The policy had five steps to take if abuse/neglect was suspected that included: 1. Take immediate steps to assure the protection of the resident(s). This may involve separation from the alleged abuser and/or provision of medical care. 2. Notify the appropriate/designated organization/authority that an investigation is being initiated immediately following intervention for the resident's safety. 3. Conduct a careful and deliberate investigation centering on facts, observations and statements from the alleged victim and witnesses. 4. Notify law enforcement authorities if indicated (i.e., a crime such as physical or sexual abuse, theft, etc.). 5. Report the investigation findings to all necessary state and/or local agencies and any other identified persons as required by law. The Steps in Abuse Prevention included Screening, Training, Prevention, Identification, Investigation, Protection, and Reporting/Response. .V. Investigation: Have procedures to: Investigate all allegations of abuse, neglect, exploitation, and misappropriation of property. Identify [the] staff responsible for [the] investigation. All allegations will be investigated by the Administrator or Designee immediately. .VI. Protection: Have procedures to: Protect residents from physical and psychosocial harm during the investigation. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	.VII. Reporting/Response.Have procedures to: All allegations and/or suspicions of abuse must be reported to the Administrator immediately. If the Administrator is not present, the report must be made to the Administrator's Designee. All allegations of abuse will be reported to your state agency immediately (within 2 hours) after the initial allegation is received. A final investigation report will be submitted to your state agency within 5 working days. If the event that results in [an] allegation of abuse also causes the individual to suspect a crime, the facility will also report to the local law enforcement agency. Report to [the] State Nurse Registry and/or Department of Professional Regulations if the employer has knowledge of any action by the court of law against the licensed employee.

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F 0760 Level of Harm - Actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, policy review, and manufacturer's instructions review, the provider failed to ensure residents were free from significant medication errors for one of one sampled resident (7) who was not administered his physician-ordered carbidopa/levodopa (a medication to treat Parkinsons disease; a progressive movement disorder) and clonazepam (a medication used to treat anxiety and tremors) according to the medications' administration schedules which resulted in increased tremors (shaking), muscle spasms (sudden, involuntary, and often painful contraction of one or more muscles), and anxiety (anticipation of future danger or misfortune with feelings of distress and/or sadness and symptoms such as restlessness or irritability), and for one of one sampled resident (3) who was administered the incorrect physician-ordered dose of insulin by licensed practical nurse (LPN) (W) which increased his risk for having diabetic complications, including hypoglycemia (an abnormally low blood sugar level). Findings include: 1.Observation and interview on 4/21/26 at 8:19 a.m. with resident 7 in his room revealed his right foot repeatedly tapped on the floor and he had tremors to his upper extremities. His voice was soft, and he spoke slowly. He had a percutaneous endoscopic gastrostomy (PEG) tube (a tube surgically placed through the abdomen into the stomach to administer liquid nutrition, fluids, and medications). He often received his medication late, especially at night. 2. Review of resident 7's electronic medical record (EMR) revealed he admitted to the facility on [DATE]. His 2/3/26 Brief Interview of Mental Status (BIMS) assessment score was 15, which indicated his cognition was intact. He had a 9/29/25 physician's order for carbidopa/levodopa 25-100 milligrams (mg) one and one-half tablets to be administered every four hours through his PEG tube for his Parkinsons disease and a 3/31/26 physician's order for clonazepam 0.5 mg one-half tablet to be administered every six hours for tremors. Resident 7's April 2025 medication administration record (MAR) indicated that on 4/11/26 at 4:00 p.m. his dose of carbidopa/levodopa was not documented as administered. Resident 7's 4/7/26 physician's visit by medical director (MD) LL indicated resident 7 reported crampy sensation in the ankle and foot with tremors, and he was currently tapering clonazepam, [he] expressed concerns about possible increased anxiety and tremors. His general appearance was described as frail appearing gentleman with jerking movements and tremors sitting in [his] wheelchair. Clonazepam dose reduction initiated as per GDR [gradual dose reduction]. Monitor for increased anxiety or tremors. Resident 7's medication administration times from 4/1/26 through 4/22/26 indicated that his midnight scheduled dose of carbidopa/levodopa was administered late (more than one hour before or after scheduled) on 4/9/26 when it was administered at 1:39 a.m., on 4/13/26 when it was administered at 3:52 a.m., (the same time his scheduled 4:00 a.m. dose of carbidopa/levodopa was documented as administered), on 4/15/26 when it was administered at 1:15 a.m., and on 4/17/26 when it was administered at 2:10 a.m. Resident 7's 4:00 a.m. scheduled carbidopa/levodopa was administered late on 4/8/26 when it was administered at 5:02 a.m., on 4/9/26 when it was administered at 5:45 a.m., on 4/12/26 when it was administered at 1:37 a.m., on 4/14/26 when it was administered at 5:22 a.m., on 4/16/26 when it was administered at 5:20 a.m., and on 4/21/26 when it was administered at 5:18 a.m. (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	Resident 7's 8:00 a.m. scheduled carbidopa/levodopa dose was administered late on 4/3/26 when it was administered at 9:29 a.m., on 4/6/26 when it was administered at 9:07 a.m., on 4/9/26 when it was administered at 9:21 a.m., on 4/10/26 when it was administered at 9:30 a.m., on 4/11/26 when it was administered at 9:38 a.m., on 4/12/26 when it was administered at 9:21 a.m., on 4/13/26 when it was administered at 9:14 a.m., and on 4/14/26 when it was administered at 9:41 a.m. Resident 7's 12:00 p.m. scheduled carbidopa/ levodopa dose was administered late on 4/11/26 when it was administered at 1:32 p.m., and on 4/16/26 it was administered at 1:24 p.m. Resident 7's 4:00 p.m. scheduled carbidopa/levodopa dose was administered late on 4/3/26 when it was administered at 9:18 p.m. (the 4/3/26 8:00 p.m. scheduled dose was documented as administered at 8:02 p.m.), on 4/4/26 when it was administered at 5:19 p.m., on 4/7/26 when it was administered at 5:01 p.m., on 4/10/26 when it was administered at 5:09 p.m., on 4/13/26 when it was administered at 5:02 p.m., on 4/17/26 when it was administered at 5:18 p.m., and on 4/18/26 when it was administered at 5:06 p.m. Resident 7's 8:00 p.m. scheduled carbidopa/levodopa dose was administered late on 4/5/26 when it was administered at 10:31 p.m., on 4/8/26 when it was administered at 10:41 p.m., on 4/11/26 when it was administered at 10:17 p.m., on 4/12/26 when it was administered on 4/13/26 at 12:05 a.m., and on 4/16/26 when it was administered at 11:20 p.m. Resident 7 did not have any late administrations of his 5:00 a.m. scheduled clonazepam. Resident 7's 11:00 a.m. scheduled clonazepam dose was administered late on 4/1/26 when it was administered at 12:14 p.m., on 4/2/26 when it was administered at 12:17 p.m., on 4/3/26 when it was administered at 12:24 p.m., on 4/4/26 when it was administered at 12:17 p.m., on 4/5/26 when it was administered at 12:07 p.m., on 4/6/26 when it was administered at 12:10 p.m., on 4/7/26 when it was administered at 12:27 p.m., on 4/8/26 when it was administered at 12:23 p.m., on 4/9/26 when it was administered at 12:49 p.m., on 4/10/26 when it was administered at 12:46 p.m., on 4/11/26 when it was administered at 1:32 p.m., on 4/14/26 when it was administered at 12:08 p.m., on 4/15/26 when it was administered at 12:20 p.m., on 4/16/26 when it was administered at 1:24 p.m., on 4/17/26 when it was administered at 12:25 p.m., on 4/18/26 when it was administered at 12:18 p.m., and on 4/19/26 when it was administered at 12:23 p.m. Resident 7's 5:00 p.m. scheduled clonazepam dose was administered late on 4/3/26 when it was administered at 6:44 p.m., and on 4/11/26 when it was administered at 6:08 p.m. Resident 7's 11:00 p.m. schedule clonazepam dose was administered late on 4/1/26 when it was administered at 1:01 a.m. on 4/2/26, when his 4/8/26 dose was administered on 4/9/26 at 1:43 a.m., when his 4/9/26 dose was administered on 4/10/26 at 12:05 a.m., when his 4/10/26 dose was administered on 4/11/26 at 12:02 a.m., when his 4/11/26 dose was administered on 4/12/26 at 1:39 a.m., when his 4/12/26 dose was administered on 4/13/26 at 12:31 a.m., when his 4/14/26 dose was administered on 4/15/26 at 1:15 a.m., and when his 4/17/26 dose was administered on 4/18/26 at 12:54 a.m. 3. Interview on 4/27/26 at 2:36 p.m. with resident 7 revealed he had received his 4/26/26 8:00 p.m. medications two hours and forty-five minutes late. When his mediations were late, he started sweating, his tremors and jerking movements got worse, the late medication administration and movements kicks up his metabolism and it made him feel like he needed to urinate but due to his (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	increased tremors and jerking movements it was hard for him to use his urinal. This made him feel, not good. 4. Interview on 4/28/26 at 2:31 p.m. with licensed practical nurse (LPN) N revealed the residents' medications were expected to be administered within one hour before or one hour after their scheduled administration times. She attempted to administer resident 7's medication as close to the scheduled time as possible because if his medications were late, his nerves would start acting up. He would become more nervous, and his movements would become more pronounced. 5. Interview on 4/29/26 at 8:24 a.m. with licensed pharmacist JJ revealed he was the consultant pharmacist for the provider. He expected the residents' medications to be administered within one hour before or one hour after their scheduled administration time. Carbidopa/levodopa was to be administered on a schedule because it was a time sensitive medication. If carbidopa/levodopa was not administered on schedule the resident may develop adverse symptoms. He explained that the negative outcomes regarding clonazepam may not be as significant as carbidopa/levodopa if it was administered late, but it should be administered within an hour before or an hour after the scheduled time. He acknowledged that a resident attempting a GDR of clonazepam may not have an accurate interpretation of symptoms if the resident was not receiving his clonazepam or carbidopa/levodopa as ordered by the physician. 6. Interview on 4/29/26 at 10:09 a.m. with director of nursing (DON) B revealed she was told three or four days ago that the night nurse gave resident 7's medication late. She expected resident 7's carbidopa/levodopa to be given within 15 minutes of when it was scheduled. She did not know if resident 7 experienced any symptoms related to those medications being administered late. She stated he does not leave his room, and that she expected resident 7's medications to be administered as scheduled. DON B acknowledged that resident 7's clonazepam not being administered as scheduled may alter the outcome of his attempted GDR because the staff would not be able to determine if his increased symptoms were the result of the decreased medication dose or the inconsistent administration times of his medications. 7. Interview on 4/29/26 at 11:47 a.m. with MD LL revealed she was resident 7's physician revealed the carbidopa/levodopa dose and the scheduled administrations times were based on each person's symptoms. She verified resident 7 was attempting a GDR of his clonazepam. She expected carbidopa/levodopa and clonazepam to be administered within 30 minutes of their scheduled time. If they were not given as scheduled, resident 7 could feel cramps, restlessness, tremors, and have right leg spasms when his medications were not administered at their scheduled times. The carbidopa/levodopa and clonazepam not being administered as scheduled could alter the outcome of his GDR attempt because she would not be able to determine if resident 7's symptoms were related to the GDR, or the late administration of the medications. She considered missed and late doses of carbidopa/levodopa and clonazepam significant medication errors. 8. Review of the provider's 4/11/25 Medication Variance report for resident 3 indicated, At 5:50 PM, resident [3's] BS [blood sugar level] was 122 and [he] was given 7 units of Humalog (a rapid-acting, prescription insulin analog used to improve blood sugar control) when [he] did not need any insulin. Resident 3's BS number was mixed up with [his] roommates' BS number that was 258. The director (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	of nursing, resident 3's daughter, and the resident's physician were notified. 9. Review of resident 3's EMR revealed he admitted to the facility on [DATE]. His 6/12/24 care plan (personalized plan that addresses a resident's care needs, goals, and interventions) had a focus area that indicated he had diabetes. An 11/13/25 revised intervention indicated Please administer diabetic medications as ordered per MAR. There was an 11/24/23 physician's order for resident 7 to be given a HumaLOG Injection Solution 100 UNIT/ML [milliliter] (Insulin Lispro) Inject as per sliding scale [an individualized insulin regimen that adjusts the dose based on the resident's blood sugar level]: if 0 - 70 = Call MD [medical doctor]; 71 - 150 = 0 Units; 151 - 200 = 3 Units; 201 - 250 = 5 Units; 251 - 300 = 7 Units; 301 - 350 = 9 Units; 351 - 400 = 11 Units; 401 - 999 = Call MD, subcutaneously [under the skin] four times a day related to TYPE 2 DIABETES MELLITUS WITH OTHER DIABETIC KIDNEY COMPLICATION. His 1/12/26 Brief Interview for Mental Status (BIMS) assessment score was 15, which indicated his cognition was intact. His diagnoses included Type 2 Diabetes Mellitus with other diabetic kidney complications. Resident 3's MAR revealed that on 4/11/26 at 5:30 p.m., his blood sugar level was recorded as 258, and he was administered 7 units of Humalog insulin. There was a 4/11/26 physician's order to Recheck BS 30 min after eating supper and again 1 hour after eating supper. One time a day related to TYPE 2 DIABETES MELLITUS WITH OTHER DIABETIC KIDNEY COMPLICATION. Those blood sugar levels were documented as 209 at 7:32 p.m. and 242 at 8:30 p.m. on 4/11/26. 10. Phone interview on 4/28/26 at 11:59 a.m. with LPN W, revealed she was in training with registered nurse (RN) EE on 4/11/26. They had gone into resident 3's room together. LPN W checked resident 3's blood sugar level while RN EE checked the roommate's (resident 4), blood sugar level before that evening's meal. LPN W stated she was rushing to complete that task, and when she returned to the computer, she entered resident 4's blood sugar level of 258 into resident 3's EMR, and based on resident 3's physician's ordered sliding scale, she administered seven units of Humalog insulin to resident 3. She realized right away she had given resident 3 insulin based on resident 4's blood sugar level. Resident 3 did not require any insulin for his blood sugar level of 122. She immediately notified RN EE of what she had done. RN EE contacted DON B, resident 3's daughter, and the resident's physician. The physician ordered that additional blood sugar levels be monitored. Resident 3 was allowed an extra ice cream at dinner, and his blood sugar levels were within an acceptable range. LPN stated she was still in training and had been told by RN WW and DON B that she needed to slow down and complete one resident's blood sugar level readings at a time. 11. Interview on 4/28/26 at 2:45 p.m. with DON B and regional nurse consultant C revealed LPN W was a new nurse and was receiving training by RN EE. DON B was notified on 4/11/26 by RN EE that LPN W administered an incorrect dose of insulin to resident 3. She ensured that resident 3's daughter, his physician, and the medical director were notified, and that the Medication Variance form had been completed. DON B educated RN EE and LPN W to slow down and to only check one resident's blood sugar level at a time. LPN W did not complete the Licensed Nurse Skills Competency Checklist because she was still in training. (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	12. Interview on 4/28/26 at 4:50 p.m. with RN EE revealed that on 4/11/26, she was training LPN W. LPN W told RN EE that she documented resident 4's blood sugar level of 258 in resident 3's EMR and administered 7 units of insulin to resident 3 based on his physician's ordered insulin sliding scale. Resident 3's blood sugar level was 122, and he should not have received any insulin. RN EE did not expect LPN W to administer insulin without her present, because LPN W was still training. She felt that LPN W was in a hurry. She knew that administering seven units of insulin to resident 3 when he did not require insulin was a significant medication error that could have caused resident 3's blood sugar level to drop too low. She contacted DON B, resident 3's daughter, and his physician immediately. Resident 3's blood sugar levels were monitored, he was provided with additional dessert, and his blood sugar levels did not drop. 13. Interview on 4/29/26 at 8:33 a.m. with licensed pharmacist JJ revealed that resident 3 receiving seven units of insulin when his BS was 122, could be considered a significant medication error. He felt that the significance would depend on how quickly that error was recognized and what steps were taken after it occurred. He felt that the correct actions were taken quickly after the error was discovered by LPN W and RN EE, but that there could have been a significant negative outcome for resident 3 because his blood sugar levels could have dropped too low. 14. Review of RN EE's 8/27/25 Licensed Nurse Skills Competency Checklist revealed she had met all competency criteria listed under the use of a Subcutaneous Insulin Pen. 15. Review of the provider's December 2019 Medication Administration-General Guidelines policy revealed the FIVE RIGHTS- Right resident, right drug, right dose, right route and right time, are applied for each medication being administered. Medications are administered within [60 minutes] of scheduled time, except before, with or after meal orders, which are administered [based on mealtimes]. If a dose of regularly scheduled medication is withheld, refused, not available, or given at a time other than the scheduled time (e.g., the resident is not in the facility at the scheduled dose time, or a starter dose of antibiotic is needed), the space provided on the front of the MAR for that dosage administrations is initialed and circled. If electronic MAR is used, documentation of the unadministered dose is done as instructed by the procedures for use of the eMAR system. 16. Review of the provider's 5/14/25 Medication Errors policy revealed Each medication error discovered will be documented on the Medication Error Report form. The person discovering the error will complete Part 1 of the Form. Part 3 of the Form will address how this error occurred and can be prevented in the future. This section will be completed by the nurse/medication aide most closely responsible for the error. 17. Review of the 4/7/26 Carbidopa and Levodopa manufacturer's instructions revealed it is important that carbidopa/levodopa be taken at regular intervals according to the schedule outlined by the physician. The patient should be cautioned not to change the prescribed dosage regimen Patients should be advised that sometimes a 'weaning-off' effect may occur at the end of the dosing interval. 18. Review of the provider's January 2018 Specific Medication Administration Procedures policy revealed that, related to injectable medication administration, the purpose was to administer medications via subcutaneous, intradermal and intramuscular routes in a safe, accurate, and effective manner. (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	Check order on the medication administration record to see that an injection is currently ordered and due. Prepare the resident.Check 5 rights. 19. Review of the provider's 1/14/26 Safe Injection Practices policy revealed it did not contain specific information regarding the administration of insulin.

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Keep residents' personal and medical records private and confidential. Based on observation, interview, and policy review, the provider failed to ensure all residents' right to privacy and confidentiality of protected health information (an individual's health, treatment, and payment information, also known as PHI) were protected related to a facility census document that was stored in an area accessible to anyone who passed by. Findings include:1.Observation on 4/27/26 at 11:35 a.m. near the nurse's desk revealed a hanging file organizer that contained a facility census report with resident private information, including name, admission date, and payer source. That report was not in a secure location and could have been accessed by anyone. 2. Interview on 4/27/26 at 11:42 a.m. with administrator A revealed that the document contained confidential information and was in an area that was accessible to the public. She agreed this was a violation of resident confidentiality. 3. Review of the provider's 11/18/25 Medical Records: Storage & Destruction policy revealed that the resident's record set was comprised of the resident's medical and billing record, and that the facility will maintain the confidentiality of all information contained in the medical record. 4. Review of the provider's 11/18/25 Resident Dignity & Privacy policy revealed that Protected Health Information should not be in [the] viewing area of [the] public.

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Administer the facility in a manner that enables it to use its resources effectively and efficiently. Based on observation, interview, record review, policy review, and job description review, the provider failed to ensure the facility was operated and administered by administrator A and director of nursing (DON) B in a manner that ensured quality of life and overall well-being for all 45 residents in the facility.Findings include:1. Observations, interviews, record reviews, and policy reviews throughout the survey on 4/21/26 through 4/23/26 and 4/27/26 through 4/29/26 revealed administrator A and DON B did not ensure the management, safety, quality of life, and overall well-being of all the residents who lived at the facility. Those were evidenced by a widespread system breakdown to ensure services provided met professional standards as it pertained to resident dignity, informed decision for psychotropic medications, resident self-administration of medications, resident meal choices/preferences, responses to resident concerns after resident council meetings, resident health information security, how to file a grievance, allegations of resident abuse, consent/diagnoses for psychotropic medications, reporting allegations timely, Ombudsman reports upon discharge, accurate Minimum Data Set (MDS) assessments (a federally mandated clinical assessment tool for nursing home residents, used to evaluate functional capabilities)/PASSR (Pre-admission Screening and Resident Review) (a federally mandated assessment required before admission to a Medicaid-certified nursing facility to ensure proper placement for individuals with serious mental illness or intellectual disabilities), PASSR refiling due to new resident diagnoses, resident specific baseline care plans within 48 hours of being admitted to the facility, updating resident care plans, notifying a physician of a resident's increased blood sugar levels, accident hazards related to bed side rails, nebulizer and nasal canula cleaning and storage, bed siderail assessments, orders and consent, call light wait times, controlled substance accountability, medication errors, and the storage of drugs and biologicals.2. Interview on 4/29/26 at 9:30 a.m. with administrator A revealed she had worked at this facility for approximately five years, left in 2021 to open a facility for another provider, and had returned to this facility in October of 2025. She confirmed she was responsible for the daily operations of the facility. She stated the siderail issue was frustrating because the company specifically bought new siderails to be compliant. 3. Review of the providers 4/23/25 updated administrator job description revealed, In keeping with our organization's goal of improving the lives of the residents we serve, the Administrator provides overall direction for all activities related to administration personnel, physical structure, information systems, office management and marketing of the entire facility. The Administrator works closely with all members of the management team and others to ensure their responsibilities are effectively and consistently discharged . The Administrator will ensure all facility operations are in compliance with federal, state and local regulations.4. Review of the providers 12/1/19 updated director of nursing job description revealed In keeping with our organization's goal of improving the lives of the Guests we serve, the Director of Nursing plays a critical role in providing superior customer service and nursing services to all Guests in the facility. The Director of Nursing is responsible for the planning, development and overall operation of the Nursing Department which ensures Guests receive quality care 24 hours a day.Refer to F550, F552, F554, F583, F585, F600, F605, F609, F628, F641, F644, F655, F657, F658, F689, F695, F700, F755, F759, F760, F761, and F806.

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F 0837 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Establish a governing body that is legally responsible for establishing and implementing policies for managing and operating the facility and appoints a properly licensed administrator responsible for managing the facility. Based on observations, interviews, record reviews, and policy reviews, the governing body failed to ensure the facility was operated in a manner that ensured the safe management and overall well-being of 45 residents in the facility.Findings include:1. Observations, interviews, record reviews, and policy reviews throughout the survey on 4/21/26 through 4/23/26 and 4/27/26 through 4/29/26 revealed administrator A and DON B did not ensure the management, safety, quality of life, and overall well-being of all the residents who lived at the facility.Those were evidenced by a widespread system breakdown to ensure services provided met professional standards as it pertained to resident dignity, informed decision for psychotropic medications, resident self-administration of medications, resident meal choices/preferences, responses to resident concerns after resident council meetings, resident health information security, how to file a grievance, allegations of resident abuse, consent/diagnoses for psychotropic medications, reporting allegations timely, Ombudsman reports upon discharge, accurate Minimum Data Set (MDS) assessments (a federally mandated clinical assessment tool for nursing home residents, used to evaluate functional capabilities)/PASSR (Pre-admission Screening and Resident Review) (a federally mandated assessment required before admission to a Medicaid-certified nursing facility to ensure proper placement for individuals with serious mental illness or intellectual disabilities), PASSR refiling due to new resident diagnoses, resident specific baseline care plans within 48 hours of being admitted to the facility, updating resident care plans, notifying a physician of a resident's increased blood sugar levels, accident hazards related to bed side rails, nebulizer and nasal canula cleaning and storage, bed siderail assessments, orders and consent, call light wait times, controlled substance accountability, medication errors, and the storage of drugs and biologicals.2. Interview on 4/29/26 at 9:30 a.m. with administrator A revealed she stated when she returned to the administration position she was informed by corporate staff that there were some serious issues to work on and to utilize the corporate consultants for help. Social services had a consultant review the job expectations and they had reached out to another social services consultant for help. The dietary consultant was in the building every two or three weeks mentoring the dietary manager. The registered dietitian's services had been expanded to focus on areas that were identified. The activities consultant had also been there to do an orientation. The regional nurse consultant had been there on a regular basis. There was an administrator consultant in the building when she came back to the position. She had called other area company administrators and they had been to the building to offer guidance. The minimum data set (MDS) coordinator consultant was coming once a month and had weekly calls. Every department checked in with a peer monitor/consultant at least once a week based on the standup meetings. 3. Review of the providers 4/23/25 updated administrator job description revealed, In keeping with our organization's goal of improving the lives of the residents we serve, the Administrator provides overall direction for all activities related to administration personnel, physical structure, information systems, office management and marketing of the entire facility. The Administrator works closely with all members of the management team and others to ensure their responsibilities are effectively and consistently discharged . The Administrator will ensure all facility operations are in compliance with federal, state and local regulations.4. Review of the providers 12/1/19 updated director of nursing job description revealed In keeping with our organization's goal of improving the lives of the Guests we serve, the Director of Nursing plays a critical role in providing superior customer service and nursing services to all Guests in the facility. The Director of Nursing is responsible for the planning, development and overall operation of the Nursing Department which ensures Guests receive quality care 24 hours a day.Refer to F550, F552, F554, F583, F585, F600, F605, F609, F628, F641, F644, F655, F657, F658, F689, F695, F700, F755, F759, F760, F761, and F806.

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a plan that describes the process for conducting QAPI and QAA activities. Based on interview and quality assurance and performance improvement (QAPI) plan policy review, the provider failed to ensure they had identified and corrected quality deficiencies when they occurred throughout the facility and that performance improvement projects (PIP) were thoroughly identified, implemented, or monitored related to quality of care, quality of life, and safety concerns for areas affecting residents such as siderails on residents' beds, incident reporting, medication administration and storage, and baseline care plans.1. Interview on 4/29/26 at 9:30 a.m. with administrator A regarding the QAPI program and committee revealed that she was the QAPI coordinator for the provider and that each department manager conducted their own audits. She reviewed and consolidated the reports to be discussed at the QAPI meeting. The QAPI committee reviewed the reports and implemented any plan needed for correction. The provider's QAPI committee was comprised of all the department managers, administrator A, director of nursing (DON) B, the medical director, pharmacist, consultant dietitian, and regional nurse consultant. They review the QAPI minutes and from there discuss resident care, quality of life or safety issues that had been identified and created a PIP team to investigate the issues. They had improvement in the 5star quality measures in quality of care going from 1 star to 4 stars. They had seen downward trending as well in wounds and falls so, the QAPI committee was currently working on Ad Hoc (PIP) projects that included resident wounds and reducing resident falls. Regarding areas of non-compliance identified by the survey team that included siderails on the residents' beds, incident reporting, medication administration and storage, and baseline care plans, she stated they relied on the maintenance department to do the siderail inspections as part of a monthly checkoff. They were struggling with the siderail issue because the maintenance department utilized a grid system from the Food and Drug Administration (FDA) for the siderail inspections. The grid system did not identify the 4.75 inch as a maximum height for an opening in the siderail. She confirmed the QAPI committee did not currently have siderails, incident reporting, medication administration and storage, and baseline care plans identified as concerns to review and monitor.2. Review of the provider's undated QAPI Plan revealed, Our vision is to lead healthcare back to a place where people are treated like people-one where care is more personal, empathetic, and customized to every individual. We believe that each resident/patient entrusted to our care is given our full attention in all that we do. To that end, our key values include: Service excellence to our residents/patients, Quality care in a caring environment, A work environment that encourages excellence, Dedication and responsiveness, Enthusiasm: When you love what you do, you have more to give, Commitment: When you believe you can make a difference, you do make a difference! The QAPI Steering Committee will have oversight of the QAPI program and shall consist of representation from Nursing, Infection Control, Consulting Pharmacist, Compliance Officer, Dietary, Housekeeping, Laundry, Maintenance, Social Services, Activities and Administration. The Administrator has responsibility and is accountable to our corporation for ensuring that QAPI is implemented throughout our organization. Our facility Medical Director will also serve on the QAPI Steering Committee to provide guidance and direction where necessary. When the need is identified, we will implement corrective action plans or performance improvement projects to improve processes, systems, outcomes and satisfaction. An interdisciplinary subcommittee will be developed to work on Performance Improvement Projects (PIPs) at the discretion of the QAPI Steering Committee . Refer to F585, F600, F609, F655, F689, F700, F755, F759, F760, and F761.

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, resident council meeting interview, and policy review, the provider failed to:*Ensure prompt response to call light times, and that the necessary cares and services were provided within a timely manner for four of four residents (2,16, 24, and 61) to maintain their physical, mental, and emotional well-being. *Implement an effective grievance process to ensure residents' have the knowledge on how to file a grievance, where the grievance forms are located at and a process in place on how to file grievances anonymously.Findings Include:1. Interview on 4/21/26 at 9:38 a.m. with resident 16 revealed the problems with living in this facility is that she is not getting help when she needs it. She revealed that sometimes she had to wait an hour to have staff come to help her in her room. She used her call light for the staff to help her change positions, or to help with personal cares from being incontinent (involuntary urine or bowel leakage) of urine. She said, I will just be soaking wet and she voiced her peri-area (perineum, the skin between the genitals and anus) will burn until she gets help.2. Interview on 4/21/26 at 10:12 a.m. with resident 24 revealed they [the staff] don't answer their call lights. They put me in a diaper [incontinent product] and when I am in the bathroom I have to wait because I can't put a new one on myself. I have sat on the toilet for 25 minutes after I'm done just waiting for someone to come. They have more people living here than they have the help to keep up. If I am in the dining room and ask for a cup of hot water, they just walk away. Another resident will ask again for me and then I will finally get it.3. A resident council meeting was held on 4/22/26 at 4:00 p.m. revealed resident 2 voiced complaints about her concerns of call light response times being 30 minutes. Resident 61 voiced complaints about her call light response times being 45 minutes.4. Interview on 4/28/26 at 10:07 a.m. with licensed practical nurse (LPN) KK revealed that she would expect the staff to respond to call lights in no more than five minutes.5. Interview on 4/28/26 at 10:17 a.m. with certified nursing assistant (CNA) K revealed that she would expect the staff to respond to call light in no more than five minutes.6. Interview on 4/28/26 at 1119 a.m. with the director of nursing B revealed that the residents should not have to wait longer more than five to ten minutes for a call light to were responded to for help.7. Interview on 4/28/26 at 1130 a.m. with activities director (AD) GG revealed that the concerns about the call lights taking too long to be responded to had been consistent. AD GG revealed she had voiced this as an issue as well in the facility stand up meetings. She said that she had witnessed resident 29 waiting in his room with his family, with his call light on for fifteen to twenty minutes prior to staff arriving to assist with his needs.8. Interview on 4/29/26 at 9:00 a.m. with administrator A revealed call light wait time grievances were a trend she recognizes, they have increased the call light audits and managers to do this task more frequently, but due to nurse management loss was not as frequent.9. Interview on 4/29/26 at 9:27 a.m. with the social service designee (SSD) J revealed that she saw the call light times and extended wait times as a trend with grievances.10. Request for call light logs for residents revealed the facilities call light system does not track the location or timing information of the call light activation or the response time.11. Review of the call light audits completed from November 2025 through April 2026 revealed that in April 2026 of the sixteen observations completed five response times were ten minutes, six minutes and fifty-seven seconds, six minutes, and seven minutes.Review of the March 2026 call light audit revealed that of the four observations completed one response time was ten minutes and thirty-seven seconds. March audit frequency was to be completed one time per week by designated manager and 1 time on a weekend by the manager on duty (MOD). No complete weekend audit provided.Review of the February 2026 call light audit revealed that no audits were provided for this month.Review of the January 2026 call light audits revealed of the six observations completed three were seven minutes and four seconds, six minutes and five seconds, and eight minutes and two seconds.Review of the December 2025 call light audits (continued on next page)

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Avantara Watertown	415 Fourth Ave NE Watertown, SD 57201

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	revealed of the four observations completed one response time was seventeen minutes and thirty-two seconds and one response time was thirty-six minutes and sixteen seconds. December audit frequency was to be completed one time per week by designated manager and one time on a weekend by the manager on duty (MOD). No completed weekday audit provided.Review of the November 2025 audits revealed of the twenty audits completed three were nine minutes and fifteen seconds, six minutes and forty seconds, and seven minutes and forty seconds,12. Review of the resident council's meeting minutes from October 2025 through March 2026 revealed there were recurring topics of concerns with waiting for food to be served at meals times, types of food being served, and call light wait times.13. Review of the provider's October 2025 through April 2026 grievances revealed fourteen of forty-four grievances were various concerns of quality of cares being given to the residents, nine of the forty-four grievances were related to long wait times.14. Review of the provider's 11/18/2025 Call Light Policy revealed 1. The facility shall answer call lights in a timely manner. If immediate assistance cannot be provided and there is not an emergent need, call light may be turned off and resident informed that staff member will be back to assist them shortly. 4. Ensure call lights are placed within reach of residents. 5. Ensure that when the call light is triggered, it will either alert the staff visually or audibly or both.15. Interview on 4/21/26 at 9:44 a.m. with resident 16 revealed she did not know how to fill out a grievance form to notify the facility of her concerns.16. A resident council meeting held on 4/22/26 at 4:00 p.m. revealed that six of six residents did not know how to file a grievance or where the grievance forms were located.17. Interview on 4/27/26 with social service designee (SSD) J revealed the location of the grievance forms was probably not accessible to all the residents due to the height of them hanging on the wall in a file organizer by the nurses station. She said, I never thought of that.When asked if the residents were able to file a grievance anonymously SSD J stated There is no drop box where they could put it, so they would have to give it to somebody, and they probably couldn't access it from the wheelchair anyways.SSD J revealed she provided education to the activities director (AD) GG regarding the process on how to help the resident council file a grievance if they needed to.If she had grievances from the resident council and she was aware which resident they were regarding she would follow up with that specific resident on the grievance resolution, but if not, she would give the grievance resolution to AD GG to review with the resident council members at their next resident council meeting.18. Interview on 4/27/26 at 3:03 p.m. with administrator A revealed that she did not think the grievance forms were accessible to the resident who were in a wheelchair and there was no process for a resident to file a grievance anonymously.19. Interview on 4/28/26 at 4:33 p.m. with SSD J revealed that she expected the grievance form to include the date the resolution was provided, the discussion with the complainant, including whether they wanted a written copy, and if they were satisfied with the resolution.20. Review of the grievance documentation for the forty-four grievances reviewed revealed that seven of the forty-four grievances reviewed did not have notification to the complainant or resident, sixteen of the forty-four residents did not have documentation if the complainant or resident wanted written communication of the resolution, fourteen of the forty-four grievances reviewed did not document if the person notified of the resolution was satisfied with the outcome.21. Review of the provider's 5/14/25 Grievances Policy revealed 2. The facility will notify the residents individually or through postings in prominent locations of the facility to the right to file grievance(s) orally, in writing or anonymously. 2a. The notification will include the name, address, and phone number of the grievance official, a reasonable time frame to investigate the grievance, and the residents right to obtain a written copy of the grievance investigation if requested. 2b. The notification will also include the contact information for agencies where the grievances can also be reported to appropriate state agencies. 4. The administrator or designees shall confer with persons involved in the incident and other relevant persons and within three (3) days of receiving the grievance shall provide a written explanation, upon request, of findings and proposed remedies to the complainant and the aggrieved party, if other than the complainant and legal representative, if any. Where appropriate, due to the (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	mental or physical condition of the complainant or aggrieved party, an oral explanation shall accompany a written one. 5. During the investigation, the facility will put in place immediate action to prevent potential violation of resident rights. 6. If the grievance includes suspected abuse, neglect, injury of unknown source, or misappropriation of property, abuse protocol will be followed. (See abuse and Neglect Policy). 7. All grievance decisions will include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusion regarding the resident's concern(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action to be taken by the facility as a result of the grievance, and the date the written decision was issued. 8. If the grievance is confirmed, the facility will take appropriate corrective action. The facility will maintain results of grievances for 3 years.22. Review of the provider's 2025 Contract Between Resident and Avantara Watertown revealed 3. The resident may file a grievance regarding any aspect of their care and treatment at the Facility without fear of discrimination or reprisal. For information on filing a grievance, contact [SSD], Avantara Watertown Grievance Officer at [PHONE NUMBER].23. Review of the provider's 5/14/25 Resident Council policy revealed, 2. Generally staff members do not attend meeting unless they are invited to do so by the council. A staff member is designated as a meeting facilitator and may attend and take notes if desired by the council. 6. The facility will act promptly upon grievances and recommendations expressed from the council in accordance with the facility grievance policy. 7. Appropriate department director or appointed staff will follow up with the individual resident voicing concern(s) to discuss response/resolution. A collective resident council grievance will be follows up with the Resident Council President.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on observation, interview, record review, and policy review, the provider failed to implement procedures to ensure allegations of abuse were reported to the required entities for two separate allegations of abuse:*A sexual abuse allegation made by one of one sampled residentˆ(21) to registered nurse (RN)ˆF and RNˆD involving certified nursing assistant (CNA)ˆE and an unidentified staff member.*A possible financial abuse allegation made by one of one sampled resident's (40) family member to social services designee (SSD)ˆJ.Findings include: 1. Observation on 4/21/26 at 9:17 a.m. of resident 21 in the hallway revealed he reported to RN D that contracted travel CNA E had touched him in a private area without his consent, which upset him (resident 21). RN D told the resident they had handled that situation. 2. Interview on 4/21/26 at 10:02 a.m. with resident 21 revealed that he was touched in a private area without his consent by one of one contracted travel certified nursing assistant (CNA) (E). At 6:00 a.m. on 4/21/26, he woke up with a quick startle when someone had their hands in my pants. I said, what the hell are you doing? He said that contracted travel CNA E replied, I am trying to see if you are wet. Resident 21 then stated to CNA E, I said you get the hell out of here, and per resident 21, CNA E left his room. The resident said that CNA E did not stop to explain anything to him. He stated that CNA E groped him with her hands down his pants and it made him feel cheap. He said he does not normally get checked for incontinence (involuntary urine or bowel leakage) at night. He was awake for an early morning blood sugar checks or blood lab draws, but not for going to the bathroom, because he used a urinal at night. 3. Interview on 4/21/26 at 11:18 a.m. with RN D revealed resident 21 had stopped her in the hallway and said that he was woken up at 6:00 a.m. that morning by a lady's hands down his pants. There was a contracted travel CNA working on the 4/20/26 night shift and RN D stated that we did speak with the traveler and normally he [resident 21] is able to take himself to the bathroom and put his call light on if he needs help to go to the bathroom. RN D knew resident 21 reported the allegation to RN F, who then had the conversation with the contracted travel CNA. RN D did not report this allegation to director of nursing (DON) B, but RN D was aware of the provider's process to inform the DON of the situation. The DON would then visit with the resident and contact the resident's family about the incident. RN D was aware that facilities had two hours to report allegations of abuse to the South Dakota Department of Health (SD DOH). The failure to report and investigate the allegation of abuse to the DON regarding the allegation, and provide safety to resident 21 and all the residents to prevent similar situations from occurring. 4. Interview on 4/21/26 at 11:47 a.m. with assistant director of nursing (ADON) G and DON B revealed they became aware of resident 21's abuse allegation at approximately 11:32 a.m. on 4/21/26 when RN D informed them. DON B confirmed that allegation should have been reported, and she expected RN D to have reported the allegation sooner. DON B said the allegation had not been investigated yet, but she attempted to call CNA E. 5. Interview on 4/21/26 at 11:58 a.m. with RN F revealed that she was in resident 21's room to check his blood sugar and administer his medications at around 7:00 a.m. that morning. She confirmed that resident 21 told her that someone came into his room at 6:00 a.m. and placed their hands down his pants to ensure he was dry. RN F did not think it was appropriate for a staff member to put their hands down a resident's pants to check their incontinent products, and she talked with CNA E about (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the situation to educate her. RN F confirmed she did not report resident 21's allegations to anyone else after talking with CNA E. She explained that she was going to tell the DON but had not yet. RN F did not know the reporting time frame for abuse allegations. 6. Interview on 4/21/26 at 1:34 p.m. with administrator A revealed that RN D reported resident 21's allegations to her on 4/21/26 at 11:15 a.m. She would have expected staff to recognize that as an abuse allegation and that it should have been reported to the SD DOH within two hours of learning about the allegation. She explained that RN D should have reported resident 21's allegations to herself as the administrator or the nurse on call. She submitted a report to the SD DOH at 12:45 p.m. Administrator A did not contact the local law enforcement agency regarding the incident. She stated she would not report such allegations of abuse to law enforcement until their investigation determined if abuse occurred. She said, At this point we are going to interview the resident and staff and get part way through the investigation prior to getting them [law enforcement] involved. 7. Review of the provider's 4/21/26 SD DOH facility reported incident (FRI) report revealed that law enforcement and the ombudsman were not notified. 8. Interview on 4/28/26 at 11:19 a.m. with DON B revealed that if they received an allegation of abuse or neglect outside of business hours, she or administrator A would come to the facility to start the investigation process. They started by writing a reportable. Their investigation process included calling the staff for witness statements, reviewing the cameras, talking to family members, calling the police if it warrants, and sending a report to the SD DOH and the local ombudsman. She said that the time of the day doesn't matter when it came to reporting or investigating an allegation. 9. Review of resident 40's progress notes revealed that on 4/17/26 at 4:55 p.m., social service designee (SSD) J was made aware of concerns from resident 40's family member that there may be suspected financial abuse. SSD J provided the contact information for the states attorney's office for reporting suspected abuse along with how to file a report with [adult protective services]. 10. Interview on 4/29/26 at 9:00 a.m. with administrator A revealed that resident 40's family member had informed SSD J of a concern with financial abuse on 4/17/26. She said they did not get any details about the potential financial abuse that the resident's family member was worried about, so she did not think she needed to report the abuse allegation to SD DOH. She and SSD J provided resources to the resident's family member about where to report potential financial abuse. 11. Interview on 4/29/26 at 9:27 a.m. with SSD J revealed that on 4/17/26, she notified administrator A of resident 40's family members' concern regarding suspected financial abuse. 12. Review of the provider's 4/28/26 SD DOH FRI revealed that at approximately 1:00 p.m. on 4/28/26, [resident 40] reported concerns that her power of attorney (POA, someone designated on a legal document to act on behalf of a resident) may be misappropriating her funds. 13. Review of the provider's 5/14/25 Abuse and Neglect policy revealed the policy statement read, It is the policy of the facility to provide professional care and services in an environment that is free from any type of abuse, corporal punishment, misappropriation of property, exploitation, neglect, or mistreatment. The facility follows the federal guidelines dedicated to prevention of abuse and timely and thorough investigations of allegations. These guidelines include compliance with the seven (7) (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	federal components of prevention and investigation. The policy had five steps to take if abuse/neglect was suspected that included: 1. Take immediate steps to assure the protection of the resident(s). This may involve separation from the alleged abuser and/or provision of medical care. 2. Notify the appropriate/designated organization/authority that an investigation is being initiated immediately following intervention for the resident's safety. 3. Conduct a careful and deliberate investigation centering on facts, observations and statements from the alleged victim and witnesses. 4. Notify law enforcement authorities if indicated (i.e., a crime such as physical or sexual abuse, theft, etc.). 5. Report the investigation findings to all necessary state and/or local agencies and any other identified persons as required by law. The Steps in Abuse Prevention included Screening, Training, Prevention, Identification, Investigation, Protection, and Reporting/Response. .IV. Identification: Have procedures to: Establish a written policy on how to assist staff in identifying abuse, neglect, exploitation, or misappropriation of property including the types of abuse. .V. Investigation: Have procedures to: Investigate all allegations of abuse, neglect, exploitation, and misappropriation of property. Identify [the] staff responsible for [the] investigation. All allegations will be investigated by the Administrator or Designee immediately. .VII. Reporting/Response.Have procedures to: All allegations and/or suspicions of abuse must be reported to the Administrator immediately. If the Administrator is not present, the report must be made to the Administrator's Designee. All allegations of abuse will be reported to your state agency immediately (within 2 hours) after the initial allegation is received. A final investigation report will be submitted to your state agency within 5 working days. If the event that results in [an] allegation of abuse also causes the individual to suspect a crime, the facility will also report to the local law enforcement agency. Report to [the] State Nurse Registry and/or Department of Professional Regulations if the employer has knowledge of any action by the court of law against the licensed employee.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and policy review, the provider failed to ensure the resident's baseline care plan (personalized plan that addresses a resident's care needs, goals, and interventions) included the minimum healthcare information necessary to properly care for the resident, and that the care plan was completed within 48 hours of the resident's admission to the facility for six of 19 sampled residents (2, 4, 7, 33, 40, and 59), and was reviewed with, and a copy was offered to the resident or the resident's representative within 48 hours of the resident's admission to the facility for six of seven newly admitted sampled residents (2, 4, 7, 33, 40, and 59). Findings include:1. Review of resident 4's electronic medical record (EMR) revealed he was admitted to the facility on [DATE]. There was an uploaded signed paper copy of his baseline care plan. It was signed by resident 4's representative on 9/25/25 to indicate that they had received a copy and that it was reviewed with them. His 9/25/25 baseline care plan did not indicate the level of assistance he required for transfers, bed mobility, bathing, dressing, toileting, eating, or his physician's ordered diet. 2. Review of resident 59's closed EMR revealed she was admitted to the facility on [DATE]. There was a signed paper copy of her baseline care plan. It was signed by resident 59's resident representative to indicate that they had received a copy and that it was reviewed with them. It was not dated when it was signed. The last revisions made to the printed baseline care plan were made on 1/9/26. Resident 59's baseline care plan did not indicate the level of assistance she required for transfers, bed mobility, bathing, dressing, toileting, or eating. 3. Review of resident 7's EMR revealed he was admitted to the facility on [DATE] and he did not have a baseline care plan. 4. Review of resident 33's EMR revealed she was admitted to the facility on [DATE]. Her baseline care plan was signed by her representative. There was no date when it was signed. Her baseline care plan was uploaded into her EMR on 12/19/25. Her baseline care plan did not indicate how the resident transferred, walked, if assistive devices were required, or the amount of assistance resident 33 required for dressing or toileting. 5. Review of resident 2's EMR revealed she was admitted to the facility on [DATE]. There was no baseline care plan in her EMR. 6. Review of resident 40's EMR revealed she was admitted to the facility on [DATE]. Her 4/5/26 base line care plan did not indicate how she transferred from one surface to another, her diet, or the specific rehabilitation therapies that were ordered by her physician. 7. Interview on 4/27/26 at 4:20 p.m. with regional nurse consultant C revealed residents 2 and 7 did not have individualized baseline care plans completed. 8. Interview on 4/28/26 at 2:46 p.m. with licensed practical nurse (LPN) N revealed that the nurses initiated the baseline care plans for each resident during the admission process. All the nurses and (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the leadership staff could make changes to the residents' care plans. The care plans should accurately reflect the current needs of each resident. 9. Interview on 4/28/26 at 2:09 p.m. with minimum data set/registered nurse (MDS/RN) H revealed that the staff probably really do not know how to provide care if the care plans were not resident-specific and completed. MDS/RN H revealed that she expected the baseline care plan to include information that direct caregivers needed to provide care to the resident. The baseline care plan was shared with the family and or the resident's representative when they had a care conference, and if they were unable to attend, they were to notify MDS/RN H, who would review it with them within 48 hours of the resident's admission. MDS/RN H expected the care plans to be accurate and to reflect the resident's current needs. She confirmed that resident 4 and resident 59's baseline care plans were reviewed with their representatives, but were not personalized to contain specific information on how to care for the residents. She expected that resident 4 and resident 59's baseline care plans would have been personalized to reflect their care needs before they were reviewed with the residents or their representatives. 10. Interview on 4/29/26 at 10:50 a.m. RNC C revealed that she did not think the facility had any signed baseline care plans to provide or documentation that a copy was provided to the resident or resident's representative. 11. Review of the provider's 5/14/25 Care Plans policy revealed: A Baseline Care plan is started by nursing staff on the first day of admission to provide guidance to direct caregivers as soon as possible after admission and completed no later than 48 hours after admission. Nursing, Dietary, Activities and Social Services staff complete formal assessments, interviews and observation and begin formulating the full care plan as soon after admission as possible (These departments do have areas that need to be completed by the 48-hour deadline). The areas that must be addressed in the baseline care plan include the minimum healthcare information necessary to properly care for the resident including, but not limited to: a) Initial goals based on admission orders. b) Physician orders. c) Dietary orders. d) Therapy services. e) Social Services. f) PASARR recommendations, if applicable.

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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 record review, interview, and policy review, the provider failed to ensure the care plan (personalized plan that addresses a resident's care needs, goals, and interventions) was reviewed and revised to reflect the current care needs for four of nineteen sampled residents (13, 33, 38, and 40).Findings include:1. Review of resident 40's electronic medical record (EMR) revealed she was admitted to the facility on [DATE]. Her 4/5/26 Brief Interview of Mental Status (BIMS) assessment score was a 9, which indicated his cognition was moderately impaired. Her diagnoses included Diabetes Mellitus (a condition involving disruptions in how the body regulates blood sugar), Parkinson's Disease (a brain disorder that makes it hard for a person to control their body movements), Alzheimer's Disease (a progressive and irreversible brain disorder that affects memory, thinking, social abilities, and body functions), Dementia (a group of symptoms affecting memory, thinking, and social abilities), Major Depressive Disorder, anxiety (anticipation of future danger or misfortune with feelings of distress and/or sadness and symptoms such as restlessness or irritability), and orthostatic hypotension (a sudden drop in blood pressure that happens when you stand up too quickly from sitting or lying down). Resident 40's 4/5/26 care plan revealed that it did not indicate how she transferred from one surface to another, her diet, and the specific rehabilitation therapies that were ordered by her physician. 2. Review of resident 33's EMR revealed she was admitted to the facility on [DATE]. Her 3/26/26 BIMS assessment score was 13, which indicated her cognition was intact. Her diagnoses included depression. She had a 3/29/26 physician's order for olanzapine (an antipsychotic medication) 5 milligrams (mg) daily to be administered at bedtime. There was no diagnosis identified on the physician's order that indicated why olanzapine was prescribed. The indication for use was behaviors and poor mood. She had a 12/4/25 physician's order for sertraline (an antidepressant medication) 100 mg every day to be administered at bedtime for depression. Review of resident 33's progress notes from 3/25/26 to 4/20/26 revealed a 3/25/26 progress note stated, Becomes very agitated and combative with attempts to assist resident. Grabs [the] staff, kicks, hits, scratches, and pinches. 'You just get out of here! I don't trust any of you!' Mimics sarcastically what [the] staff are asking/saying to her. A 3/28/26 progress note stated, Resident taking papers off nurse [nurses'] desk and ripping them apart. Yelling and name calling to [the] nurse and other staff. A 3/29/26 progress note stated Resident is name calling to [the] staff, arguing with [the] staff. Reaching out to pinch another resident. A 4/13/26 progress note stated, yelling at [the] staff to 'go to hell,' 'don't look at me.' 'you're all evil.' Unable to redirect [the resident]. Resident spit at [the] writer. Review of resident 33's 4/22/26 care plan revealed she had a focus area of Resident has potential for bruising, hemorrhage due to anticoagulant use, she had not taken an anticoagulant since 3/13/26. Her care plan did not indicate she was on an antipsychotic medication, that she had behaviors, or any nonpharmacological interventions that may be used when she had behaviors. The use of a psychotropic (antidepressant) medication was only identified in resident 33's care plan within the focus area related to her risk of falling. It did not indicate target symptoms for the use of her sertraline or non-pharmacological interventions. 3. Review of resident 13's EMR revealed she was admitted to the facility on [DATE]. Her current BIMS assessment score was 11, which indicated her cognition was moderately impaired. Her (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Diagnoses included chronic diastolic heart failure (chronic progressive condition where the heart muscle is too weak to pump blood effectively), paroxysmal atrial fibrillation (irregular rapid heart rate). She had a 1/16/25 physician's order for Clopidogrel (an antiplatelet medication) 75 milligrams (mg) 1 tablet to be administered by mouth (PO) daily. She had a 8/8/25 physician's order for Aspirin (pain medication) 81mg enteric coated (EC) tablet to be administered PO once daily. Her 4/29/26 care plan included a focus area of potential for bruising, hemorrhage due to anticoagulant use initiated on 1/17/25, and revised on 9/30/25. 4. Review of resident 38's EMR revealed she was admitted to the facility on [DATE]. Her current BIMS assessment score was 9, which indicated her cognition was moderately impaired. Her diagnoses included atherosclerotic heart disease (a condition where plaque builds up in the heart arteries decreasing blood flow). She had a 4/1/26 physician's order for Aspirin (pain medication) 81 mg EC tablet to be administered PO once daily. She had no anticoagulant (blood thinner) medication ordered. Her current care plan included a focus area of: I have potential for bruising, hemorrhage due to anticoagulant use and self-propelling in w/c [wheelchair] initiated on 4/1/26 and revision on 4/8/26. 5. Interview on 4/21/26 at 1:36 p.m. with CNA O revealed she referred to the facility's pocket care plan and the Kardex (a report of the resident's care needs and interventions) to determine what care she needed to provide for each resident. She stated there have been times when the packet care plans were not up to date so she referenced the residents' Kardex and notified the nurse that the pocket care plan needed to be updated. 6. Interview on 4/22/26 at 3:22 p.m. with certified nursing assistant (CNA) S revealed she referenced the residents' care plans in their EMR or on the pocket care plans (a document that identifies residents' care needs and interventions) to know how to care for each resident. 7. Interview on 4/28/26 at 2:09 p.m. with minimum data set/registered nurse (MDS/RN) H revealed she started her position as the MDS/RN in September of 2025. She thought that the staff probably really do not know how to provide care if the care plans were not resident-specific and completed. She expected care plans to be updated to the resident's current care needs. Care plans were updated at least every three months. They also did a weekly care plan meeting where a set of residents who had upcoming care plan reviews or residents who had a change in status were reviewed to ensure that the focus areas in the care plan were specific to the residents. She was responsible for updating the nursing portion of resident care plans. If a resident was taking an antipsychotic medication, she expected that to be on their care plan as well as interventions to help alleviate their behaviors. Director of nursing (DON) B, assistant director of nursing (ADON) G, and she were responsible for updating the nursing portion of the resident care plans. She confirmed residents 13 and 38 were never on an anticoagulant medication and that their care plans needed to be updated. MDS/RN H updated resident care plans at least quarterly and as needed. She expected the resident care plan to be accurate and to reflect the residents' current needs. 8. Interview on 4/28/26 at 2:46 p.m. with licensed practical nurse (LPN) N revealed the nurses initiated the residents' care plans during the admission process. All the nurses and the leadership staff could update the residents' care plans. The care plans should be updated to accurately reflect the current needs of each resident. Resident 33 had intermittent behaviors such as being rude, abrupt, and blunt to the staff and other residents. LPN N thought the CNAs experienced resident 33's behaviors during her cares more than the nurses witnessed them. LPN N acknowledged that resident 33's behaviors as well as non-pharmacological interventions should be identified in her care plan. (continued on next page)

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	435068	A. Building B. Wing	04/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	9. Review of the provider's 4/28/25 Psychotropic Medications policy revealed, Psychotropic medications will be used only when it is necessary to treat a specific condition after non-pharmacological interventions have been attempted to assist with residents displaying mood, behavior, or sleep concerns. Resident's receiving psychotropic medication will have adverse side effects and target behaviors addressed in the care plan and will be monitored, recorded, and summarized each quarter. 10. Review of the provider's revised 5/14/25 Care Plans policy revealed Individual, resident-centered care planning will be initiated upon admission and maintained by the interdisciplinary team through the resident's stay to promote optimal quality of life while in residence. In doing so, the following considerations are made: 1. Each resident is an individual. The personal history, habits, likes and dislikes, life patterns and routines, and personality facets must be addressed in addition to medical/diagnosis-based care considerations. 2. Each resident has the right to be happy, continue their life-patters as able, and feel comfortable in their surroundings. 3. Care planning is constantly in process; it begins the moment the resident is admitted to the facility and doesn't end until discharge or death. 4. Each resident is included in the care planning process and encouraged to achieve or maintain their highest practicable physical and mental abilities through the nursing home stay. 5. The physician's orders (including medications, treatments, labs, and diagnostics) in conjunction with the resident's plan constitute the total 'plan of care'. Physician orders are referenced in the resident's care plan, but not rewritten into that care plan.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, interview and policy review the provider failed to ensure infection control practices were followed regarding the residents' nasal cannulas (flexible tubing with prongs that delivers oxygen through the nose) being stored properly when they were not in use for one of three sampled residents (1) who required the use of oxygen, and two of three sampled resident (2, and 48) who used a nebulizer (a device that converts liquid medication into an inhalable mist) machine that was not cleaned after each use by the nursing staff and per their policy.Findings include:1. Observation on 4/21/26 at 9:23 a.m. of resident 1's room revealed her oxygen concentrator was off and her dated 4/7/26 (two weeks prior) nasal cannula and tubing was draped over the concentrator, and the nasal cannula was touching the floor. There was no bag attached to the concentrator to store the oxygen tubing when not in use. 2. Observation on 4/27/26 at 11:02 a.m. of resident 1's room revealed her dated 4/7/26 (three weeks prior) oxygen tubing and nasal cannula hanging over the concentrator and the nasal cannula was lying on the floor. 3. Interview on 4/27/26 at 11:55 a.m. with certified nursing assistant (CNA) HH revealed that resident 1 only wears her oxygen at night. She agreed the nasal cannula should not touch the floor. She confirmed there was no bag on the concentrator to contain the nasal cannula and tubing when not in use. She removed the nasal cannula and tubing from the concentrator and threw them away. She agreed it was an infection control issue. 4. Interview on 4/27/26 at 11:58 a.m. with licensed practical nurse (LPN) N revealed that nasal cannulas and oxygen tubing should be stored in a mesh bag when not in use. 5. Interview on 4/28/26 at 3:26 p.m. with director of nursing (DON) B revealed she expects oxygen tubing to be placed in mesh bags that are on the concentrators, for continuous users the tubing and nasal cannulas were switched between portable tanks and concentrators. She agreed that if the nasal cannula and tubing was observed on the floor they should be thrown away and replaced. After nebulizer treatments are administered the nurse needs to take apart the pieces of the kit, rinse them out, and place them to air dry before their next use. Nebulizer kits, oxygen tubing, and nasal cannula are replaced weekly. 6. Review of the provider's revised 11/18/25 Oxygen Administration policy revealed the purpose of this procedure is to provide guidelines for oxygen administration. b. The nasal cannula is a tube that is placed approximately one-half inch into the resident's nose. The nasal cannula and tubing will be changed weekly and as needed. Change of tubing and cannula should be documented. When not in use, the nasal cannula should be stored in a plastic bag. 7. Observation on 4/21/26 at 8:30 a.m. of resident 2's room revealed she had a nebulizer machine and mask on her over the bed table. The medication chamber had a clear liquid covering the bottom of the chamber. 8. Observation and interview on 4/21/26 at 10:52 a.m. with resident 2 in her room revealed the nurse would bring in her nebulizer medication, set up the nebulizer and leave the room. She stated the nurses did not rinse out her nebulizer mask after she used it but replaced the mask every few days. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	9. Observation on 4/28/26 at 9:42 a.m. of resident 2's room revealed her assembled nebulizer mask was lying on her nebulizer machine and the medication chamber had a hazy film on the inside of the chamber. 10. Review of resident 2's EMR revealed she was admitted to the facility on [DATE]. Her BIMS assessment score was 15, which indicated her cognition was intact. Her diagnoses included chronic obstructive pulmonary disease (COPD; a group of lung diseases that block airflow and can make it difficult to breathe). She had a 2/16/26 physician's order for budesonide suspension (a steroid used to treat lung inflammation) to be administered through her nebulizer two times a day for COPD, Formoterol (a medication to relax the airways to improve breathing) to be administered through her nebulizer two times a day for COPD, ipratropium/albuterol (medication to relax the airways and decrease mucous) nebulizer to be administered every four hours as needed for difficulty breathing. 11. Observation on 4/21/26 at 8:42 a.m. of resident 48's room revealed he had an assembled nebulizer mask lying on his bedside table. There was no bag near his nebulizer to store his nebulizer when it was not in use. There was a nasal cannula attached to his oxygen concentrator (a device that filters room air into purified oxygen). The nasal cannula was coiled up and stuffed under the handle of the oxygen concentrator. There was no bag attached to the concentrator to store the nasal cannula when it was not being used. 12. Observation and interview on 4/22/26 at 10:16 a.m. with resident 48 in his room revealed his nasal cannula was draped over the oxygen concentrator with the nasal prongs nearly touching the floor. He wore oxygen at night. The staff assisted him with putting on and taking off his nasal cannula because he was blind and could not do it by himself. 13. Observation on 4/27/26 at 11:05 a.m. of resident 48's room revealed that his nebulizer mask was assembled and lying on top of his bedside table. His oxygen cannula was rolled up and stuffed under the handle of his oxygen concentrator. 14. Review of resident 48's EMR revealed he was admitted to the facility on [DATE]. His 3/13/26 BIMS assessment score was 15, which indicated he was cognitively intact. His diagnoses included that he was legally blind and had COPD. He had a 4/27/22 physician's order to use one to two liters of oxygen as needed to keep his oxygen saturations above 90 percent. He had a 2/29/25 physician's order for ipratropium/albuterol solution to be administered by nebulizer every six hours while he was awake. 15. Interview and review of resident 2's EMR on 4/28/26 at 2:31 p.m. with LPN N revealed she would set up resident 2's nebulizer treatment, and when it was completed resident 2 would remove the mask, turn off the nebulizer machine, and place her nebulizer mask on top of her nebulizer machine. Sometime between resident 2's nebulizer treatments LPN N would go back into resident's room and rinse out the nebulizer mask and air dry the mask on a paper towel until the next nebulizer treatment was administered. 16. Review of the provider's January 2018 Oral Inhalation policy revealed, When treatment is complete, turn off nebulizer and disconnect T-piece, mouthpiece and medication cup. Rinse and disinfect the nebulizer equipment according to manufacturer's recommendation, or: Wash pieces except tubing with warm soapy water daily. Rinse with hot water. Allow to air dry completely on a (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	paper towel. Once a week/three times a week/daily, disinfect the equipment by using a Microsteam bag in the microwave for time recommended on bar, OR Soaking for 5 minutes in 70 % [percent] isopropyl alcohol and then rinse with sterile water. When equipment is completely dry, store in a plastic bag with the resident's name and date on it. 17. Review of the 2/13/23 budesonide manufacturer's instructions revealed The nebulizer chamber should be cleaned after every administration. Wash the nebulizer chamber and mouthpiece of face mask with hot tap water using a mild detergent. Rinse it well and dry by connecting the nebulizer chamber to the compressor or air inlet.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation, interview, and policy review, the provider failed to ensure informed consents for side rails were obtained before the side rails were installed for seven of 25 sampled resident (4, 15, 16, 23, 25, 32, and 36), physician's orders, in accordance with the provider's policy, were obtained before side rails were installed for 12 of 25 sampled residents (2, 3, 4, 8, 15, 16, 17, 19, 29, 32, 36, and 45), alternatives to the side rails were attempted before the side rails were installed for 21 of 25 sampled residents (3, 4, 8, 15, 16, 17, 19, 22, 23, 24, 25, 27, 29, 31, 33, 35, 36, 37, 45, 47, and 48), and entrapment zone assessments were completed on 23 of 25 sampled resident (2, 3, 4, 8, 12, 14, 15, 16, 17, 19, 22, 23, 24, 27, 31, 32, 33, 35, 36, 37, 45, 47, and 48) who had side rails on their bed. Findings include:1. Review of the maintenance logbook for side rail inspections for January 2026 through April 2026 revealed in January the side rail audits documented that zone 1 (the opening within the side rail) was the only entrapment zone assessed. The other six zones of entrapment were documented as not applicable. In February all seven zones of entrapment were documented as having passed the audit on every bed assessed. In March only zone 1 was documented as being assessed, all the other six zones were documented as not applicable. In April six side rail assessments were documented as passed for zone one with not applicable for the other 6 zones. Twenty-one side rail audits were documented as not applicable for all seven zones. Those residents documented as not applicable for all seven entrapment zones in April 2026 included residents 2, 3, 4, 12, 14, 16, 17, 22, 23, 31, 33, 35, 36, 37, 45, 47, and 48. Resident identified as having side rails that were not on the April 2026 side rail audit included residents 8, 27, and 32. There were no entrapment assessments for zone 7 (space between a mattress and headboard or footboard) from January 2026 through April 2026 documented for residents without a bed rail. Residents 15, 19, and 24 had side rails installed, but maintenance did not have record of the side rails for these residents. 2. Observation on 4/21/26 at 8:30 a.m. of resident 2's room revealed she had bilateral side rail on her bed. The opening within the sides rail measured three and one- half inches in width by 12 inches in height from the mattress to the top of the opening. Review of resident 2's electronic medical record (EMR) revealed she was admitted to the facility on [DATE]. She consented to the use of bilateral side rails for positioning and bed mobility on 2/16/26. There was a 2/17/26 physician's order for side rails. Her 2/17/26 Side rail/Devices Evaluation indicated the alternative attempted before the implementation of her side rails was Directed/supervised ambulation. Review of the maintenance record revealed resident 2's bilateral side rails were installed on 2/16/26. 3. Observation on 4/22/26 at 3:25 p.m. of resident 45's side rails revealed she had bilateral side rails on her bed and the opening within her side rails measured three and one-half inches in width and 11 inches in height. Review of resident 45's EMR revealed she admitted to the facility on [DATE]. She signed a consent (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	for 1/4 on 4/22/22. There was no physician's order for side rails. The Side rail/Other Devices Evaluation was completed on 6/24/22 for bilateral side rails. There were no documented alternatives attempted prior to the implementation of the side rail. Review of the maintenance record revealed resident 45's bilateral side rails were installed on 4/20/22, before her admission date. 4. Observation on 4/21/26 at 8:36 a.m. of resident 14's room revealed she had one side rail on her bed. Review of resident 14's EMR revealed she was admitted to the facility on [DATE]. A side rail consent was completed on 7/22/25 for a left side rail. There was a 7/22/25 physician's order for a left side rail. Resident 14's Side rail/Other Devices Evaluation was completed on 10/14/25. Alternatives that had been attempted were increased involvement in structured programming activities, psychotropic medication review, physical/occupational therapy screen, and restorative nursing program screen. Review of the maintenance record revealed resident 14 did not have side rails installed. 5. Observation on 4/22/26 at 4:30 p.m. of resident 17's bilateral side rails revealed two openings within the side rail. The top opening measured four and three-quarters inches in width by five and one-half inches in height. The bottom opening measured four and three-quarters inches in width by four and one-half inches in height. Review of resident 17's EMR revealed she was admitted to the facility on [DATE]. She did not have a physician's order or consent for her bilateral side rails. Her 9/10/25 Side rail/Other Devices Evaluation indicated that the alternatives attempted before the implementation of the side rails were mobility bars [side rails] Review of the maintenance record revealed resident 17's bilateral side rails were installed on 4/24/26. 6. Observation and interview on 4/22/26 at 10:31 a.m. with resident 35 in his room revealed his bilateral side rails moved away from his bed one to two inches. He stated they had been like that since he admitted to the facility. Observation on 4/22/26 at 3:27 p.m. of resident 35's bed revealed there was a gap of five inches between the top of his mattress and the headboard. The top opening of his bilateral side rails measured four and three-quarter inches in width by five and one-half inches in height. The bottom opening measured four and three-quarters inches in width by four and one-half inches in height. Review of resident 35's EMR revealed he was admitted to the facility on [DATE]. His consent for a right-side rail was completed on 11/5/25. He had an 11/5/25 physician's order for a right-side side rail. His Side Rail/Other Device evaluation was completed on 2/9/26 and indicated he had bilateral side rails. The alternatives that were implemented was documented as Other and not listed. Review of the maintenance record revealed resident 35's bilateral side rails were installed on 4/23/26. 7. Observation on 4/21/26 at 8:42 a.m. of resident 48's room revealed he had bilateral side rails on his (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	bed. Observation and interview on 4/22/26 at 10:16 a.m. with resident 48 in his room revealed he had bilateral side rails on his bed. He used the left side rail to get in and out of bed, but it was loose. He did not use the right-side rail because it was against the wall. He thought the side rails were on his bed because he had nightmares which made him move around in bed and he had fallen out of his bed due to the nightmares. His left side rail could move away from the mattress three inches when pulled. He denied that he had gotten a body part stuck in either side rail. He had told a certified nursing assistant (CNA) and his daughter that his left side rail was loose but did not know when he told them. He thought it had been a week or so. Observation on 4/22/26 at 3:27 p.m. of resident 48's side rails revealed the opening within the side rail measured three and one-half inches wide by 11 inches in height. Review of resident 48's electronic medical record (EMR) revealed he was admitted to the facility on [DATE]. He had a 3/13/26 Brief Interview of Mental Status (BIMS) assessment score of 15, which indicated his cognition was intact. His diagnoses included that he was legally blind. On 8/15/25 he had a dream and fell out of his bed. He was sent to the emergency room after that fall and was diagnosed with a brain bleed (a vessel or around the brain busts causing blood to pool in the skull). Resident 48 had a 4/26/22 consent and physician's order for bilateral side rails. He had a 4/26/22 and 8/20/25 Side rail/Other Device Evaluation that did not identify alternatives were attempted before the implementation of the side rails. Review of the maintenance record revealed resident 48's bilateral side rails were installed on 4/26/22. 8. Observation on 4/21/26 at 8:55 a.m. of resident 25 revealed she had bilateral side rails on her bed. Review of resident 25's EMR revealed she was admitted to the facility on [DATE]. Her 1/20/25 side rail consent had her initials on it, but it did not indicate if she consented or refused bilateral side rails. She had a 1/17/25 physician's order for bilateral side rails and her Side rail/Other Devices Evaluation was completed on 10/14/25, nine months after the side rail was installed on her bed. Review of the maintenance record revealed resident 25's bilateral side rails were installed on 1/17/25. 9. Observation on 4/21/26 at 9:31 a.m. of resident 8's room revealed she had bilateral side rails on her bed. Review of resident 8's EMR revealed she had a 10/17/23 consent for bilateral side rails and a 12/23/24 physician's order for bilateral side rails. Her 2/12/26 Side rail/Other Devices evaluation indicated she did not have side rails. Review of the maintenance record revealed resident 8's bilateral side rails were installed on 10/17/23. 10. Observation and interview on 4/21/26 at 10:04 a.m. of resident 33's room revealed she had bilateral side [NAME] on her bed and she uses them to get out of bed. The opening within the side (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	rails measured three and one-quarter inches wide by 14 inches in height from the top of the mattress to the top of the opening within the side rail and 17 inches from the bed frame to the top of the opening in the side rail. Review of resident 33's EMR revealed she was admitted to the facility on [DATE]. She had a 12/4/25 physician's order and the consent for bilateral side rails. Her 12/4/25 Side rail/Other Devices Evaluation indicated she did not have side rails. Review of the maintenance record revealed resident 33's bilateral side rails were installed on 12/4/25. 11. Observation on 4/21/26 at 10:10 a.m. of resident 15's room revealed she had a left side rail on her bed. Review of resident 15's EMR revealed she was admitted to the facility on [DATE]. On 7/11/25 a consent for bilateral side rails was signed. On 7/11/25 a physician's order was received for bilateral side rails. Her Side rail/Other Devices Evaluation was not completed until 10/13/25, three months after she consented for the side rails. Review of the maintenance record revealed resident 15's did not have side rails installed. 12. Observation on 4/21/26 at 10:12 a.m. of resident 24's room revealed she had a left side rail. Review of resident 24's EMR revealed she was admitted to the facility on [DATE]. She had a signed consent for a left side rail on 3/18/26. The 3/19/26 physician's order did not include a specific side or if there was to be bilateral side rails installed. There was no completed Side rail/Other Device Evaluation completed. Review of the maintenance record revealed resident 24's did not have a side rail installed. 13. Observation on 4/21/26 at 10:23 a.m. of resident 36's room revealed she had one side rail on her bed. Review of resident 36's EMR revealed she was admitted to the facility on [DATE]. There was no consent, or physician's order for side rails. Her Side rail/Other Devices Evaluation was not been completed. Review of the maintenance record revealed resident 36's bilateral side rails were installed on 4/1/26. 14. Observation on 4/21/26 at 10:29 a.m. of resident 23's room revealed she had bilateral side rails. Observation and interview on 4/22/26 at 10:36 a.m. with resident 23 in her room revealed she used the side rails to roll over in bed. The right-side rail moves away from the bed two to three inches. Resident 23 did not know how long her side rail had been loose. The opening within the side rails measured three and one-half inches wide by 13 inches in height. The space between the foot of her mattress and the foot board was seven inches. Review of resident 23's EMR revealed she was admitted to the facility on [DATE]. A physician's order was received for bilateral side rails on 12/17/21. A consent was signed for bilateral side rails (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	on 12/17/25. The Side rail/Other Devices Evaluation for bilateral side rails were completed on 3/21/22, 6/21/22, 11/5/25, and 2/5/26 and did not indicate that any alternative interventions were attempted before the side rails were installed. Review of the maintenance record revealed resident 23's left side rail was installed on 4/23/26. 15. Observation on 4/21/26 at 10:33 a.m. of resident 31's room revealed she had bilateral side rails on her bed. Review of resident 31's EMR revealed she was admitted to the facility on [DATE]. She consented to bilateral side rails on 8/4/25. A physician's order for bilateral side rails was obtained on 8/5/25. Her Siderail/Other Device Evaluation was not completed until 10/13/25. Review of the maintenance record revealed resident 31's bilateral side rails were installed on 8/4/25. 16. Observation on 4/21/26 at 10:35 a.m. of resident 37's room revealed he had one side rail on his bed. Review of resident 37's EMR revealed he was admitted to the facility on [DATE]. A consent for a right-side rail was signed on 5/12/25, prior to her admission to the facility. There was a 5/14/25 physician's order for a right-side rail. Her Side rail/Other Devices Evaluation was not completed until 10/14/25. Review of the maintenance record revealed resident 37's right side rail was installed on 8/4/25. 17. Observation on 4/21/26 at 11:10 a.m. of resident 19's room revealed she had bilateral side rails on her bed. Review of resident 19's EMR revealed she was admitted to the facility on [DATE]. A consent for bilateral side rails was signed on 10/20/25. There was no physician's order for side rails. There were no Side rail/Other Device Evaluations completed. Review of the maintenance record revealed resident 19 did not have side rails installed. 18. Observation and interview on 4/22/26 at 6:25 p.m. with licensed practical nurse (LPN) N in resident 32's revealed resident 32 had a side rail on the right side of her bed. LPN N determined if a side rail or mattress was a risk for entrapment for a resident if there was a gap that a body part could be trapped in. LPN N measured the space at the top of the mattress to the side rail and the bottom of the mattress to the side rail when she assessed for an entrapment. She centered the mattress on the bed when she took the measurement even if the mattress could be slid over. Resident 32's mattress was able to slide to the wall leaving an eight-inch gap between the mattress and the side rail. Review of resident 32's EMR revealed she was admitted to the facility on [DATE]. Resident 32's representative declined the installation of side rails on 2/4/26. Review of the maintenance record revealed that resident 32 did not have a side rail installed. 19. Review of resident 3's EMR revealed he was admitted to the facility on [DATE]. He consented for bilateral side rails on 6/22/23. A physician's order was obtained for bilateral side rails on 6/23/23, (continued on next page)

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	435068	A. Building B. Wing	04/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avantara Watertown	415 Fourth Ave NE Watertown, SD 57201

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	after the bed rails had been installed. His Side rail/Other Device Evaluation was completed on 4/6/26, three years after the side rails were installed. Review of the maintenance record revealed resident 3's bilateral side rails were installed on 6/22/23. 20. Review of resident 47's EMR revealed she was admitted to the facility on [DATE]. She signed a consent for bilateral side rails on 10/25/24. On 10/28/24 a physician's order for bilateral side rails was received. Her 8/30/25 Side rail/Other Devices Evaluation documented alternatives attempted before the implementation of her side rails was mobility bars. Review of the maintenance record revealed resident 47's bilateral side rails were installed on 10/25/25. 21. Review of resident 12's EMR revealed he was admitted to the facility on [DATE]. He had a 10/8/24 physician's order for bilateral side rails. There was a consent signed on 10/8/24 for bilateral side rails and on 1/21/25 for a left side rail. His care plan indicated he had a left side rail that was initiated on 10/23/24 and revised on 10/21/25. There was no Side rail/Other Devices Evaluation completed for his side rails. Review of the maintenance record revealed resident 12's left side rail was installed on 4/23/26. 22. Review of resident 16's EMR revealed she was admitted to the facility on [DATE]. There was a consent signed for bilateral side rails on 12/5/24. The physician's order for bilateral side rails was obtained on 10/30/24, after the side rails had been installed. Her Side rail/Other Devices Evaluation was not completed until 10/14/25. Review of the maintenance record revealed resident 16's bilateral side rails were installed on 10/29/24. 23. Review of resident 22's EMR revealed he was admitted to the facility on [DATE]. A consent was signed for bilateral side rails on 4/3/25. A physician's order for the bilateral side rails was obtained on 4/4/25. His 10/8/25 Side rail/Other Devices Evaluation indicated the alternative attempted before the implementation of the side rails was Other with nothing else documented. Review of the maintenance record revealed resident 22's bilateral side rails were installed on 4/3/25. 24. Review of resident 4's EMR revealed he was admitted to the facility on [DATE]. The consent for bilateral side rails was completed on 10/20/25, twenty days after the side rail had been installed. A physician's order for bilateral side rails was obtained, and his Side rail/Other Device Evaluation was completed on 10/15/25, two weeks after the side rails were installed. Review of the maintenance record revealed resident 4's bilateral side rails were installed on 9/30/25. 25. Review of resident 29's EMR revealed he was admitted to the facility on [DATE]. A consent for bilateral side rails was obtained on 12/18/25. There was a 12/23/25 physician's order for bilateral side rails, five days after the side rail was installed. His Side rail/Other Device Evaluation was completed on 12/19/25, one day after the side rail was installed. Review of the maintenance record revealed resident 29's side rail was installed on 12/18/25. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	26. Review of resident 27's EMR revealed she was admitted to the facility on [DATE]. She consented to a left side rail on 3/13/26. A physician's order for a left side rail was obtained on 3/13/26. Her Side rail/Other Device Evaluation was not completed. Review of the maintenance record revealed resident 27's left side rail was installed on 3/13/26. 27. Interview on 4/22/26 at 6:06 p.m. with director of nursing (DON) B revealed she was unsure if the provider had a policy related to entrapment assessments. She thought maintenance did the entrapment assessments on the residents' beds. The side rail assessments were to be completed by the nurse on the resident's admission if the resident or resident's representative wanted a side rail and quarterly by the Minimum Data Set (MDS) nurse. DON B completed the consent for side rails with the resident or the resident's representative and that consent had the risks versus benefits of a side rail on it. 28. Interview and review of the maintenance logbook for side rail inspections on 4/28/26 at 10:15 a.m. with regional maintenance II revealed when the maintenance staff completed the side rail audits they would first verify with the nurses that the residents still need the side rail on their bed, and if they have a left, right, or bilateral side rails. The maintenance staff would check the side rail to be sure it is tightly secured to the resident's bed, and measured the entrapment zones to be sure they were less than four and three-quarter inches. He expected all seven entrapment zones to be checked but with the style of side rail that was in the facility only three of the zones applied. The side rail audits were to be completed by maintenance monthly. During the side rail audits the mattress was to be measured to be sure there was not a large gap between the mattress and the footboard or headboard. The measurements of the gaps between the mattress and head and footboard as well as the side rails were completed with a tape measure. He was not aware that in March 2026, only entrapment zone one was audited, and all the other zones were documented as not applicable or that in April 2026 the side rail audit indicated all seven zones were not applicable. He expected all entrapment zones to be checked monthly and documented as passed or not applicable. He acknowledged that there were gaps between some residents' mattresses and their head or footboard which posed a risk for entrapment and there were loose side rails on the residents' beds which posed a risk for injury. 29. Interview on 4/29/26 at 9:30 a.m. with administrator A revealed that maintenance staff was responsible for completing monthly audits of the residents' side rails to be sure nothing had changed or been modified since their original installation. The audits of the side rails were documented in the facility's online maintenance system. Administrator A reviewed that system to be sure the side rail audits were completed. If a resident was identified as needing a side rail installed that recommendation was communicated to the family and the resident's physician. The risks and benefits of the side rail, including entrapment, were reviewed with the resident or the resident's family, and representative, and once those steps were completed the maintenance department would install the side rail. The maintenance staff were to ensure the entrapment zone measurements were in compliance with the recommendations from the food and drug administration (FDA). (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	She stated the measurements within the opening of the side rails were to be less than the four and three-quarter inches in width, and the FDA guidance did not address the measurements related to the height of the opening within the side rails. 30. Interview on 4/29/26 at 10:09 a.m. with DON B revealed the consent for side rails was in the admission packet and all residents were offered side rails at the time of their admission. DON B stated she knew that alternate interventions should be attempted before side rails were put on a resident's bed, but she was following the resident's and resident representative's wishes. The physical and occupational therapy staff also recommended side rails for some residents who received therapy to improve their mobility and independence. DON B acknowledged that there was missing documentation related to side rail assessments, consents, and physician orders. She stated there were side rails on residents' beds that were not documented when they were put on. She acknowledged that there was a risk for resident entrapment and injury when entrapment zone measurements and assessments were not completed on side rails and mattresses, and when the side rails were loose. 31. Review of the provider's 11/18/25 Bed Rail policy revealed, These bars [side rails] pose safety hazards and must be evaluated for appropriate placement for the sole purpose of transfer and bed mobility assistance for the resident. The Side Rail/Other Devices Evaluation UDA [Universal Design for Assessment] is: a. Completed prior to implementation of a rail by a licensed nurse. b. Completed on admission, readmission, quarterly, or upon change in condition and in conjunction with the RAI [Resident Assessment Instrument] process for each resident using a device. Physician Orders for Device(s): a. Should not be obtained until the appropriate steps have been completed. B. Should include the type of rail used and how many rails are to be used. c. Should not be obtained until the nurse discusses prior interventions attempted with resident's physician and resident or resident representative. These interventions should be listed on the UDA. Bed Rails are implemented after addressing the risk and benefits with the resident and/or resident's representative and obtaining the Physical Device Consent. The Entrapment Zone Review Form (or electrical format in TELS) is completed upon placement of rails, quarterly and with a resident change of condition. Entrapment zones should be assessed with any changes of mattress.

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, and policy review, the provider failed to ensure the staff educated the resident or resident's representative of the risk versus benefits of medications or of alternative treatments to make an informed decision and consent for the use of psychotropic medications (drugs that affects brain activities associated with mental processes and behavior) before they were given for two of two sampled residents (3 and 33). Findings include: 1. Review of resident 33's electronic medical record (EMR) revealed she was admitted to the facility on [DATE]. Her 3/26/26 Brief Interview for Mental Status (BIMS) assessment score was 13, which indicated her cognition was intact. Her diagnoses included depression. She had a 3/6/26 physician's order quetiapine (an antipsychotic medication; a drug that alters neurotransmitter activity in the brain to reduce symptoms of mental health conditions) 25 milligrams (mg) at bedtime that did not have a diagnosis that the medication was prescribed to treat. Her Antipsychotic Medication Consent Form listed Quetiapine and was signed and dated by the resident representative and director of nursing (DON) B on 3/20/26. The form indicated the antipsychotic medication was being used for resident 33's mood. The area on the form where the alternatives to the prescribed medications that may be used instead of this medication was blank. The area on the Antipsychotic Medication Consent form labeled, Check Here if Taking before each listed antipsychotic medication's warnings, did not have a check mark in front of the warnings for quetiapine. Resident 33 had a 3/29/26 physician's order to stop the quetiapine and start olanzapine (an antipsychotic medication) 5 mg daily at bedtime. There was no diagnosis identified on the physician's order that supported what olanzapine was prescribed for. Her Antipsychotic Medication Consent Form listed Olanzapine and was signed and dated by the resident representative and DON B on 3/30/26. The area on the form that indicated what the olanzapine was ordered for was blank. The area on the form where the alternatives to the prescribed medications that may be used instead of this medication was blank. The area on the Antipsychotic Medication Consent form that indicated, Check Here if Taking before each listed antipsychotic medication's warnings, did not have a check mark in front of the warnings for olanzapine. Her 4/22/26 care plan did not identify that she was taking an antipsychotic medication, that she had an alteration in her mood, or that she displayed any behaviors. 2. Interview on 4/29/26 at 10:09 a.m. with DON B revealed that she expected all antipsychotic medications to have a diagnosis to indicate what the antipsychotic medication was being used for. If a medication was started after the resident was in the facility, she expected the nurse who received the order to confirm there was a diagnosis for that medication and if there was not, she expected that nurse to call or fax the physician to get the diagnosis for that medication. 3. Review of resident 3's EMR revealed he was admitted to the facility on [DATE]. His 1/12/26 BIMS assessment score was 15, which indicated his cognition was intact. His diagnoses included major depressive disorder (a serious, common mood disorder characterized by at least two weeks of persistent, severe low mood, loss of interest, and low energy that disrupts daily life, bipolar disorder (a chronic mental health condition characterized by intense, alternating mood swings between highs and lows), current episode manic (high mood) severe with psychotic (a loss of contact with reality) features, schizophrenia (chronic, severe brain disorder affecting how a person thinks, feels, and (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	behaves, causing a disconnection from reality) and insomnia (a sleep disorder characterized by persistent difficulty sleeping). There was a 1/31/25 physician's order for paroxetine (an antidepressant) 10 mg (milligrams) and aripiprazole (an antipsychotic) 15 mg at bedtime. His Psychotropic Medication Consent form listed Aripiprazole and Paroxetine and was signed and dated by the resident and the facility representative on 2/18/25. There was no documentation of the doses of those medications, the frequency they were to be provided, the diagnosis, or the targeted behavior. There was no documentation that the risks and/or benefits of those medications were discussed with the resident or his representative. Those areas of the form were left blank. His care plan had a focus area revised on 1/13/25 and 4/17/25 that indicated I am on Psychoactive medications (medications that alter brain function, causing changes in perception, consciousness, mood, cognition, or behavior): antipsychotic and antidepressant to manage dx of Depression, bipolar disorder, insomnia, [and] schizophrenia. The 8/29/24 interventions included administering medications as ordered, monitoring his behavior while on medication, monitoring for any ill effects related to the medication, Please monitor me for s/s [signs/symptoms] of adverse reactions to antidepressant and antipsychotic medications each shift. Written consent for Psychotropic medication [was] obtained from the resident, in the care plan was dated 8/29/24. 4. Interview on 4/28/26 at 2:45 p.m. with director of nursing (DON) B and regional nurse consultant C revealed that they did not work at the facility in 2025, however they expected that the Medication Consent Form to have been completed and to include the doses of those medications, the frequency they were to be provided, the diagnosis, or the targeted behavior and that the risks and/or benefits of those medications were discussed with the resident or the resident representative. Written informed consents were not obtained from a resident or resident representative before beginning a psychotropic medication, and when the doses were adjusted. 5. Review of the provider's 4/28/25 Psychotropic Medication policy revealed Informed Consent for psychotropic medications will be obtained from the resident or the resident representative at the initiation of the medication and for any medication dose increases. The Black Box Warning for antipsychotic medications will be included on the informed consent.

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and policy review, the provider failed to ensure four of four sampled residents (2, 17, 28, and 48) had been assessed to determine their ability to safely self-administer medications, and a physician's order had been obtained to self-administer those medications. Findings include: 1. Observation on 4/21/26 at 8:30 a.m. of resident 2's room revealed she had a nebulizer (a device that converts liquid medication into an inhalable mist) and mask on her bedside table. The medication chamber had a clear liquid covering the bottom of the chamber. There was an open, empty unit dose container labeled formoterol (a medication used to relax the airways in the lungs to make breathing easier) lying on her bedside table beside the nebulizer. 2. Observation and interview on 4/21/26 at 10:52 a.m. with resident 2 in her room revealed the nurse would bring in her nebulizer medication, set up the nebulizer and leave the room. She stated the nurse would come back after she completed the nebulizer treatment. During the interview at 10:57 a.m. licensed practical nurse (LPN) V entered resident 2's room and handed resident 2 a nasal spray. Resident 2 administered the nasal spray to herself while LPN V put a liquid medication into her nebulizer medication chamber. She told resident 2 that she had set up her nebulizer treatment and after she was done with the interview resident 2 could turn on the nebulizer machine and start the nebulizer treatment then LPN V left the room. 3. Observation on 4/28/26 at 9:42 a.m. of resident 2's room revealed her nebulizer mask was lying on her nebulizer machine and the medication chamber had a hazy film on the inside of the chamber. 4. Review of resident 2's electronic medical record (EMR) revealed she was admitted to the facility on [DATE]. Her Brief Interview for Mental Status (BIMS) assessment score was 15, which indicated her cognition was intact. Her diagnoses included chronic obstructive pulmonary disease (COPD; a group of lung diseases that block airflow and can make it difficult to breathe). There was no medication self-administration assessments completed in resident 2's EMR to determine if she could safely self-administer medications. Her 4/23/26 care plan did not indicate she had been assessed to safely self-administer her medications. She had a 2/16/26 physician's order for budesonide suspension (a steroid used to treat lung inflammation) to be administered through her nebulizer two times a day for COPD, Formoterol (a medication to relax the airways to improve breathing) to be administered through her nebulizer two times a day for COPD, ipratropium/albuterol (medication to relax the airways and decrease mucous) nebulizer to be administered every four hours as needed for difficulty breathing. None of these physician's orders that indicated resident 2 was able to self-administer the nebulizer medications. 5. Observation on 4/21/26 at 8:42 a.m. of resident 48's room revealed he had an assembled nebulizer mask lying on his bedside table. 6. Observation on 4/27/26 at 2:42 p.m. of resident 48 in his room revealed he was sitting in his recliner. He had his nebulizer mask on his face, and the nebulizer machine was running. There were no staff members in his room or in the hallway to monitor his administration of the nebulizer medication. (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	7. Observation on 4/28/26 at 2:02 p.m. revealed that LPN N stated to herself while walking down the hallway that she needed to go to resident 48's room and take his nebulizer mask off. LPN N walked down the hallway to his room; there were no other staff members in resident 48's room when she entered. 8. Review of resident 48's EMR revealed he was admitted to the facility on [DATE]. His 3/13/26 BIMS assessment score was 15, which indicated his cognition was intact. His diagnoses included that he was legally blind, and he had COPD. He had a 2/29/25 physician's order for ipratropium/albuterol solution to be administered by nebulizer every six hours while he was awake. The physician's order did not include that resident 48 was able to self-administer his medications. He had a 4/26/22 medication self-administration assessment completed that indicated his visual impairment was a disqualifying factor, but the assessment indicated he could safely administer his medications after they were set up by a nurse. An 8/11/25 medication self-administration assessment indicated he did not want to self-administer his medications. His 4/23/26 care plan did not support he was assessed to safely self-administer his medications. 9. Interview and review of resident 2's EMR on 4/28/26 at 2:31 p.m. with LPN N revealed that resident 2 was the only resident who self-administered medications. LPN N would set up the nebulizer treatment for resident 2 to self-administer, and when it was completed resident 2 would remove the mask and turn off the nebulizer machine. Sometime between that nebulizer treatment and before the next scheduled nebulizer treatment LPN N would go back into resident 2's room and rinse out the nebulizer mask and let it air dry on a paper towel. LPN N stated there were certain diagnoses that would exclude a resident from being able to safely self-administer their medications. These diagnoses were indicated on the medication self-administration assessment that was to be completed by the nurse who admitted the resident to the facility. Review of resident 2's EMR revealed that a medication self-administration assessment was not completed upon her admission and there was no physician's order for her to self-administer her medications. LPN N stated that a self-administration assessment and a physician's order should have been completed before resident 2 was allowed to self-administer her medications. 10. Observation on 4/21/26 at 8:40 a.m. with resident 28 in her room revealed she was asleep, and there was a small plastic medication cup that contained a clear liquid on the bedside table. Resident 28 did not wake when she was spoken to. 11. Observation and interview on 4/21/26 at 9:34 a.m. with resident 17 in her room revealed that there was a small plastic medication cup that contained an off-white cream/gel-like substance on her bedside table. The cup had her initials on it. It appeared unused. She stated that staff members assisted her in putting cream on her shoulder and her bottom. She was unsure what the medication in the cup was or which area of her body it was to be used for. 12. Observation and interview on 4/21/26 at 12:19 p.m. with resident 28 in her room revealed that there was a small plastic medication cup that contained a clear liquid on the bedside table. She stated that at times it was hard for her to swallow and that she had an awful taste in her mouth. The medication in the plastic cup was for her dry mouth. The nurse had left it there this morning before breakfast, and she had not used it. She liked to use it before and after her meals or when she had a (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	bad taste in her mouth. She liked to use the mouthwash and suck on cough drops to make her mouth taste better. 13. Observation and interview on 4/22/26 at 2:04 p.m. with resident 28 in her room revealed there was a small plastic medication cup that contained a clear liquid on the bedside table. She stated that she ate her meals in her room, chose not to eat often, but thought that the medication in the cup helped make her mouth a little better. 14. Observation and interview on 4/23/26 at 3:09 p.m. with resident 17 in her room revealed there was a small plastic medication cup that contained a small amount of an off-white cream in it on the table near her chair. The cup was not labeled. The cream appeared as if it had been used, as it was pressed against the side of the cup. Resident 17 was unsure what the cream was. She thought it might be the cream that the staff member put on her bottom. 15. Review of resident 28's electronic medical record (EMR) revealed she was admitted on [DATE], and her 1/16/26 Brief Interview of Mental Status (BIMS) assessment score was 15, which indicated her cognition was intact. Her diagnosis included bipolar disorder (a chronic mental health condition characterized by intense, alternating mood swings between highs and lows), dementia, anxiety, and depression. She had a 3/26/24 physician's order that indicated May have cough drops at bedside. She had a 7/1/25 physician's order for BIOTENE LIQ [liquid] DRY MTH [mouth] GIVE 15ML [milliliter] BY MOUTH THREE TIMES DAILY FOR DRY MOUTH Administered by clinician. There was no documentation of a physician's order for resident 28 to self-administer her mouthwash or her cough drops. Her April medication administration record (MAR) indicated her Biotene Mouthwash had been administered three times each day at 9:00 a.m., 1:00 p.m., and 8:00 p.m. Her 11/13/25 care plan indicated Administer medications as ordered, Administer dry mouth spray as ordered, and I have reported at times that I have 'difficulty swallowing', this has been anxiety related in the past. I do refuse to take my medications at times d/t [due to] my 'mouth tastes bad'. Please encourage me to take a few deep breaths and try a sip of water to assess for any swallowing concerns. Administer anxiety medication as ordered. Her 2/27/24 Medication Self-Administration Evaluation indicated Disqualifying Factors included noncompliance- Stated she does not want medication. Her 4/13/26 Medication Self-Administration Evaluation indicated that no medications listed as Medications to be Self-Administered, and the remainder of the assessment was incomplete. 16. Review of resident 17's EMR revealed she was admitted on [DATE], and her 3/17/26 BIMS assessment score was 15, which indicated her cognition was intact. Her diagnosis included pain in the right hip, chronic pain syndrome, and impingement syndrome (a common condition causing shoulder pain when the tendons of the rotator cuff or the bursa (fluid-filled sac) are compressed, rubbed, or pinched between the bones of the shoulder joint) of her right and left shoulders. She had physician's orders for Menthol Gel 5 % [five percent]. Apply topically every 8 [eight] hours as needed for hips, buttocks, [and] back pain., Preparation H Cream 1 % [one percent] (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avantara Watertown	415 Fourth Ave NE Watertown, SD 57201

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	(Hydrocortisone) Apply to hemorrhoids topically as needed for hemorrhoids, apply as often as needed, Apply lotion as needed, Diclofenac Sodium External Gel 1 % (Diclofenac Sodium (Topical)) Apply to neck, bilat [bilateral(both)] shoulders topically at bedtime for arthritic pain Apply 2 grams to neck and 2 grams to each shoulder topically at bedtime. Use [the included measurement] card to measure dose, and Diclofenac Sodium External Gel 1 % (Diclofenac Sodium (Topical)) Apply to R [right] knee topically every morning and at bedtime for Pain Apply 4 grams use [the included measurement] card to measure dose. There was no documentation of a physician's order for resident 17 to self-administer her creams. Her 9/30/25 care plan indicated to provide medications as ordered and to monitor for the effectiveness or ill effects of her medications. Her 3/11/26 Medication Self-Administration Evaluation indicated that no medications were listed as Medications to be Self-Administered. 17. Observation and interview on 4/27/26 at 3:40 p.m., with registered nurse (RN) D in resident 28's and resident 17's shared room revealed RN D identified that the clear liquid in the medication cup at resident 28's bedside was Biotene mouthwash. She stated that she had administered it to resident 28 before lunch, and resident 28 used the mouthwash, and then RN D discarded the remainder of the medication. Resident 28 became upset and wanted some of the mouthwash left at her bedside for her to use when she wanted it. RN D provided resident 17 with more mouthwash to keep her from escalating her behaviors. RN D confirmed that the medication cup with a cream in it at resident 17's bedside had been her topical menthol gel used for her hips and shoulder. She thought that resident 17 liked to put that on her shoulder herself when she had shoulder pain. RN D confirmed that resident 28 and resident 17 did not have a physician's order to self-administer medications. She expected that when a resident's physician ordered medications for self-administration, the medication self-administration evaluation would have been completed. 18. Interview on 4/28/26 at 2:50 p.m. with director of nursing (DON) B and regional nurse consultant (RNC) C regarding residents self-administering medications revealed there were no residents in the facility at that time who had been assessed or had a physician's orders to self-administer medications. DON B was aware that resident 28 had Biotene mouthwash at her bedside and attempted to take it away from her yesterday (4/27/26). Resident 28 became upset and wanted the mouthwash left at her bedside. She was unaware that resident 28 had a physician's order for cough drops at bedside. DON B felt that a self-administration evaluation and the need for a physician's order would depend on what the medications were. She faxed resident 28's physician yesterday (4/27/26) to request an over the counter Biotene lozenge that could be left at resident 28's bedside. DON B was unsure if resident 28 would require a medication self-administration evaluation for that medication. DON B expected that the medication self-administration evaluation would be completed on admission to the facility. If a resident was unable to self-administer medications at the time of the evaluation but the physician added a medication at a later time, then the resident would be allowed to (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	self-administer that medication because the physician had ordered it. DON B and RNC C thought that the cream in the medication cup left at resident 17's bedside had been a barrier cream that the certified nurses assistants used when they completed a resident's personal care that did not require a physician's order or a medication self-administration evaluation, but confirmed that they had not seen the cream to identify it. RNC C expected that no physician-ordered pills, liquids, or creams would be left at the resident's bedside if the resident did not have an order to self-administer that medication and a medication self-administration evaluation had been completed that determined the resident was safe to self-administer that medication. She expected the medication self-administration evaluations to be completed on admission, quarterly, and if there was a new medication that the resident wanted to self-administer. 19. Review of the provider's January 2018 Self-Administration of Medications policy revealed If the resident desires to self-administer medications, an assessment is conducted by the interdisciplinary team of the resident's cognitive (including orientation to time), physical, and visual ability to carry out this responsibility during the care planning process. For those residents who self-administer, the interdisciplinary team verifies the resident's ability to self-administer medications by means of a skill assessment conducted on a quarterly basis or when there is a significant change in condition. The results of the interdisciplinary team assessment of resident skills and of the determination regarding bedside storage are recorded in the resident's medical record, on the care plan. For each medication authorized for self-administration, the label contains a notation that it may be self-administered. If the resident demonstrates the ability to safely self-administer medications, a further assessment of the safety of bedside storage is conducted. Bedside medication storage is permitted only when it does not present a risk to confused residents who wander into the rooms of, or room with, residents who self-administer.

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and policy review, the provider failed to ensure there was documented need, treatment alternatives, non-pharmacological interventions, and a specific condition identified for one of one sampled resident (33) who was started on an antipsychotic (a drug that alters neurotransmitter activity in the brain to reduce symptoms of mental health conditions) medication. Findings include: 1. Interview on 4/21/26 at 8:56 a.m. with resident 33 in her room revealed she stated in the middle of a conversation about her having a doctor appointment, The old cook in the dining room told another person to give me that piece [of food] because I do not pay my taxes, That made me mad because I paid taxes most of my life, and then went on to discuss the nursing staff in the facility. 2. Review of resident 33's EMR revealed she was admitted to the facility on [DATE]. Her 3/26/26 Brief Interview of Mental Status (BIMS) assessment score was 13, which indicated her cognition was intact. Her diagnoses included depression. There was a 12/4/25 physician's order for sertraline (an antidepressant medication) 100 milligrams (mg) every day at bedtime for depression.She had a 3/6/26 physician's order quetiapine (an antipsychotic medication) 25 mg at bedtime that did not indicate a diagnosis that the medication was being prescribed to treat. Her Antipsychotic Medication Consent Form listed Quetiapine and was signed and dated by the resident representative and director of nursing (DON) B on 3/20/26. The form indicated the antipsychotic medication was being used for resident 33's mood. The area on the form where the alternatives to the prescribed medications that may be used instead of this medication was blank. The area on the Antipsychotic Medication Consent form labeled, Check Here if Taking before each listed antipsychotic medication's warnings did not have a check mark in front of the warnings for quetiapine.She had a 3/29/26 physician's order to stop the quetiapine and start olanzapine (an antipsychotic medication) 5 mg daily at bedtime. There was no diagnosis identified on the physician's order that indicated what olanzapine was prescribed for. Her Antipsychotic Medication Consent Form listed Olanzapine and was signed and dated by the resident representative and DON B on 3/30/26. The area on the form that indicated what the olanzapine was ordered for was blank. The area on the form where the alternatives to the prescribed medications that may be used instead of this medication was blank. The area on the Antipsychotic Medication Consent form labeled, Check Here if Taking before each listed antipsychotic medication's warnings did not have a check mark in front of the warnings for olanzapine.Review of resident 33's progress notes from 1/1/26 to 4/20/26 revealed the first progress note related to behaviors was on 3/25/26 and stated, Becomes very agitated and combative with attempts to assist resident. Grabs [the] staff, kicks, hits, scratches, and pinches. ?You just get out of here! I don't trust any of you!' Mimics sarcastically what [the] staff are asking/saying to her. A 3/28/26 progress note stated, Resident taking papers off nurse [nurses'] desk and ripping them apart. Yelling and name calling to [the] nurse and other staff. A 3/29/26 progress note stated Resident is name calling to [the] staff, arguing with [the] staff. Reaching out to pinch another resident. A 4/13/26 progress note stated, yelling at [the] staff to ?go to hell,' ?don't look at me.' ?you're all evil.' Unable to redirect [the resident]. Resident spit at [the] writer.Review of resident 33's 4/22/26 care plan revealed that her care plan did not support she was on an antipsychotic medication, that she had behaviors, or any nonpharmacological interventions that may be used when she had behaviors. The use of a psychotropic (drugs that affect brain activities associated with mental processes and behavior) medication was only identified in resident 33's care plan within the focus area related to her fall risk. It did not indicate target symptoms for the use of her sertraline or non-pharmacological interventions. 3. Interview on 4/28/26 at 2:09 p.m. with Minimum Data Set (MDS)/registered nurse (RN) H revealed she was responsible for updating the nursing portion of resident care plans. If a resident was taking an antipsychotic medication, she would expect that to be on their care plan as well as interventions to help alleviate (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	their behaviors. 4. Interview and review of resident 33's EMR on 4/28/26 at 2:46 p.m. with licensed practical nurse (LPN) N revealed that resident care plans should be updated to accurately reflect the current needs of each resident. Resident 33 had intermittent behaviors such as being rude, abrupt, and blunt to staff and other residents. She thought the CNAs experienced her behaviors during cares more than the nurses witnessed them. She acknowledged that resident 33's behaviors as well as non-pharmacological intervention should be identified in her care plan.LPN N stated she did not know if resident 33's behaviors were actual behaviors or if they were her personality because her family was aware of the behaviors since she was admitted and did not seem troubled by them.LPN N verified there was no diagnosis for the administration of resident 33's olanzapine. She stated each medication should have a diagnosis to indicate what it was being administered for, and an antipsychotic medication cannot be given just because a resident has behaviors. 5. Interview on 4/29/26 at 10:09 a.m. with DON B revealed that she expected all antipsychotic medications to have a diagnosis to indicate what the antipsychotic medication was being used for. If a medication started after the resident was in the facility, she expected the nurse who received the order to confirm there was a diagnosis for that medication and if there was not, she expected that nurse to call or fax the physician to get the diagnosis for that medication. 6. Review of the provider's 4/28/25 Psychotropic Medications policy revealed, Psychotropic medications will be used only when it is necessary to treat a specific condition after non-pharmacological interventions have been attempted to assist with residents displaying mood, behavior, or sleep concerns. Resident's receiving psychotropic medication will have adverse side effects and target behaviors addressed in the care plan and will be monitored, recorded, and summarized each quarter. Assessments will include resident specific behaviors, non-pharmacological interventions attempted and the resident's response to the intervention.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, and policy review the provider failed to ensure the Office of State Long-Term Ombudsman (an advocate of residents' overall quality of care and rights) was notified when a resident discharged from the facility, for one of three sampled residents (54).Findings include:1. Review of resident 54's electronic medical record (EMR) revealed he had been discharged on 1/27/26 to another facility. His primary care physician (PCP) was notified of intent to discharge on [DATE] and the provider received orders on 1/26/26 to discharge. His representative signed the discharge summary on 1/27/26. There was no documentation that the Office of State Long-Term Care Ombudsman was notified of resident 54's transfer to another facility.2. Interview on 4/27/26 at 10:57 a.m. with Social Services Designee (SSD) J revealed that she did not complete the notifications to the Office of State Long-Term Ombudsman. She thought administrator A completed those notifications.3. Interview on 4/27/26 at 11:00 a.m. with administrator A revealed she was not responsible for notifying the Office of State Long-Term Ombudsman of resident discharges. When asked who oversaw those notifications, she stated, I will have to ask the team and get back to you. The form Report Discharge or Transfer to Department of Human Services (DHS) Ombudsman Program was completed on 4/27/26 at 11:12 a.m. that had been submitted by SSD J. It listed the discharge date for resident 54 as 1/26/26.4. Review of the provider's revised April 28, 2025 Discharge and Transfer of Residents/Bed Hold Policy revealed To ensure a safe transition is planned for any resident with a discharge or transfer to another setting. To ensure adequate care is given to any resident with a change of condition. The Notice of Transfer/Discharge form and bed hold policy will be given to the resident or resident representative prior to the discharge or transfer. If resident is being transferred emergently, the form will be given as soon after the transfer as practicable. For South Dakota, ombudsman are notified by the following: Report the discharge/transfer and upload the Notice of Discharge form on the following link: http://sddhs.seamlessdocs.com/f/report discharge transfer ombudsman program.

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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 record review, interview, policy review, and the Centers for Medicare and Medicaid Services Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual Version 1.20.1 October 2025 review, the provider failed to ensure two of two sampled residents' (2 and 40) Minimum Data Set (MDS) (a tool used to evaluate a resident's health status and to develop and individualized care plan to manage the resident's care needs) assessments were accurately coded for the areas required for the Pre-admission Screening and Resident Review (PASRR) (a mandatory federal process that ensures people with mental illness or intellectual disabilities are not inappropriately placed in nursing homes). Findings Include: 1. Review of resident 2's EMR revealed she was admitted to the facility on [DATE] from another long-term care facility. Her diagnoses included bipolar disorder (mental condition causing extreme shifts in mood, energy, and activity levels), generalized anxiety disorder (anticipation of future danger or misfortune with feelings of distress and/or sadness and symptoms such as restlessness or irritability), adjustment disorder (a short-term, stress-related mental health condition triggered by an identifiable life change or event), and binge eating disorder (regularly eating a lot of food over a short period of time until you are uncomfortable). Her 1/24/23 level II [2] PASRR stated, This individual was not exempt from a Level II review and the following determination was made: Requires level of services provided by Medicaid certified swing bed to nursing facility due to the individual's physical or mental conditions. Based on the documentation provided for the Level II PASRR Review, this individual meets the minimum standards for Nursing Facility admission at this time. Item A1500 of her 3/4/26 comprehensive MDS assessment was coded No to the question Is the resident currently considered by the state level II PASRR process to have serious mental illness and/or intellectual disability or a related condition? 2. Review of resident 40's electronic medical record (EMR) revealed on 6/17/24 the resident had a diagnosis of major depressive disorder (serious, common, and treatable mental health condition characterized by persistent, intense sadness or a loss of interest in activities). Further review of the resident 40's MDS within the EMR revealed A1500 was marked no, indicating the resident does not have a serious mental illness and/or intellectual disability or a related condition. 3. Interview and review of resident 2's and resident 40's EMR on 4/28/26 at 3:27 p.m. with MDS/registered nurse (RN) H and social service designee (SSD) J revealed the residents' PASRRs were usually completed by the hospital staff before they admitted to the facility. Upon admission MDS/RN H and SSD J reviewed the resident's diagnoses and medications and compared them with the appropriate boxes on the completed PASRR screening to be sure the PASRR had been completed accurately prior to the resident's admission to the facility. If there was something omitted or not completed accurately SSD would resubmit the PASRR screen. MDS/RN H was responsible for entering the PASRR information into the residents' MDS assessments. MDS/RN H acknowledged she had coded resident 2's 3/4/26 section A1500 inaccurately. 4. Review of resident 40's electronic medical record (EMR) revealed on 6/17/24 the resident had a diagnosis of major depressive disorder (serious, common, and treatable mental health condition characterized by persistent, intense sadness or a loss of interest in activities). Further review of the resident 40's MDS within the EMR revealed A1500 was marked no, indicating the resident does not have a serious mental illness and/or intellectual disability or a related condition. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	5. Interview on 4/28/26 at 3:30 p.m. with MDS/registered nurse (RN) H confirmed resident 40 had a qualifying major depressive disorder upon admission, indicating the facility should have marked yes for questions A1500 on the MDS, and that section was marked no on 4/15/2026. 6. Review of provider's 5/14/25 Preadmission Screening and Resident Review PASRR policy revealed The Preadmission Screening and Resident Review (PASRR) is a federal requirement to ensure Nursing Facility (NF) residents with Serious Mental Illness (SMI) or Intellectual and Developmental Disability (ID/DD) are: Identified and evaluated; Placed in the most appropriate and least restrictive setting available; Transitioned to an appropriate community setting when they no longer meet criteria for NF placement; Provided with the MI/ID/DD services they need, including specialized services. Individuals who have or are suspected to have MD [mental disorder], ID [intellectual disability] or a related condition (as indicated by a positive level I screen) may not be admitted to a Medicaid-certified nursing facility unless approved based on Level II PASARR [PASRR] evaluation and determination. 7. Review of the CMS Long-Term Facility RAI 3.0 User's Manual Version 1.20.1 October 2025 revealed that Section N, Page N6 and N7, Steps for Assessment: 1. Review the resident's medical record for documentation that any of these medications were received by the residents and for the indication of their use during the 7-day look-back period (or since admission/entry or reentry if less than 7 days). 2. Review documentation from other health care settings where the resident may have received any of these medications while a resident of the nursing home (e.g., valium given in the emergency room). When answering the PASRR question on the MDS assessment, question A1500 should be coded as a yes if the resident had a PASRR Level II, which would then require question A1510 to be answered to indicate the reason for PASRR Level II, Serious mental illness, Intellectual Disability, or Other related conditions.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, and policy review, the provider failed to complete a Level II (2) Preadmission Screening and Resident Review (PASRR) (a mandatory federal process that ensures people with mental illness or intellectual disabilities are not inappropriately placed in nursing homes) for one of one sampled resident (40) with a qualifying mental health diagnosis and resubmit a Level I screening PASRR for one of one sampled resident (33) who was newly prescribed an antipsychotic (a drug that alters neurotransmitter activity in the brain to reduce symptoms of mental health conditions) medication.Findings include:1. Review of resident 40's electronic medical record (EMR) revealed she was admitted to the facility on [DATE] and had a diagnosis of major depressive disorder (a serious, common, and treatable mental health condition characterized by persistent, intense sadness or a loss of interest in activities) that was documented on 6/17/24. 2. Resident 40's 3/31/26 PASRR level 1 screening form did not indicate a confirmed or suspected mental illness diagnosis. 3. Review of resident 40's PASRR documentation revealed no additional PASRR level 1 screening was completed, nor was a PASRR level 2 submitted to the appropriate state agencies for review. 4. Interview on 4/28/26 at 3:28 p.m. with social services designee (SSD) J revealed that she did not complete a PASRR level 2 on resident 40. She was not aware of the Major Depressive Disorder diagnosis for the resident during her admission process. 5. Review of resident 33's EMR revealed she was admitted to the facility on [DATE]. Her 3/26/26 Brief interview of Mental Status (BIMS) assessment score was 13, which indicated her cognition was intact. Her diagnoses included depression. She had a level I PASRR screening before her admission to the facility. She had a 3/6/26 physician's order quetiapine (an antipsychotic medication) 25 milligrams (mg) at bedtime. There was no supported documentation of a diagnosis for the prescribed medication. She had a 3/29/26 physician's order to stop the quetiapine and start olanzapine (an antipsychotic medication) 5 mg daily at bedtime. There was no diagnosis identified on the physician's order that indicated what olanzapine was prescribed for. There was no documentation that resident 33's PASRR level I screening had been resubmitted for evaluation after she was prescribed antipsychotic medications. 6. Interview and review of resident 33's EMR on 4/28/26 at 3:27 p.m. with MDS/registered nurse (RN) H and social service designee (SSD) J revealed the residents' PASRRs were usually completed by the hospital staff before they were admitted to the facility. Upon admission, MDS/RN H and SSD J reviewed the residents' diagnoses and medications and compared them with the appropriate boxes on the completed PASRR screening to be sure the PASRR had been completed accurately before the resident's admission to the facility. If there was something omitted or not completed accurately, SSD J would resubmit the PASRR screen to the state designated authority. If a resident was started on a new psychotropic or antipsychotic medication, or they were diagnosed with a serious mental illness, intellectual disability (a condition characterized by significant limitations in both intellectual functioning (learning, reasoning, problem-solving) and adaptive behavior (everyday social and practical skills), or developmental disability (a chronic mental or physical impairment that emerges (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	before age [AGE], lasts throughout a person's lifetime, and causes substantial functional limitations in major life activities), a new PASRR level I screening would be submitted to determine if the resident needed a level II PASRR. When a resident was started on a new medication or diagnosed with a serious mental illness, intellectual disability, or developmental disability, MDS/RN H and SSD J were to be notified of this change in their daily morning meetings. SSD J stated she was not aware that resident 33 had an antipsychotic medication added to her medication list. MDS/RN H acknowledged that the addition of an antipsychotic medication to resident 33's regimen should have triggered them to complete a new PASRR screening. 7. Review of provider's 5/14/25 Preadmission Screening and Resident Review PASRR policy revealed The Preadmission Screening and Resident Review (PASRR) is a federal requirement to ensure Nursing Facility (NF) residents with Serious Mental Illness (SMI) or Intellectual and Developmental Disability (ID/DD) are: Identified and evaluated; Placed in the most appropriate and least restrictive setting available; Transitioned to an appropriate community setting when they no longer meet criteria for NF placement; Provided with the MI/ID/DD services they need, including specialized services. A negative Level I screen permits admission to proceed and ends the pre-screening process unless possible serious mental disorder with intellectual disability arises later.

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	435068	A. Building B. Wing	04/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avantara Watertown	415 Fourth Ave NE Watertown, SD 57201

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. Based on record review, interview, and policy review, the provider failed to ensure the staff followed nursing professional standards of practice for notifying the physician of elevated blood glucose (the amount of glucose-a type of simple sugar-present in your blood at any given time) for one of one sampled resident (40).Findings include:1. Review of resident 40's electronic medical record (EMR) revealed from 4/8/26 to 4/12/26 there were seven occurrences where resident 40's blood glucose results were over 400 milligrams per deciliter (mg/dL), indicating the concentration of glucose in the blood.Review of resident 40's EMR revealed six of the seven elevated blood glucose results were not reported to the physician.Review of her blood glucose orders revealed that blood glucose checks were started on 4/3/26 two times per day with no parameters for when to notify the physician.Review of resident 40's insulin orders revealed that there were no parameters for the blood glucose testing included with the 4/13/26 sliding scale insulin orders.2. Interview on 4/28/26 at 10:07 a.m. with licensed practical nurse (LPN) KK revealed that she would contact the doctor for blood glucose levels as per the parameters on the orders. If there were no parameters within the orders, and a blood glucose level was elevated or low she would contact the director of nursing (DON) and then the doctor's office for further orders or instruction.3. Interview on 4/28/26 at 11:19 a.m. with DON B revealed that if the ordering doctor does not give parameters for a resident's blood glucose, then she would expect the nursing staff to use the protocol/standing orders.4. Interview on 4/29/26 at 11:47 a.m. with the medical director (MD) LL revealed that it is her expectation that the physicians ordering the blood glucose and sliding scale insulin would have given orders with parameters of when the staff should contact the doctor.She further stated that she would expect the staff to contact the doctor and ask for parameters for the blood glucose checks if it was not indicated in the order.MD LL stated she would consider the protocol standing orders to be an acceptable guideline for nursing to follow if they did not have parameters and she would expect that staff would contact a doctor if a blood glucose was over 400 mg/dL.5. Review of the provider's Protocol Orders revealed the staff should contact the medical doctor (MD) if the blood glucose is less than 60 [mg/dl] or greater than 400 [mg/dl] unless otherwise specified.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Based on observation, interview, record review, and policy review, the provider failed to ensure a medication error rate of less than 5 percent related to a lidocaine patch (a topical pain-relieving patch) was removed as prescribed for one of one observed resident (30) by licensed practical nurse (LPN) SS and sucralfate (a medication used to treat and prevent ulcers) was administered before the noon meal as prescribed for one of one observed resident (19) by LPN KK. Those observed errors resulted in a medication error rate of 7.41%. Findings include:1. Observation, interview, and medication administration (MAR) review on 4/28/26 at 8:51 a.m. with LPN KK while she applied a lidocaine patch to resident 30's lower back revealed she brought the lidocaine patch into resident 30's room. When she lifted the back of resident 30's shirt to apply the lidocaine patch, LPN KK stated there was a patch on her lower back. She removed the lidocaine patch which was dated 4/27 and applied the new patch. LPN KK stated she needed to look at resident 30's physician's order because lidocaine patches are usually applied for 12 hours and then removed.LPN KK reviewed the order and stated the physician's order in resident 30's MAR indicated the patch was to be removed as scheduled. She then verified it was documented as removed on 4/27/26 at 6:59 p.m. by LPN SS. LPN KK stated she would notify director of nursing (DON) B that the lidocaine patch was not removed as documented on 4/27/26. 2. Review of resident 30's electronic medical record (EMR) revealed she had an 8/29/25 physician's order for a lidocaine external patch 4% to be applied to her lower back one time a day for pain and remove the patch as scheduled. The order in the MAR scheduled the removal of the patch for 6:59 p.m. 3. Observation and interview on 4/28/26 at 2:11 p.m. with LPN KK while she administered medications to resident 19 revealed LPN KK prepared acetaminophen and sucralfate to be administered by mouth and one topical pain relief gel. The pain relief gel and the acetaminophen were scheduled to be administered three times per day and were due to be administered. The sucralfate was scheduled to be administered before meals and at bedtime. LPN KK stated she did not realize that resident 19 had a medication she was supposed to receive prior to the noon meal. 4. Review of resident 19's EMR revealed she had a 3/7/23 physician's order for sucralfate one gram before every meal and at bedtime for gastro-esophageal reflux disease (heartburn). 5. Interview on 4/28/26 at 2:31 p.m. with LPN N revealed medications were expected to be administered within one hour before or one hour after their scheduled times. If a medication error was discovered the person who discovered the medication error was to notify the DON and the DON would complete the medication error report. She stated that only managers completed medication error reports. 6. Interview on 4/29/26 at 8:24 a.m. with registered pharmacist JJ revealed sucralfate was ordered to be administered before meals because it was meant to coat the stomach and if there was food in the stomach it may not be as effective. 7. Interview on 4/29/26 at 10:09 a.m. with DON B revealed she expected that when a medication error was identified, the staff member would report the medication error to her. She would complete the medication error report. The nurse was responsible for notifying the resident's physician and representative of the medication error and enter the medication error into the computer under risk management (an internal tracking system).The risk management form was the only medication error form the nurses had access to. DON B verified that LPN KK had notified her of the lidocaine patch that was not removed from 30's lower back on 4/27/26. DON B stated she started a medication error report for the lidocaine patch that was not removed as it was documented to have been.She expected medications to be administered to the resident within one hour before or after the medication was scheduled to be administered. She expected medications that were scheduled to be administered before meals would be administered before the meal. 8. Review of the provider's December 2019 Medication Administration-General Guidelines policy revealed the FIVE RIGHTS- Right resident, right drug, right dose, right route and right time, are applied for each medication being administered. Medications are administered withing [60 minutes] of scheduled time, except before, with or after meal orders, which are administered [based on mealtimes]. 9. Review of the provider's 5/14/25 (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Medication Errors policy revealed Each medication error discovered will be documented on the Medication Error Report form. The person discovering the error will complete Part 1 of the Form. Part 3 of the Form will address how this error occurred and can be prevented in the future. This section will be completed by the nurse/medication aide most closely responsible for the error.

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F 0761 Level of Harm - Minimal harm or potential for actual harm 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and policy review, the provider failed to ensure the temperature was monitored in one of two sampled refrigerators in one of one medication room that had influenza vaccines stored in it and two of two observed glucometer test strip containers with a shortened expiration date (supplies that, after opening, expire before the manufacturer's expiration date) were dated when they were opened. Findings include:1. Observation and interview on [DATE] at 12:53 p.m. with registered nurse (RN) D in the medication room revealed there were two refrigerators in the medication room. The first refrigerator contained various medications. The second refrigerator had four boxes of influenza vaccine. When the refrigerator temperature monitoring log was requested RN D produced the log for the refrigerator with multiple medications listed on it.She stated the second refrigerator's temperature was not monitored. It was the refrigerator they used for their specimens collected from residents that needed to be sent for testing. She verified there were influenza vaccines in the second refrigerator and that the refrigerator was occasionally used for overflow of medications when the first refrigerator became too full. There were no specimens in the second refrigerator. 2. Observation and interview on [DATE] at 11:10 a.m. with licensed practical nurse (LPN) N in the medication room revealed there were four boxes of influenza vaccine in the second refrigerator. The date those boxes were dispensed from the pharmacy was [DATE] and the influenza vaccine labels indicated the vaccine was to be stored between 36 and 46 degrees Fahrenheit (F). There was no thermometer in the refrigerator. LPN N thought the influenza vaccines may have been put in that refrigerator because the other refrigerator was too full. She verified that the temperature of that refrigerator was not monitored, and it was used for specimen storage in the past, but she had not seen it used for that in there for a long time. 3. Observation on [DATE] at 8:32 a.m. in resident 47's room revealed she had a blue plastic container on her over-the-bed table. In the container was a glucometer (a machine used to check blood sugar levels) and glucometer test strips. The bottle of glucometer test strips was partially empty. There was no date documented on the bottle to indicate when the bottle had been opened, to determine when it would expire. 4. Observation and interview on [DATE] at 11:00 a.m. with LPN N in resident 32's room revealed LPN N removed a glucometer and a glucose test strip from a plastic container at resident 32's bedside. LPN N checked resident 32's blood sugar level with that glucose test strip and glucometer. There was no date to indicate when the container of glucose test strips had been opened, to determine when it would expire.LPN N verified there was not a date on the container of glucose test strips. She stated she did not date glucose test strips when she opened them, she referred to the manufacturer's expiration date to determine when they expired and needed to be disposed of. She did not know if glucose test strips had a shortened expiration date after they were opened. She stated she would have to ask the director of nursing (DON). 5. Interview on [DATE] at 10:09 a.m. with DON B and regional nurse consultant C revealed the refrigerators in the medication room were used to store vaccines and medications. All refrigerator temperatures were to be monitored to ensure the temperature of the refrigerator was maintained at a safe storage temperature.Regional nurse consultant C stated she had been in the medication room recently and verified that there were influenza vaccines stored in the second refrigerator. Neither she nor DON B was aware that the temperature of that refrigerator was not being monitored. They expected the temperature of the refrigerators in the medication room to be monitored to ensure safe storage of medications and vaccines.DON B expected glucose test strips to be dated when they were opened because they would outdate before the manufacturer's expiration date once they were opened. DON B did not know how long after opening the glucose test strips were able to be used before they needed to be disposed of. Regional nurse consultant C verified the glucose test strips (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	needed to be disposed of 30 days after they were opened. 6. Review of the provider's [DATE] Medication Storage In The Facility policy revealed, Medications and biologicals are stored safely, securely, and properly, following manufacturer's recommendations or those of the supplier. All medications are maintained within the temperature ranges noted in the United States Pharmacopeia (USP) and by the Centers for Disease Control (CDC). Refrigerated at 36 [degrees] F to 46 [degrees] F (2 [degrees] C [Celsius] to 8 [degrees] C) with a thermometer to allow temperature monitoring. 7. Review of [DATE] UltrTRAK Complete Blood Glucose Test Strips manufacturer's instructions revealed, Test strips expire 3 months after first opening. Write the first opening date on the test strip vial when you first open it.

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. Based on observation, interview, and record review, the provider failed to ensure that staff honored one of one sampled resident's (22) meal choice preferences for one of four observed meals. Findings include:1. Observation on 4/21/26 at 12:08 p.m. in the dining room revealed licensed practical nurse (LPN) V reading the noon meal options aloud to resident 22, who said he did not like the fish being served that day and would rather have a hamburger. LPN V wrote on his meal ticket and left the dining room. At 12:19 p.m. resident 22 was served a plate containing fish. As LPN V walked past him, he told his tablemate, I don't want fish. LPN V stopped at the table and said, If you don't fill out your menu you get what they're serving. The resident left the dining room a few moments later, without eating the fish. 2. Interview on 4/21/26 at 1:47 p.m. with resident 22 revealed that his meal ticket and care plan included his preference for no fish. He said, I have it right there on the menu what I like and don't like, and I said no fish. I keep telling them, but they keep bringing it to me. He said LPN V had helped him request a hamburger at lunchtime, but that staff brought him fish instead. 3. Interview on 4/21/26 at 2:15 p.m. with resident 22's family member revealed that he did not like fish, chicken, or tomatoes, but they always put that stuff on his plate. She stated that resident 22 would leave the dining room hungry if they served food he did not like. 4. Interview on 4/22/26 at 2:51 p.m. with dietary manager (DM) CC revealed that residents could request substitution food items from an always available menu that included a variety of soups, sandwiches, hamburgers, and chicken strips. She said if a resident was not happy with the meal they received, she expected staff to offer substitute items from that menu. She was aware that resident 22's meal ticket included a preference for no chicken, fish, or tomatoes. 5. Interview on 4/22/26 at 3:04 p.m. with social services designee (SSD) J revealed that managers monitor mealtimes to make sure the residents' diet orders and preferences were accommodated. SSD J said residents were encouraged to submit alternative meal requests up to two hours before mealtimes, but residents could also request substitutions during the meal. Staff serving the food should cross-check the request with the resident's meal ticket. She stated, If I know a resident doesn't like chicken or fish, for example, when I'm [the] manager on duty I will ask him what he wants instead. She stated she was aware that resident 22 did not like chicken, fish, or tomatoes, and she expected that the managers on duty would help ensure he received food he liked. 6. Interview on 4/27/26 at 12:03 p.m. with CNA DD revealed that staff serving meals should check a resident's meal ticket to ensure order accuracy. She stated that if the order was wrong, we take the plate back or set it off to the side, then go ask the resident what they want instead. 7. Interview on 4/27/26 at 2:34 p.m. with cook OO revealed that residents' dietary preferences were added to their meal tickets upon admission to the facility. Residents received tickets for each meal and crossed off menu items they did not want, she said. An alternative menu was always available and that if a resident's preferences changed, she notified the DM to update their meal ticket. 8. Review of resident 22's 10/25/25 care plan revealed a dietary intervention dated 7/23/25 that read, no fish, no chicken, and no whole/chunked tomatoes per my preferences. 9. Review of resident 22's 4/27/26 meal ticket revealed a note that read, no fish, no chicken, and no whole/chunked tomatoes; dislikes: chicken, fish, fresh tomatoes. 10. Review of resident 22's medical record revealed nutrition assessments dated 1/9/26 and 10/10/25 where registered dietitian (RD) RR stated he prefers no fish, no chicken, no whole tomato chunks.Recommend to continue to provide a well-balanced intake.according to diet order and preferences.