| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 525454 | A. Building<br>B. Wing | 03/11/2026 |

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| Oakwood Health Services | 2512 New Pine Dr<br>Altoona, WI 54720 |

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| F 0697<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide safe, appropriate pain management for a resident who requires such services.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences for 7 of 7 residents reviewed (R7, R11, R39, R41, R44, R70, and R74).There was no documentation of non-pharmacological interventions for pain for R7, R11, R39, R41, R44, R70, and R74.Facility ran out of pain medications for R44.Findings include:<br><br>Facility Policy titled, Pain Management, last revised on 08/09/2022, reads in part: The facility must ensure that pain management is provided to residents who require such services consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.Non-pharmacological interventions will include but are not limited to: Environmental comfort measures.loosening restrictive clothing.cold compress, warm shower/bath, massage.music, relaxation techniques, activities, diversions.<br><br>Example 1<br><br>R74 was admitted to the facility on [DATE].<br><br>Most recent Minimum Data Set (MDS) reflects a Brief Interview for Mental Status (BIMS) score of 15/15 indicating R74 is cognitively intact.<br><br>Pertinent diagnoses include hypertension, chronic kidney disease with heart failure, congestive heart failure, lymphedema, peripheral venous insufficiency, and dependence on other enabling machines and devices.<br><br>Pertinent physician orders include lidocaine external patch, acetaminophen, tramadol, and document any non-pharmacological pain interventions attempted. 1. Heat 2. Cold 3. Positioning 4. Massage 5. Environmental Control 6. Imagery 7. Music 8. Distraction 9. Gentle Range of Motion (ROM) 10. Tens 11. Other- Specify in progress note 12. NA- Denies Pain<br><br>Care plan includes focus of pain in the knees and hips with a goal of will express that pain management is within acceptable limits, and interventions including administer pain medication per orders and encourage/assist to reposition frequently to position of comfort.<br><br>On 03/09/26 at 1:02 PM, Surveyor interviewed R74. R74 reported he has chronic pain in both knees and legs. R74 reported it sometimes takes a long time to receive pain medication when requested. R74 stated that no non-pharmacological interventions have been offered/tried since admission.<br>(continued on next page) |

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

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| F 0697<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Surveyor reviewed R74's Electronic Health Record (EHR). Physician orders for documenting non-pharmacological interventions in the treatment administration record (TAR) are blank since admission, indicating none were offered. Surveyor did not find any documentation of non-pharmacological interventions offered in progress notes when pain levels were obtained.<br><br>Example 2<br><br>R44 was admitted to the facility on [DATE].<br><br>Most recent MDS reflects a BIMS score of 15/15 indicating R44 is cognitively intact.<br><br>Pertinent diagnoses include peripheral vascular angioplasty with implants and grafts, polyneuropathy, history of stroke, and history of circulatory surgical procedure.<br><br>Pertinent physician orders include oxycodone, acetaminophen, tizanidine, diclofenac sodium external gel, gabapentin, and document any non-pharmacological pain interventions attempted. 1. Heat 2. Cold 3. Positioning 4. Massage 5. Environmental Control 6. Imagery 7. Music 8. Distraction 9. Gentle ROM 10. Tens 11. Other- Specify in progress note 12. NA- Denies Pain<br><br>Care plan includes a focus of pain in left leg related to fasciotomy and polyneuropathy with a goal of reduce episodes of breakthrough pain through next review date, and interventions including administer pain medication per orders and notify provider if pain frequency/intensity is worsening or if current analgesia regimen has become ineffective.<br><br>On 03/09/26 at 1:46 PM, Surveyor interviewed R44. R44 reported the facility ran out of his oxycodone and needed to wait for a new script and delivery. R44 reported the facility does not offer any non-pharmacological interventions for pain. R44 reported R44 was not aware of the order for diclofenac topical pain gel, as R44 was never informed it was available and was never offered any.<br><br>Surveyor reviewed R44's EHR. Physician orders for documenting non-pharmacological interventions in the TAR are blank since admission, indicating none were offered. Surveyor did not find any documentation of non-pharmacological interventions offered in progress notes when pain levels were obtained. The medication administration record (MAR) indicated that R44's diclofenac pain relieving gel was never administered.<br><br>Progress note from 03/08/26 reads in part: Patient is currently out of Oxycodone and awaiting provider approval for new script.<br><br>On 03/11/26 at 7:46 AM, Surveyor interviewed Registered Nurse (RN) D. RN D stated to monitor a resident's pain they ask the resident each shift to rate it. If unable to do so, they have the PAINAD assessment for non-verbal residents. RN D stated if giving as needed medication, they also do a follow up pain level and enter the number in the charting. RN D stated they do offer non-pharmacological interventions and believes they would just add that in a progress note. RN D stated if the interventions were ineffective, RN D would check on other options or readdress non-pharmacological. RN D stated if all of those interventions were still not effective, RN D would call the provider to have it addressed. RN D stated if RN D noticed a trend in continuous pain, RN D would call and update the provider after a week at most. RN D stated the facility does not run out of pain medications, but if they did, RN D would contact the provider, see if the medication is available in contingency, and if not, get a rush order from pharmacy. RN D stated the facility's main pharmacy<br>(continued on next page) |

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| F 0697<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | delivers twice a day, so an urgent need would come from a local pharmacy.<br><br>On 03/11/26 at 7:56 AM, Surveyor interviewed Medication Aide (MA) E. MA E stated to monitor/assess a resident for pain, MA E would ask the resident to rate their pain out of 10 if able. If not able, MA E would watch for body language and other non-verbal indications of pain. MA E stated that when giving an as needed medication they wait approximately an hour and return to follow up on the pain level and sooner if warranted. MA E stated if pain medications are not effective, MA E would inform the nurse and see if there are other options including a warm compress or creams for pain and that information would get documented in the progress note. MA E stated MA E has not come across pain medications that have run out, but MA E would inform the nurse and contact the pharmacy right away. On 03/11/26 at 9:57 AM, Surveyor interviewed Director of Nursing (DON) B. DON B stated it would be the expectation that nurses would complete a pain assessment, the MDS Coordinator would complete a pain interview, and daily the nurses would ask the resident or assess a resident for pain. DON B stated if a PRN medication was administered, they would wait about an hour or so and reassess the resident's pain level and this would be documented she believed in either the MAR or TAR. When asked if this was being completed, DON B stated, I would like to believe that. Non-pharmacological and gels and creams for pain management should also be offered. DON B stated that if a trend is noticed, the doctor will be updated on rounds or sooner if urgent. DON B stated they try to get medication scripts on time but if they don't, they will call pharmacy, see if the medication is available in contingency, or ask the doctor if there is an alternative until their medication is available. DON B stated the facility does have a fast run option for pharmacy if not available in house.<br><br>Example 3<br><br>R11 was admitted to the facility on [DATE] with diagnoses that include unsteady on feet, heart failure, and stroke. R11 was hospitalized after a fall at home. R11 had a Brief Interview of Mental Status (BIMS) score of 11 out of 15 completed on 2/20/26 that indicated that R11 had moderate impaired cognition.<br><br>On 03/09/26 at 3:06 PM, Surveyor interviewed R11 who reported that s/he has pain from when s/he fell at home. A pain assessment was completed by the facility on 02/23/26. The pain assessment notes R11's pain is occasional and ranges from 3 - 9 on a 0 to 10 scale and the location is in the neck and back.<br><br>R11's care plan dated 02/20/26 identifies the following:<br><br>~Pain to spine evidenced by verbal complaints r/t fall at home<br><br>~Administer pain medication per MD orders<br><br>~Notify MD if pain frequency/intensity is worsening or if current analgesia regimen has become ineffective.<br><br>Surveyor reviewed R11's physician orders, dated 02/20/26, which noted:<br><br>Document any non-pharmacological pain interventions attempted. 1. Heat 2. Cold 3. Positioning 4. Massage 5. Environmental Control 6. Imagery 7. Music 8. Distraction 9. Gentle ROM 10. Tens 11. Other- Specify in progress note 12. NA- Denies Pain<br>(continued on next page) |

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| F 0697<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Surveyor reviewed R11's March 2026 medication and treatment records and found no documentation of nonpharmacological interventions tried. All areas were blank. There were number recorded under pain assessment where R11 reported pain 6 out of 10 days in March and rated the pain 2 or 4 and one time a 5 out of a 0 to 10 scale.<br><br>Example 4<br><br>R39 was admitted to the facility on [DATE] with a diagnosis that included fracture of the sacrum, unsteadiness on feet, and age-related osteoporosis.<br><br>Most recent MDS dated [DATE] indicated R39 had a BIMS score of 12 out of 15 that indicated that R11 had moderate impaired cognition.<br><br>On 3/09/2026 at10:18 AM, Surveyor interviewed R39 who reported that she has pain from when she fell at home. R39 stated she has not been offered anything for pain relief besides occasionally ice, occasionally repositioning, and her pain medications.<br><br>A pain assessment was completed by the facility on 02/13/26. The pain assessment notes R39's pain is daily pain and ranges from 4 to 7 on 0- 10 pain scale and the location is the sacrum.<br><br>R39's care plan dated 2/13/26 identifies the following: -Pain to sacrum evidenced by facture.-Will express that pain management is within acceptable limits -Administer pain medication per MD orders-Implement non-drug therapies to assist with pain and monitor for effectiveness.-Notify MD if pain frequency/intensity is worsening or if current analgesia regimen has become ineffective.-Report nonverbal expressions of pain such as moaning, striking out, grimacing, crying, thrashing, change in breathing, etc.<br><br>Surveyor reviewed R39's physician orders, dated 02/13/26, which included: -Tramadol HCL 25 mg by mouth every 6 hours as needed for severe pain-Lidocaine external patch 4%- Apply to buttock topically at bedtime for pain and remove in AM.-Document any non-pharmacological pain interventions attempted. 1. Heat 2. Cold 3. Positioning 4. Massage 5. Environmental Control 6. Imagery 7. Music 8. Distraction 9. Gentle ROM 10. Tens 11.Other- Specify in progress note 12. NA- Denies Pain Surveyor reviewed R39's medication and treatment records since her admission and found no documentation of nonpharmacological interventions offered. All areas were blank.<br><br>R39's pain level was assessed every shift and with Tramadol given. Surveyor noted assessment of R39 reported pain a 5 or greater daily on a 0 to 10 scale since her admission.<br><br>On 3/10/26 at 11 AM, Surveyor interviewed Licensed Practical Nurse (LPN) H, who stated non-pharmacological pain interventions might get documented in the progress notes. LPN H stated that when R39 is offered ice or any other non-pharmacological intervention, it probably doesn't get documented.<br><br>Example 5<br><br>R70 was admitted to the facility on [DATE] with a diagnosis that included surgical after care following surgery on the digestive system, diverticulitis of the large intestine with perforation and abscess, intestinal bypass, fracture of the upper end of the right radius, and displaced fracture of the right ulna.<br>(continued on next page) |

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| F 0697<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Most recent MDS indicated R70 had a BIMS score of 12 out of 15 completed on 3/10/26 that indicated that R11 had moderate impaired cognition.<br><br>On 3/10/2026 at 7:28 AM, Surveyor interviewed R70 who reported her pain is in her right wrist. R70 has a hard cast on her fractured right wrist and winces in pain when it is moved. R70 reported her pain has been as high as a 10 on a scale of 0-10 pain scale. Surveyor asked if any non-pharmacological interventions were offered to her. R70 replied that she usually tries to keep it elevated but could not say if other interventions have been offered besides her pain medications.<br><br>Surveyor noted a pain assessment was completed by the facility on 3/6/26. The pain assessment notes R70's pain is occasional and ranges from 2 to 7 on a o-10 pain assessment scale. R70's care plan dated 3/5/26 indicated the following:-Pain [right upper extremity] RUE evidenced by rating/potential for pain [related to] r/t [right] R wrist [fracture]fx<br><br>-Will express that pain management is within acceptable limits.-Administer pain medication per MD orders -Notify MD if pain frequency/intensity is worsening or if current analgesia regimen has become ineffective.<br><br>Surveyor did not find non-pharmacological interventions for pain not addressed in care plan or Kardex.<br><br>Surveyor reviewed R70's physician orders, dated 3/5/26, which included:-oxycodone HCl Oral Tablet 5 MG (Oxycodone HCl) *Controlled Drug*, give 5 mg by mouth every 6 hours as needed for pain rated 7-10/10 -Document any non-pharmacological pain interventions attempted. 1. Heat 2. Cold 3. Positioning 4. Massage 5. Environmental Control 6. Imagery 7. Music 8. Distraction 9. Gentle ROM 10. Tens 11. Other- Specify in progress note 12. NA- Denies Pain-Resident pain level every shift.<br><br>Surveyor reviewed R70's medication and treatment records since her admission and found no documentation of nonpharmacological interventions offered. Surveyor noted R70 rated her pain a 7 out of 10 on three days since her admission.<br><br>On 3/10/26 at 7:34 AM, Surveyor interviewed LPN H, who when asked if R70 was offered non-pharmacological interventions for R70's pain, LPN H replied R70 usually keeps her arm elevated and takes pain medication but was unsure if any other interventions were offered.<br><br>Example 6<br><br>R7 was admitted to the facility on [DATE], and has diagnoses that include anxiety disorder, major depression, adult failure to thrive, pulmonary nodules, anemia, hypothyroidism, viral hepatitis, peripheral vascular disease, high blood pressure, unsteadiness of feet.<br><br>R7's MDS assessment, dated 2/4/26, states that R7 is cognitively intact, has clear speech and understands what is being said. R7 can ambulate with therapy only, needs assist of one in a wheelchair for locomotion, and assist of 2 for all transfers and bed mobility.<br><br>R7 care plan, dated 2/11/26, states: Focus: opioid use for pain management, with the intervention administering medications as ordered. R7's care plan does not include non-pharmacological pain interventions.<br><br>R7's Treatment Administration Record (TAR) reviewed December 2025 through March 2026, states,<br>(continued on next page) |

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| F 0697<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Document nonpharmacological pain interventions attempted. 1. Heat 2. Cold 3. Positioning 4. Massage 5. Environmental Control 6. Imagery 7. Music 8. Distraction 9. Gentle ROM 10. Tens 11. Other- specify in progress notes. 12. NA- [NAME] pain as needed.<br><br>This order is on the TAR starting 11/21/25 and discontinued on 1/27/26, 1/30/26 and discontinued 2/2/26 and started 2/3/26 and still active. On November 2025, December 2025, January 2026, February 2026, and March 2026 TAR reports, no documentation related to this order was completed. There is no order or documentation available in Certified Nursing Assistant (CNA) Kardex (plan of care) or Point of Care charting either.<br><br>On 3/9/26 at 1:18 PM, Surveyor interviewed R7 who stated R7 gets pain medication for leg pain. R7 stated he was on a scheduled pain medication before R7 went into the hospital. R7 stated it changed when I got back, now it is when R7 asks. R7 states, I don't know why they changed it. If I don't watch the clock and wait, then my pain gets intolerable. R7 states I have to ask all the time. R7 stated right now my pain is tolerable but usually it is worse. R7 stated R7's pain is usually an 8 on a scale of 1-10, with 10 being the worst.<br><br>On 3/11/26 at 7:53 AM, Surveyor interviewed CNA F who stated that CNA F does nothing related to pain management, there are no non-pharmacological pain interventions for R7, except reporting pain to the nurse.<br><br>On 3/11/26 at 8:11 AM, Surveyor interviewed RN H who stated pain assessment is at least once a shift, sometimes that is on the Medication Administration Treatment Record (MAR) and sometimes the TAR for documentation. RN H stated that the high chronic pain residents will have scheduled analgesia like Tylenol by mouth or topical like diclofenac or lidocaine, we try those things first. RN H stated that we have people like R7 who are always an 8 and have oxycodone every 4 hours as needed. RN H stated R7 watches the clock and requests his oxycodone on the dot. Surveyor asked if R7 had any non-pharmacological pain interventions. RN H opened the MAR and identified there are non-pharmacological interventions on the MAR. RN H stated there is nowhere to document in the MAR so we should document in progress notes. RN H paused and read the order closer and stated, wait specify in charting is for the option titled other, there are numbers (way documentation happens in the MAR). RN H opened the order and identified that it was listed as PRN and does not pull up every shift. RN H stated RN H guesses it would just be documented if people are thinking of looking in PRN. RN H stated that orders are expected to be done, and actions are expected to be charted. RN H stated she is going to fix that in the MAR so it pulls up every shift.<br><br>Example 7<br><br>R41 was admitted to the facility on [DATE] and has diagnoses that include polyosteoarthritis (arthritis of many joints), chronic pain syndrome, adult failure to thrive, high blood pressure, major depression, anxiety, restless legs and type 2 diabetes with diabetic neuropathy (nerve pain).<br><br>R41's MDS assessment, dated 2/19/26, states that R41 is cognitively intact with clear speech and can understand what is being said. R41 needs the assistance of 2 for bed mobility, dressing, toileting, and requires an assist of 2 with a mechanical lift for transfers. R41 can feed herself after set-up and requires the assistance of 1 for hygiene and grooming.<br><br>R41's care plan dated 12/26/25 states: Focus: Pain as evidence by reported generalized pain, restless leg syndrome. Date initiated 6/14/24 Revision 11/21/24.<br>(continued on next page) |

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| F 0697<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Intervention: Implement non-drug therapies (hot or cold therapy, repositioning) to assist with pain and monitor for effectiveness. Dated Initiated 11/21/24 Revision on 11/21/24.<br><br>R41's MAR and TAR for December 2025, January 2026, February 2026, March 2026 do not have an order for non-drug therapies.<br><br>On 3/11/26 at 8:04 AM, Surveyor interviewed CNA G who stated that R41 complains of pain when rolling, states our (CNA's) fingers feel pointy. R41 complains about her legs and one shoulder but only mentions it when we roll her. CNA G stated that R41 does not have non-pharmacological interventions as far as CNA G knows. CNA G stated if R41 complains of pain, we tell the nurse.<br><br>On 3/11/26 at 8:11 AM, Surveyor interviewed RN H regarding non-pharmacological pain interventions for R41. RN H looked up R41's orders in the computer and stated no. Surveyor asked RN to look at R41's pain related care plan. RN H looked at care plan and stated it is on her care plan but not on her MAR. RN H is not sure how that happened. RN H opened the care plan history and identified a box was not checked that puts a care planned intervention on the MAR or TAR. RN H stated we have not been offering non-pharmacological interventions to R41; honestly, she wouldn't have accepted them anyway.<br><br>On 3/11/26 at 10:25 AM, Surveyor interviewed Nursing Home Administrator (NHA) A who stated that non-pharmacological interventions sometimes are not going to suffice; in a perfect world we will try these interventions and then a med. NHA A stated it depends on the residents, whether they are open to attempting them, or are they going to push for pharmacological interventions. Surveyor told NHA A there are non-pharmacological interventions on the care plan or part of the MAR and no documentation for months that any were attempted. Surveyor asked what is your expectation for staff in response to the care plan. NHA A stated they follow the plan of care. Surveyor asked how do you know if they are following the care plan. NHA stated the expectation is that they document what tasks they are completing. |

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| F 0554<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Allow residents to self-administer drugs if determined clinically appropriate.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility did not determine safe self-administration of medications for 1 out of 17 residents (R) reviewed (R39).Surveyor observed R39 to have a cup of medications on the bedside table sitting in front of her while she was sleeping in her chair. R39 did not have an assessment for self-administration of medications, and R39 did not have a physician's order for self-administration.This is evidenced by: The facility's policy titled, Medication Administration, Section 7.3, Self-Administration by Resident dated 1/26, states in part, . Residents who desire to self-administer medications are permitted to do so with a prescriber's order and if the medications are appropriate and safe for self-administration. The facility's policy titled, Medication Administration, Section 7.1, General Guidelines dated 1/26, states in part, 13. Explain to resident the type of medication being administered and the procedure. R39 was admitted to the facility on [DATE] with diagnoses that included: fracture of the sacrum, age-related osteoporosis, and unsteadiness on her feet. R39's Minimum Data Set (MDS), dated [DATE], indicates a Brief Interview for Mental Status (BIMS) score of 12 out of 15, indicating R39 is cognitively intact. On 3/10/2026 at 10:25 AM, Surveyor was walking past R39's room and noted R39 had medication in a med cup on a tray table in front of her. R39 was asleep and did not wake up when Surveyor knocked on her open door. On 3/10/2026 at 10:27 AM, Surveyor interviewed Licensed Practical Nurse (LPN) H, who reported doing the medication administration for hall B. LPN H reported there were no residents in hall B that would be considered able to self-administer their medications. Surveyor asked LPN H how she would know when it is appropriate to leave medications in a resident's room. LPN H stated it would be in the medication administration record (MAR). LPN H stated did med pass in B hall and she thought all residents took their medications. LPN H and Surveyor together went to R39's room. R39 had three pills in the medication cup in front of her on the table. LPN H woke R39 and asked why she hadn't taken her medications. R39 stated she was concerned and wanted to know what the medications are because some are making her dizzy. LPN H identified R39's medications as vitamin D, Senna plus (stool softener), and her torsemide (diuretic). R39 then took her medications one at a time. On 3/10/2026 at 11:00 AM, Surveyor interviewed LPN H who stated she had not gone through R39's medications when giving them this morning. LPN H stated she had watched R39 put her med cup up to her mouth to take her medications. Surveyor asked if LPN H thought R39 had spit them out. LPN H stated, she didn't know but, I probably should have stayed and watched her to make sure she swallowed them. On 3/10/26 at approximately 11:30 AM, Surveyor interviewed R39 who stated she is frustrated with the nurses and wants to know what she is taking for her medication because she's not sure if they are giving her medications that she does not want. R39 stated she has told several nurses this and they don't listen to her. R39 also reported she prefers to take her medications with applesauce and takes one pill at a time. On 3/11/2026 at 10:17 AM, Surveyor interviewed DON B who stated residents who request to self-administer meds would require a provider order and an assessment to self-administer. DON B agreed that nursing staff should be providing residents the knowledge on what type of medication they are being given if the resident asks. Surveyor informed DON B that LPN H admitted she did not explain the medications given or ensure R39 swallowed her oral medications safely. DON B replied, yes, the nurse should have ensured that residents take their medications. |

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|---|---|---|---|
| | 525454 | A. Building<br>B. Wing | 03/11/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Oakwood Health Services | 2512 New Pine Dr<br>Altoona, WI 54720 |

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| F 0572<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Give residents a notice of rights, rules, services and charges.<br><br>Based on interview and record review, the facility did not ensure 1 resident (R39) of 5 medication administration observations was fully informed of but not limited to; resident rights and required medication information with options as requested by R39 prior to administering R39's medications during medication administration. Registered Nurse (RN) N did not provide information as requested by R39 before administering questionable medications that R39 had concern for.Findings include: Facility policy titled Medication Administration, last revised 01/26, stated in part, .medication administration #13. Explain to resident the type of medication being administered and the procedure. On 03/11/2026 at 7:14 AM, Surveyor observed RN N entering R39's room. RN N placed medications on the table. R39 asked RN N where R39's applesauce is as R39 takes medications with applesauce. RN N reported that kitchen did not have applesauce, but RN N brought chocolate pudding instead. R39 reported that R39 did not want chocolate pudding. R39 complained of not wanting to take medications because R39 does not know what medications R39 is on. R39 stated, They have changed my medications so much that I don't know what I am on anymore, and it's frustrating. Something is causing me to be dizzy. I reported this to staff the other day, and it keeps happening, so I really want to know what medications I am on before taking them. RN N reported to R39 that RN N was unaware that R39 was complaining of being dizzy. RN N stated to R39, I can make a list of medications for you explaining what you are taking, but I cannot leave the room until you take medications. R39 seemed discouraged, looked at RN N, and looked at medication cup. R39 then proceeded to take one pill out at a time to swallow. R39 took two pills then accidentally dropped two more pills on the floor. RN N stated, I will need to go get new meds for you since these dropped. R39 grabbed another pill out of medication cup and asked RN N what the medication was. RN N stated, I am not entirely sure, but I think it is your losartan blood pressure med. R39 looked confused and stated, Oh, ok I guess. During medication administration, R39 began to have a nosebleed. RN N handed R39 a Kleenex. R39 stated, Yea I am having a bad nosebleed, I guess. RN N observed R39 finish medications. RN stated to R39, I am going to get a set of vitals since you have a nosebleed. Surveyor observed RN N exit R39's room. On 03/11/2026 at 7:21 AM, Surveyor observed RN at medication cart. Surveyor made RN N aware that RN N did not prepare R39's medications with losartan in the medication cup and the order for losartan is at bedtime not morning time. Surveyor asked RN N to clarify where the losartan medication came into play during medication administration observation. RN N stated to Surveyor, Oh you're right I did not administer losartan. The pill must be torsemide then that I administered. RN N then walked into R39's room with Lidocaine patch and other medications that had dropped on the floor. RN N administered medications to R39 and exited room. Surveyor did not observe RN N explain medications to R39 or identify the accuracy of what medication R39 took that was potentially called losartan. On 03/11/2026 at 7:27 AM, Surveyor interviewed RN N and asked what RN N's process is for educating R39 on medications that R39 does not know she is taking or correcting the misinformation about the losartan given. RN N reported that RN N will need to write a list for R39 down to show R39 what she is taking. RN N reported that RN N should have probably completed the education to R39 prior to having R39 taking medications but did not. On 03/11/2026 at 10:47 AM, Surveyor interviewed Director of Nursing (DON) B and asked expectation of RN N to educate R39 on medications prior to making R39 take medications when R39 did not want to due to concern of dizziness. DON B reported that RN N should have printed the MAR and educated R39 before administering medications. DON B reported to Surveyor that Assistant Director of Nursing (ADON) O will print a MAR and explain medications to R39 right away. Surveyor observed ADON O print R39's MAR and exit DON B's office. |

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| F 0607<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Develop and implement policies and procedures to prevent abuse, neglect, and theft.<br><br>Based on record review and interview, the facility did not ensure employees were screened for a prior history of abuse, neglect, exploitation of residents, or misappropriation of resident property for 1 of 8 employees reviewed.The facility did not ensure their abuse policy was implemented when one employee's background information disclosure (BID) was not obtained before employee started working at facility. (LPN M).Findings include:The facility policy, titled Abuse, Neglect, Mistreatment, and Misappropriation of Resident Property, last revised 01/26, stated in part, .Employee screening and training: a. Before new employees are permitted to work with residents' board registrations and certifications regarding prospective employees' backgrounds will be checked. d. A criminal background check will be conducted on all prospective employees as provided by the facility's policy on criminal background checks.On 03/11/26 at 10:14 AM, Surveyor reviewed 8 random staff Background Information Disclosures (BID).Licensed Practical Nurse (LPN) M was hired on 01/29/26. Surveyor found BID dated 09/13/24 with question #4 answered, Yes, lived in Minnesota from 2001-2021. Surveyor did not find a background performed for the state of Minnesota prior to LPN M working at facility. Surveyor did not find an updated BID form for facility to run an updated background upon LPN M's hire. On 05/06/25 at 11:42 AM, Surveyor interviewed Nursing Home Administrator (NHA) A and asked where LPN M's BID, DOJ, and IBIS were. NHA A indicated that somehow LPN M's Minnesota background was missing when there were role changes in the facility. NHA A reported to Surveyor that the background will be completed today right away since it was not performed upon LPN M's hire date. |

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| F 0690<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility did not ensure that a resident receives appropriate treatment and services to prevent urinary tract infections to the extent possible for 1 of 3 reviewed. (R20)-R20 has a suprapubic catheter, and it was not kept below the bladder level.The facility policy titled, Catheter Care, dated 03/15/23, indicates drainage bags are to be located below the level of the bladder to discourage backflow of urine. There is no mention of proper tubing placement. R20 was admitted to the facility on [DATE] with diagnoses including multiple sclerosis, retention of urine, dysfunction of bladder, cystostomy, and history of MRSA. R20's Minimum Data Set (MDS), dated [DATE], indicated that R20 had a Brief Interview for Mental Status (BIMS) score of 6 out of 15 indicating that R20 had moderately impaired cognition. R20's care plan dated 08/15/25 notes, Use of indwelling urinary catheter suprapubic needed due to neurogenic bladder secondary to MS. R20 is dependent on staff for eating, bed mobility, transfers using a mechanical lift, and toileting/bed pan and catheter management. On 03/09/2026 at 1:53 PM. Surveyor interviewed R20's family member who was concerned that R20 gets frequent urinary tract infections (UTI). Surveyor observed R20's catheter tubing was above bladder level while R20 was up in Broda chair and hanging down in a coil that would not allow proper drainage. On 03/10/2026 at 6:42 AM, Surveyor observed R20's Foley catheter tubing below the bladder level and looped off the side of the bed hanging down. (It was not looped on top of the bed to allow adequate drainage.) The clip was not secured to anything. On 03/10/2026 at 8:04 AM, Surveyor observed Certified Nursing Assistant (CNA) I and CNA J providing care on R20. Both CNAs assisted with morning care that included suprapubic catheter care. Surveyor asked the CNAs about the catheter tubing. CNA J stated it is supposed to be coiled on the bed. CNA J then moved the tubing onto the bed, and a significant amount of urine began pouring into the drainage bag. After the cares were finished, CNAs applied a Hoyer sling under R20, hooked up sling to the lift, then attached the urinary drainage bag to the top hook on the lift that was approximately 1 1/2 feet above R20's bladder. CNAs finished the transfer and lowered R20 onto a Broda chair. CNA J then took the drainage bag and clipped it by the foot of the Broda chair. The tubing was coiled in a downward loop. Surveyor asked the CNAs if they felt the urine would drain well with the tubing positioned that way. CNA J stated it probably would not, then clipped the bag under the seat of the chair and ensured the tubing was positioned to allow the urine to flow freely into the bag. Surveyor reviewed R20's physician orders since admission and found R20 was treated for a UTI from 1/9/26 to 1/19/26 with Cipro for UTI. There were no other UTIs found in the record.^On 03/10/2026 at 9:21 AM, Surveyor interviewed Director of Nursing (DON) B and asked what should be done with tubing when a resident with a catheter is in bed or chair. DON B stated the tubing should be on the bed and clipped to the sheet and tubing should always be placed to allow the urine to flow into the bag. Surveyor then asked where the catheter bag should be during a transfer with a Hoyer lift. DON B stated it should be hooked low on the lift and below the bladder level. Surveyor explained what was observed and DON B stated that was not proper and will educate the staff. |

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| F 0698<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide safe, appropriate dialysis care/services for a resident who requires such services.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not ensure ongoing assessment of the resident's condition and monitoring for complications before dialysis treatments for 2 of 2 residents reviewed (R1, R6).R1 and R6 did not have pre-dialysis weights performed. Previous dialysis day's weights utilized for majority of assessments.Findings include:Facility Policy titled, Hemodialysis, last revised on 09/10/23, reads in part: This facility will provide the necessary care and treatment, consistent with professional standards of practice, physician orders, the comprehensive person-centered care plan, and the resident's goals and preferences, to meet the special medical, nursing, mental, and psychosocial needs of residents receiving hemodialysis.This will include: The ongoing assessment of the resident's condition and monitoring for complications before and after dialysis treatments.nutritional/fluid management including documentation of weights.Example 1R1 was admitted to the facility on [DATE].Most recent Minimum Data Set (MDS) indicates a Brief Interview for Mental Status (BIMS) score of 14/15 indicating intact cognitive function.R1's pertinent diagnoses include hypertensive heart and chronic kidney disease with heart failure and with stage 5 chronic kidney disease, or end state renal disease, and dependence on renal dialysis.R1 has scheduled dialysis outside the facility on Mondays and Fridays.R1's orders include completing pre-dialysis assessment prior to treatments, and post-dialysis assessments upon return from treatment. Order in place to obtain weight prior to and after dialysis treatments on Monday and Friday.Surveyor reviewed R1's Electronic Health Record (EHR). Weights were not obtained prior to dialysis appointments. The previous dialysis day's weight was used in place of obtaining a new one. The weights were obtained upon return post-dialysis.Example 2R6 was admitted to the facility on [DATE].Most recent MDS indicates a BIMS score of 13/15 indicating intact cognitive function.R6's pertinent diagnoses include hypertensive heart and chronic kidney disease with heart failure and with stage 5 chronic kidney disease, or end state renal disease, type 2 diabetes mellitus with diabetic chronic kidney disease, and dependence on renal dialysis.R6 has scheduled dialysis outside the facility on Monday, Wednesday, and Friday.R6's orders include completing pre-dialysis assessment prior to treatments, and post-dialysis assessments upon return from treatment. Order in place to obtain weight prior to and after dialysis treatments on Monday, Wednesday, and Friday.Surveyor reviewed R1's Electronic Health Record (EHR). Weights were not obtained prior to dialysis appointments. The previous dialysis day's weight was used in place of obtaining a new one. The weights were obtained upon return post-dialysis.On 03/10/26 at 8:32 AM, Surveyor interviewed Certified Nursing Assistant (CNA) C. CNA C stated CNA C was not sure when the dialysis residents got weighed but was pretty sure it was before they leave for the appointment. CNA C stated the nurses just tell them when they need a weight obtained and they get weights on everyone the first of the month and on shower days.On 03/10/26 at 8:43 AM, Surveyor interviewed Registered Nurse (RN) D. RN D stated for dialysis residents, vitals signs are checked before and after dialysis. RN D stated there is a pre-dialysis and post dialysis assessment that is to be completed. RN D stated RN D wasn't sure if one or both residents required a weight before dialysis but they both required weights after returning from dialysis.On 03/10/26 at 8:38 AM, Surveyor interviewed Director of Nursing (DON) B. DON B stated the expectation for dialysis residents would be for the nurses to complete a full set of vitals including weights, before and after dialysis appointments. DON B stated the nurses would obtain the vitals and may ask the CNAs to obtain the weight. DON B acknowledged Surveyor's record review of unobtained weights prior to dialysis appointments. |

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| F 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.<br><br>Based on observation, record review, and interview, the facility did not ensure drugs and biologicals were labeled with an open date/expiration date in accordance with currently accepted professional principles for 1 of 1 resident (R) (R11).Facility did not have an open/expiration date label on R11's opened bottle of Roxanol.Findings include:On 03/10/2026 at 9:38 AM, Surveyor observed medication cart on Aspen unit. Surveyor observed in narcotic box R11's Roxanol 20mg/ml liquid bottle. Surveyor observed R11's Roxanol liquid bottle opened with no open date label. Surveyor asked Medication Aide (MA) E if it is normal process for liquid controlled substances to not be labeled once opened. MA E reported that R11's Roxanol bottle should have been labeled with an open date label. Surveyor asked MA E when MA E's last dose was given. MA E reported after looking at R11's Medication Administration Record (MAR), R11 received Roxanol second dose today on 03/10/26 at 3:00 AM. On 03/10/2026 at 3:52 PM, Surveyor interviewed Director of Nursing (DON) B and asked DON B for expectation of open liquid-controlled substance such as Roxanol being labeled. DON B reported to Surveyor that all staff are to label any liquid bottles that are opened with the open date so that staff know when it will expire and to reconcile appropriately with controlled substances. DON B reported that someone should have labeled R11's bottle once opened. DON B reported to Surveyor that DON B will discard the open unlabeled bottle and replace it with a new one. |

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| F 0810<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide special eating equipment and utensils for residents who need them and appropriate assistance.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility did not provide special eating equipment and utensils for residents who need them when consuming meals for 1 of 17 residents reviewed. (R14)R14 requires the use of a divided plate, built up utensils, and a nosey cup. R14 was not provided with built up utensils or the nosey cup during lunch.R14 was admitted on [DATE] with diagnoses that include dementia, stroke, abnormal posture, dysphagia, and diabetes. R14's most recent Brief Interview of Mental Status (BIMS) score was 0 of 15 which indicates R14 had severe cognitive impairment. R14's care plan with a revision date of 01/27/26 notes R14 is at risk for nutritional status due to diabetes and dementia. Interventions include set up assistance and to encourage to use divided plates, nosey cup, built-up utensils and clothing protector. On 03/09/26 at 12:17 PM, Surveyor observed R14 in the dining room using a divided plate, and regular cup and utensils. Certified Nursing Assistant (CNA) K was feeding R14. At 12:46 PM, Surveyor reviewed R14's dietary card that noted adaptive equipment needed was divided plate, nosey cup, and built-up utensils. Surveyor asked CNA K if R14 was to have the adaptive equipment of the nosey cup and built-up utensils, and CNA K said yes and she will go grab them. CNA K then retrieved the nosey cup and gray handled built-up silverware. On 03/10/26, Surveyor interviewed Dietary Manager L and asked what the expectation would be for staff to provide adaptive equipment at mealtime. Dietary Manager L stated that all staff should be following what is on the residents' tickets. |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide and implement an infection prevention and control program.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility did not establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 1 out of 3 residents (R) observed for wound care (R70) Staff did not change gloves or perform hand hygiene during observation of wound care.R70's wound suction tubing was unplugged, and the open end of suction vacuum tubing was touching the floor. Staff did not clean or disinfect the tubing end prior to reconnecting to clean wound suction dressing. Findings include:The facility policy titled, Personal Protective Equipment, revised 3/17/2023, states in part, 4. Indications/considerations for PPE use: a. Gloves:. iv. Change gloves and perform hand hygiene between clean and dirty tasks, when moving from one body part to another, when heavily contaminated, or when torn.The Center for Disease Control (CDC) wound care guidelines states in part, Emphasize strict infection control through hand hygiene, proper use of personal protective equipment (PPE), and aseptic techniques to prevent cross-contamination. Ensure clean environments for wound care and prevent exposure to dirty water or surfaces.R70 was admitted to the facility on [DATE] with a diagnosis that included, encounter for surgical after care following surgery on the digestive system. R70's orders included, Wound Vac - Apply vacuum-assisted closure device at 125 mmHG with green foam to abdomen, without bridge dressing, and transparent semipermeable cover dressing every day shift every Tue, Thu, Sat and as needed.On 3/10/26 at 6:54 AM, Surveyor observed Licensed Practical Nurse (LPN) H, perform R70's surgical wound change. During R70's wound care dressing change, Surveyor observed LPN H wipe stool from R70's uncovered colostomy stoma, and then without changing gloves or performing hand hygiene, LPN H proceeded to grab R70's suction tubing that had remained attached to the suction machine on one end but the other, unattached end had been lying on the floor under R70's bed. LPN H proceeded to plug the unattached end to the newly applied wound vacuum tubing. On 3/10/26 at 7:25 AM, Surveyor interviewed LPN H, who stated she didn't realize the open tubing had touched the floor.On 3/10/26 at 9:22 AM, Surveyor interviewed Director of Nursing (DON) B, who stated the expectation would be that the suction hose end that had touched floor would have been cleaned off with an alcohol prep pad before reconnecting to the resident's wound vac. DON B agreed LPN H should change gloves and use hand hygiene after cleaning stool from R70's colostomy stoma site and before reconnecting suction tubing. |