DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
May 7, 2026

Administrator
SAINT THERESE AT OXBOW LAKE
9751 REGENT AVENUE NORTH
BROOKLYN PARK, MN 55443

RE: CCN: 245619
Cycle Start Date: February 26, 2026

Dear Administrator:

On April 29, 2026, the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Compliance Analyst | Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Office: 651-201-4112

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245619	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BLDG B. WING	(X3) DATE SURVEY COMPLETED 02/24/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAINT THERESE AT OXBOW LAKE	9751 REGENT AVENUE NORTH , BROOKLYN PARK, Minnesota, 55443

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K0000 Bldg. 01	INITIAL COMMENTS FIRE SAFETY An annual Life Safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 02/24/2026. At the time of this survey, Saint Therese At Oxbow Lake was found in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, the Health Care Facilities Code. St. Therese at Oxbow Lake is a 2-story building with a partial basement that was built in 2012 and was determined to be of Type II (111) construction. The facility is divided into several separate smoke compartments on each level. The facility is fully protected throughout by an automatic fire sprinkler system and has a fire alarm system with smoke detection in the corridors, spaces open to the corridors, and the resident rooms that is monitored for fire department notification. The facility has a capacity of 64 beds and had a census of 58 at time of the survey. The requirements at 42 CFR, Subpart 483.70(a), are MET.	K0000		

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 reverse for further 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245619	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/26/2026

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E0000	Initial Comments On 2/23/26 through 2/26/26, a survey for compliance with CFR §483.73, Appendix Z, Emergency Preparedness Requirements was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E0000		03/27/2026
F0000	INITIAL COMMENTS On 2/23/26 through 2/26/26, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was NOT in compliance with §42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed: NO deficiencies were cited. H56196380C (2700128) H56196360C (2698225) H56196361C (2623563) H56194180C (2611698) H56196400C (1144694) H56196401C (1144744) H56196405C (1144742) H56196402C (1144741) H56196403C (1144740) H56196404C (1144739)	F0000		03/27/2026

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F0000	Continued from page 1 The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.	F0000		
F0550 SS = D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal	F0550	This Plan of Correction is submitted for the sole purpose of maintaining compliance with Medicare and Medicaid participation requirements. Submission of this Plan of Correction does not constitute an admission by the facility of any deficiency, violation, or non-compliance with applicable laws or regulations. The facility reserves all rights to contest the cited findings, statements, and conclusions through available legal and administrative processes. F0550 – Resident Rights: Dignity and Respect (SS=D) At the time of correction, Resident R10 no longer had an indwelling urinary catheter in place. The concern related to dignity and privacy was no longer present. Staff were reminded of expectations to maintain resident dignity and privacy at all times in accordance with facility policy and resident rights. All residents with indwelling urinary catheters were evaluated for the potential to be affected by the alleged deficient practice. The Director of Nursing (DON) or designee will complete an audit of all residents with urinary catheters to ensure that drainage bags are appropriately covered or positioned to maintain dignity and privacy when residents are visible to others. Audit completion targeted by April 3, 2026. The facility implemented the following measures to support ongoing compliance: Care plans for residents with urinary catheters will be	04/20/2026

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F0550 SS = D	Continued from page 2 from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is NOT MET as evidenced by: Based on observation and interview, the facility failed to ensure a resident was treated with dignity and respect by maintaining privacy of a urinary catheter drainage bag, resulting in the visible exposure of urine to others passing by for 1 of 1 resident observed (R10). Findings include: R10's annual Minimum Data Set (MDS), dated 1/29/26, identified R10 had severe cognitive impairment and required assistance with activities of daily living (ADLs). R10's diagnoses included stroke (a condition in which blood flow to the brain is interrupted or reduced causing brain cell damage), atrial fibrillation (an irregular and often rapid heart rhythm that can increase the risk of stroke and heart-related complications), heart failure (a chronic condition in which the heart is unable to pump blood effectively), hypertension (chronically elevated blood pressure), peripheral vascular disease (a circulatory disorder that causes narrowing or blockage of blood vessels outside of the heart and brain), gastroesophageal reflux disease (GERD) (a condition in which stomach acid frequently flows back into the esophagus causing irritation), diabetes mellitus (a metabolic disorder characterized by elevated blood glucose levels due to the body's inability to produce or effectively use insulin), aphasia (a disorder affecting the ability to communicate, including speaking or understanding language), hemiplegia (paralysis affecting one side of the body), depression (a mood disorder causing persistent feelings of sadness and loss of interest), chronic obstructive pulmonary disease (COPD) (a progressive lung disease that causes airflow limitation and difficulty breathing), aphasia following cerebral infarction (difficulty with language caused by damage to the brain following a stroke), dysphasia (difficulty swallowing), edema (swelling caused by excess fluid trapped in body tissues), acquired absence of the right leg above the knee (surgical removal or loss of the right leg above the knee), and presence of a cardiac	F0550	Continued from page 2 reviewed and updated to include dignity-related interventions, including the use of catheter bag covers, as appropriate Nursing staff were re-educated on resident rights, dignity, and proper catheter management, including maintaining privacy and use of dignity covers Dignity covers are available and accessible on all nursing units Education completed by April 3, 2026. To ensure sustained compliance, the DON or designee will: Conduct weekly audits for four (4) weeks, followed by monthly audits for three (3) months Verify that catheter drainage bags are appropriately covered or positioned and that dignity interventions are reflected in the care plan Review audit findings through the QAPI process to identify trends and implement corrective actions as needed The DON and/or designee is responsible for maintaining compliance with this requirement. Completion Date: April 10, 2026	

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F0550 SS = D	Continued from page 3 pacemaker (a device implanted in the chest that helps regulate abnormal heart rhythms). Review of R10's physician orders, dated 2/24/26, indicated a Foley catheter was present and the collection bag was to be kept below the level of the bladder at all times. The order further indicated the collection bag should not rest on the floor and staff were to ensure a dignity bag was in use at all times. Observations included the following: • 2/24/26 at 11:37 a.m. – R10's catheter drainage bag was hanging from the side of the wheelchair and was not covered. The bag contained straw-colored liquid and was visible from the hallway. • 2/24/26 at 2:59 p.m. – R10's catheter drainage bag remained in the same location on the wheelchair and continued to be visible from the hallway. • 2/25/26 at 9:05 a.m., 12:40 p.m., and 2:25 p.m. – R10 was observed sitting in a wheelchair with the drainage bag hanging from the side of the wheelchair without a dignity cover. The straw color, liquid, filled bag was visible to individuals walking past the room. • 2/26/26 at 8:12 a.m. – R10's catheter drainage bag continued to hang from the side of the wheelchair without a dignity cover and remained visible from the hallway. During an interview on 2/26/26 at 9:53 a.m., nursing assistant (NA)-D confirmed the urinary catheter drainage bag was visible and stated the bag should typically be placed in a privacy or dignity cover when the resident was in areas visible to others to maintain dignity. NA-D stated R10 did not have a dignity bag available. During an interview on 2/26/26 at 11:28 a.m., registered nurse clinical coordinator (CC)-B confirmed residents with urinary catheter drainage bags should have the bag covered or positioned in a manner that maintained the resident's dignity and prevented unnecessary exposure. During an interview on 2/26/26 at 1:32 p.m., the director of nursing (DON) stated she expected catheter	F0550		

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F0550 SS = D	Continued from page 4 drainage bags to be covered at all times to maintain resident privacy and dignity. The facility Promoting/Maintaining Resident Dignity policy, dated 10/22, indicated the facility would protect and promote resident rights and treat each resident with respect and dignity, as well as provide care in a manner and environment that maintained or enhanced each resident's quality of life. The policy further indicated all staff were responsible for promoting and maintaining resident dignity and respecting resident rights.	F0550		
F0553 SS = D	Right to Participate in Planning Care CFR(s): 483.10(c)(2)(3) §483.10(c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care. (iii) The right to be informed, in advance, of changes to the plan of care. (iv) The right to receive the services and/or items included in the plan of care. (v) The right to see the care plan, including the right to sign after significant changes to the plan of care. §483.10(c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must- (i) Facilitate the inclusion of the resident and/or resident representative. (ii) Include an assessment of the resident's strengths and needs.	F0553	F0553 – Care Conferences (SS=D) The facility conducted a review of care conference compliance to ensure conferences were completed within required timeframes, properly documented, and included appropriate interdisciplinary team members, as well as the resident and/or representative. Resident R19's care conference has been completed. Resident R8's care conference has been scheduled to ensure timely completion. All active residents were evaluated for the potential to be affected by the alleged deficient practice. A facility-wide review was conducted to identify any missed, delayed, or incomplete care conferences. Any identified concerns were addressed through scheduling and completion. The facility implemented the following process improvements: A Care Conference Tracking Log was implemented to monitor due dates and completion status Social Services staff were re-educated on care conference policy, including timeliness, participation requirements, and documentation standards Education completed by April 3, 2026. The Social Services Director or designee will: Conduct weekly audits for four weeks, followed by	04/20/2026

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F0553 SS = D	Continued from page 5 (iii) Incorporate the resident's personal and cultural preferences in developing goals of care. This REQUIREMENT is NOT MET as evidenced by: Based on record review and interview, the facility failed to ensure residents were provided the opportunity to participate in the planning of their care through timely care conferences for 2 of 7 residents reviewed for care planning (R8 and R19). Findings include: R8 R8's quarterly Minimum Data Set (MDS) dated 12/23/25 identified R8 had severe cognitive impairment and required assistance with activities of daily living (ADLs). R8's diagnoses included non-traumatic brain dysfunction (impaired brain function affecting cognition or behavior not caused by physical injury); vascular dementia – severe – without behavioral, psychological, mood, or anxiety disturbances (advanced cognitive decline caused by impaired blood flow to the brain); hypertension (chronically elevated blood pressure); arthritis (joint inflammation causing pain and reduced mobility); chronic obstructive pulmonary disease (COPD) (chronic lung disease causing airflow limitation and breathing difficulty); paroxysmal atrial fibrillation (intermittent irregular heart rhythm that increases risk of stroke); gastroesophageal reflux disease (GERD) (stomach acid flowing back into the esophagus); insomnia (difficulty falling or staying asleep); chronic idiopathic constipation (long-term constipation without a known cause); pain in the right ankle and joints of the right foot (musculoskeletal pain affecting mobility); and rheumatic tricuspid insufficiency (incomplete closure of the tricuspid valve causing backward blood flow in the heart). Review of R8’s electronic medical record (EMR) revealed the most recent care conference had been conducted on 4/10/25. Further record review indicated subsequent care conferences had been due in July 2025, September 2025, and December 2025 in accordance with facility practice. However, there was no documented evidence that the facility scheduled, conducted, or attempted to schedule the care conferences or provided R8 and/or the resident representative with the opportunity to participate in the review and development of the care plan at the time of survey.	F0553	Continued from page 5 monthly audits for two additional months Review audit findings and report through the QAPI process Any identified concerns will be addressed promptly through additional staff education and/or corrective action as appropriate. Completion Date: April 10, 2026	

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F0553 SS = D	Continued from page 6 R19 R19's quarterly Minimum Data Set (MDS) dated 2/6/26 identified R19 had moderate cognitive impairment and required assistance with activities of daily living (ADLs). R19's diagnoses included non-traumatic brain dysfunction (impaired brain function affecting cognition or behavior not caused by physical injury), Alzheimer's disease (a progressive neurodegenerative disorder that causes memory loss, impaired thinking, and decline in functional abilities), heart failure (a chronic condition in which the heart is unable to pump blood effectively to meet the body’s needs), hypertension (chronically elevated blood pressure), obstructive uropathy (blockage of urine flow that can impair kidney and bladder function), diabetes mellitus (a metabolic disorder characterized by elevated blood glucose levels due to impaired insulin production or use), anxiety disorder (a mental health condition characterized by excessive worry or fear), depression (a mood disorder causing persistent feelings of sadness and loss of interest), insomnia (difficulty falling or staying asleep), constipation (infrequent or difficult bowel movements), other reduced mobility (limited ability to move independently due to physical or medical conditions), long-term use of anticoagulants (ongoing use of medications that reduce blood clotting and increase bleeding risk), alcohol abuse (harmful or excessive use of alcohol that may impact physical and mental health), obstructive sleep apnea (a sleep disorder in which breathing repeatedly stops and starts due to airway obstruction during sleep), and atrial fibrillation (an irregular heart rhythm that increases the risk of blood clots and stroke). Review of R19’s EMR revealed the most recent care conference had been conducted on 7/29/25. Further record review indicated subsequent care conferences had been due in November 2025 and February 2026 in accordance with facility practice. However, there was no documented evidence that the facility scheduled, conducted, or attempted to schedule the care conferences or provided R19 and/or the resident representative with the opportunity to participate in the review and development of the care plan at the time of survey. During interview on 2/26/26 at 12:02 p.m., Social Services (SS)-B confirmed care conferences had not been completed for R8 and R19 within the expected timeframe and acknowledged the residents and/or their	F0553		

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F0553 SS = D	Continued from page 7 representatives had not been provided the opportunity to participate in a timely review of the residents' care plans. SS-B stated she would document in the resident's record if attempts were made to contact the family to schedule a care conference and confirmed there was no documentation indicating attempts had been made to schedule care conferences for R8 or R19. During interview on 2/26/26 at 1:32 p.m., the Director of Nursing (DON) stated care conferences were expected to be completed quarterly or with a significant change in condition. The DON stated attempts by the social worker to contact the resident's family or representative to schedule a care conference should be documented in the progress notes. Review of the facility policy titled "Care Planning – Resident Participation," dated 10/23, indicated the facility would discuss the plan of care with the resident and/or representative at regularly scheduled care plan conferences and allow them to review the care plan initially, at routine intervals, and after significant changes. The policy further indicated the facility would make an effort to schedule the conference at the best time of day for the resident or resident's representative and would obtain a signature from the resident and/or resident representative following discussion or review of the care plan.	F0553		
F0572 SS = C	Notice of Rights and Rules CFR(s): 483.10(g)(1)(16) §483.10(g) Information and Communication. §483.10(g)(1) The resident has the right to be informed of his or her rights and of all rules and regulations governing resident conduct and responsibilities during his or her stay in the facility. §483.10(g)(16) The facility must provide a notice of rights and services to the resident prior to or upon admission and during the resident's stay. (i) The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. (ii) The facility must also provide the resident with	F0572	F0572 – Resident Bill of Rights (SS=D) Outdated Bill of Rights postings were removed and replaced with current CMS-approved versions. Updated copies were made available to residents as needed. All units and common areas were reviewed to ensure that current and accurate postings are in place. A quarterly review process was implemented to ensure postings remain current and compliant The Bill of Rights will be reviewed with residents during quarterly care conferences, with signed acknowledgments maintained in the medical record Quarterly audits of postings will be conducted Findings will be reviewed by leadership and through the QAPI process	04/20/2026

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F0572 SS = C	Continued from page 8 the State-developed notice of Medicaid rights and obligations, if any. (iii) Receipt of such information, and any amendments to it, must be acknowledged in writing; This REQUIREMENT is NOT MET as evidenced by: Based on observation and interview, the facility failed to ensure the most up to date Nursing Home Resident Bill of Rights (RBOR) was provided to each resident residing in the facility and displayed for residents, visitors and staff to review. This had the potential to affect all 53 residents currently residing in the facility as well as all staff and visitors. Findings include: During observation on 2/25/26 at 3:45 p.m., displayed by the memory care entrance was the RBOR, year revised 2009. During interview on 2/25/26 at 3:50 p.m. the campus executive director (E stated she was aware of the changes to the BOR for assisted living but was not aware of the changes made 12/22/25 to the RBOR.	F0572	Continued from page 8 The Administrator and/or designee is responsible for maintaining compliance. Completion Date: April 10, 2026	
F0577 SS = C	Right to Survey Results/Advocate Agency Info CFR(s): 483.10(g)(10)(11) §483.10(g)(10) The resident has the right to- (i) Examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility; and (ii) Receive information from agencies acting as client advocates, and be afforded the opportunity to contact these agencies. §483.10(g)(11) The facility must-- (i) Post in a place readily accessible to residents, and family members and legal representatives of residents, the results of the most recent survey of the facility. (ii) Have reports with respect to any surveys, certifications, and complaint investigations made respecting the facility during the 3 preceding years, and any plan of correction in effect with respect to	F0577	F0577 – Resident Rights to Survey Results (SS=C) The facility recognizes that residents have the right to examine the results of the most recent surveys conducted by federal and state surveyors, including the Plan of Correction. During the survey, it was identified that while survey results were posted in an accessible location, the height of the display bracket was not fully accessible for residents utilizing wheelchairs. This concern had the potential to affect residents, staff, and visitors. Upon notification by the surveyor on February 25, 2026, the facility immediately corrected the concern by lowering the wall-mounted display to ensure accessibility at wheelchair height. Residents and staff were notified of this change. This correction was implemented immediately and is considered a permanent environmental modification. Therefore, no additional monitoring is required. The Administrator and/or designee is responsible for maintaining ongoing compliance with this requirement. Completion Date: February 25, 2026	04/20/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245619	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAINT THERESE AT OXBOW LAKE	9751 REGENT AVENUE NORTH , BROOKLYN PARK, Minnesota, 55443

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F0577 SS = C	Continued from page 9 the facility, available for any individual to review upon request; and (iii) Post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public. (iv) The facility shall not make available identifying information about complainants or residents. This REQUIREMENT is NOT MET as evidenced by: Based on observation and interview, the facility failed to ensure facility survey results were posted in an accessible location for residents, staff and visitors. This had the potential to affect all 53 residents residing in the facility as well as staff and visitors. Findings include: During observation on 2/25/26 at 3:40 p.m., a three-ring binder was noted to the left of the front desk, in a clear, plastic holder, screwed to the wall approximately five feet from the floor. The front cover of the binder noted, “Survey Results.” During interview on 2/25/26 at 3:51 p.m., the administrator stated a resident in a wheelchair or shorter than height at which the binder is currently stored, would not have access to the binder without assistance. Administrator stated, “It needs to come down a bit.”	F0577		
F0627 SS = D	Inappropriate Discharge CFR(s): 483.15(c)(1)(2)(i)(ii)(7)(e)(1)(2);483.21(c)(1)(2)(iv) §483.15(c) Transfer and discharge- §483.15(c)(1) Facility requirements- §483.15(c)(1)(i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless- (A)The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (B)The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility;	F0627	F0627 – Discharge Against Medical Advice (AMA) (SS=D) Staff were re-educated on appropriate AMA discharge procedures and documentation requirements. AMA forms were verified to be available on all units. A 90-day audit of AMA discharges was completed. Any identified documentation gaps were corrected. Staff education reinforced expectations for: Completion of AMA documentation Timely and accurate progress notes Provider notification at the time of discharge Education completed by April 3, 2026.	04/20/2026

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F0627 SS = D	Continued from page 10 (C)The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident; (D)The health of individuals in the facility would otherwise be endangered; (E)The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or (F)The facility ceases to operate. §483.15(c)(1)(ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose. §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (i)Documentation in the resident's medical record must include: (A) The basis for the transfer per paragraph (c)(1)(i) of this section. (B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and	F0627	Continued from page 10 Weekly audits for four weeks, followed by monthly audits for two additional months Findings reviewed by Social Services leadership and through the QAPI process The Social Services Director and/or designee is responsible for maintaining compliance. Completion Date: April 10, 2026	

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F0627 SS = D	Continued from page 11 the service available at the receiving facility to meet the need(s). (ii)The documentation required by paragraph (c)(2)(i) of this section must be made by- (A) The resident's physician when transfer or discharge is necessary under paragraph (c) (1) (A) or (B) of this section; and (B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section. §483.15(c)(7) Orientation for transfer or discharge. A facility must provide and document sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility. This orientation must be provided in a form and manner that the resident can understand. §483.15(e)(1) Permitting residents to return to facility. A facility must establish and follow a written policy on permitting residents to return to the facility after they are hospitalized or placed on therapeutic leave. The policy must provide for the following. (i)A resident, whose hospitalization or therapeutic leave exceeds the bed-hold period under the State plan, returns to the facility to their previous room if available or immediately upon the first availability of a bed in a semi-private room if the resident- (A) Requires the services provided by the facility; and (B) Is eligible for Medicare skilled nursing facility services or Medicaid nursing facility services (ii)If the facility that determines that a resident who was transferred with an expectation of returning to the facility, cannot return to the facility, the facility must comply with the requirements of paragraph (c) as they apply to discharges. §483.15(e)(2) Readmission to a composite distinct part. When the facility to which a resident returns is a composite distinct part (as defined in § 483.5), the resident must be permitted to return to an available bed in the particular location of the composite	F0627		

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F0627 SS = D	Continued from page 12 distinct part in which he or she resided previously. If a bed is not available in that location at the time of return, the resident must be given the option to return to that location upon the first availability of a bed there. §483.21(c)(1) Discharge Planning Process The facility must develop and implement an effective discharge planning process that focuses on the resident's discharge goals, the preparation of residents to be active partners and effectively transition them to post-discharge care, and the reduction of factors leading to preventable readmissions. The facility's discharge planning process must be consistent with the discharge rights set forth at 483.15(b) as applicable and- (i) Ensure that the discharge needs of each resident are identified and result in the development of a discharge plan for each resident. (ii) Include regular re-evaluation of residents to identify changes that require modification of the discharge plan. The discharge plan must be updated, as needed, to reflect these changes. (iii) Involve the interdisciplinary team, as defined by §483.21(b)(2)(ii), in the ongoing process of developing the discharge plan. (iv) Consider caregiver/support person availability and the resident's or caregiver's/support person(s) capacity and capability to perform required care, as part of the identification of discharge needs. (v) Involve the resident and resident representative in the development of the discharge plan and inform the resident and resident representative of the final plan. (vi) Address the resident's goals of care and treatment preferences. (vii) Document that a resident has been asked about their interest in receiving information regarding returning to the community. (A) If the resident indicates an interest in returning to the community, the facility must document any referrals to local contact agencies or other appropriate entities made for this purpose. (B) Facilities must update a resident's comprehensive	F0627		

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F0627 SS = D	Continued from page 13 care plan and discharge plan, as appropriate, in response to information received from referrals to local contact agencies or other appropriate entities. (C) If discharge to the community is determined to not be feasible, the facility must document who made the determination and why. (viii) For residents who are transferred to another SNF or who are discharged to a HHA, IRF, or LTCH, assist residents and their resident representatives in selecting a post-acute care provider by using data that includes, but is not limited to SNF, HHA, IRF, or LTCH standardized patient assessment data, data on quality measures, and data on resource use to the extent the data is available. The facility must ensure that the post-acute care standardized patient assessment data, data on quality measures, and data on resource use is relevant and applicable to the resident's goals of care and treatment preferences. (ix) Document, complete on a timely basis based on the resident's needs, and include in the clinical record, the evaluation of the resident's discharge needs and discharge plan. The results of the evaluation must be discussed with the resident or resident's representative. All relevant resident information must be incorporated into the discharge plan to facilitate its implementation and to avoid unnecessary delays in the resident's discharge or transfer. §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (iv) A post-discharge plan of care that is developed with the participation of the resident and, with the resident's consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment. The post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the resident's follow up care and any post-discharge medical and non-medical services. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review the facility failed to ensure discharge against medical advice (AMA) was documented for 1 of 1 residents (R76) reviewed for	F0627		

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F0627 SS = D	Continued from page 14 discharge. R76's entry minimum data set (MDS) dated 12/18/25, indicated R76 admitted to the facility on 12/18/25. R76 admitted from a hospital stay. R76's discharge MDS dated 12/18/25, indicated R76 had an unplanned discharge. R76 had diagnoses that included lumbar vertebra compression fracture, depression, hallucinations, and peripheral vascular disease. Progress note dated 12/18/25, at 2:10 p.m. indicated R76 admitted to facility following hospitalization. Progress note dated 12/18/25, at 7:06 p.m. indicated R76 had gotten agitated and physically aggressive towards staff. Staff attempted to redirect but unsuccessful. Resident was noted attempting unsafe self-transfers. An electronic medical record (EMR) Medication administration note dated 12/18/25, at 8:44 p.m. indicated R76 left AMA. Review of R76's progress noted and documents in the EMR on 2/25/26, failed to indicate R76 discharged from the facility. R76's EMR also failed to indicate the medical provider and/or family were notified R76 discharged AMA. R76's EMR failed to indicate R76 had received education and/or was not presented with AMA form for signature. Review of notes related to medication administration indicated R76 was not administered evening medications because R76 had discharged AMA. When interviewed on 2/25/26 at 4:32 p.m., registered nurse (RN)-C stated When a resident wanted to discharge AMA there was an AMA form that needed to be signed, the provider and family/resident representative need to be updated and this was to be documented in the residents EMR. When interviewed on 2/26/26 at 9:42 a.m., RN-D stated when a resident discharged AMA the nurses were expected to educate the resident/family regarding inability to provide medications, the resident/family was to sign the AMA form, update that provider, director of nursing (DON) or nurse manager then document everything in the residents progress notes in the EMR.	F0627		

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F0627 SS = D	Continued from page 15 When interviewed on 2/26/26, at 10:35 a.m. clinical coordinator (CC)-F stated when a resident discharged from the facility for any reason there should be documentation in the progress notes regarding any paperwork/information that had been discussed with the resident/family, the progress note was also expected to include the time and how the resident had discharged. CC-F reviewed R76's progress notes, CC-F stated there was no note located in the EMR regarding the discharge from the facility. When interviewed on 2/26/26, at 1:49 p.m. DON stated when a resident discharged there should be a note located in the progress notes that the resident/family had been educated on the discharge, if the resident had discharged AMA family and/or resident needed to sign AMA paperwork which would have been scanned into resident documents in the EMR. DON stated documentation of discharge and update to provider was important to ensure resident safety, and continuity of care. Facility Transfer and Discharge (including AMA) policy dated 3/2025, indicated resident and family/legal representative should be informed of risks involved, benefits of staying the facility and the alternatives to both. The Physician should be notified of the intended AMA discharge. Documentation of the notification should be entered into the nurses notes.	F0627		
F0628 SS = D	Discharge Process CFR(s): 483.15(c)(2)(iii)(3)-(6)(8)(d)(1)(2); 483.21(c)(2)(i)-(iii) §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including	F0628	F0628 – Ombudsman Notification (SS=D) Staff were educated on the requirement to inform residents and/or their representatives of the right to contact the Ombudsman, including during discharge and AMA situations. Recent discharges, including AMA discharges, were reviewed to ensure appropriate documentation of Ombudsman notification. Any identified gaps were addressed. The Discharge and AMA Checklist was updated to include required documentation of Ombudsman notification Staff education reinforced expectations for consistent communication and documentation Education completed by April 3, 2026.	04/20/2026

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F0628 SS = D	Continued from page 16 contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;	F0628	Continued from page 16 Weekly audits for four weeks, followed by monthly audits for two additional months Findings tracked and reviewed through the QAPI process The Social Services Director and/or designee is responsible for maintaining compliance. Completion Date: April 10, 2026	

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F0628 SS = D	Continued from page 17 (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.	F0628		

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F0628 SS = D	Continued from page 18 §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section.	F0628		

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F0628 SS = D	Continued from page 19 §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review the facility failed to send a copy of the notice of transfer or discharge to the representative of the Office of the State Long-Term Care (LTC) Ombudsman for 1 of 2 residents (R76) reviewed for discharge. R76's entry minimum data set (MDS) dated 12/18/25, indicated R76 admitted to the facility on 12/18/25, R76 admitted from a hospital stay. R76's discharge MDS dated 12/18/25, indicated R76 had an unplanned discharge. R76 had diagnoses that included lumbar vertebra compression fracture, depression, hallucinations, and peripheral vascular disease. Review of the December 2025 and January 2026 Ombudsman notifications sent by the facility failed to indicate Ombudsman office was notified R76 had discharged from the facility. Review of R76's electronic medical record (EMR), indicated R76 was not administered evening medications on 12/18/25, due to having discharged against medical advice (AMA). When interviewed on 2/26/26 at 1:00 p.m., social worker (SW)-B stated Ombudsman notifications were sent for all residents who discharged or were hospitalized, SW-B further stated notification was not sent for residents that had discharged AMA.	F0628		

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F0628 SS = D	Continued from page 20 When interviewed on 2/26/26 at 1:35 p.m., nursing home administrator stated she was informed R76 discharged AMA but was not aware Ombudsman office needed to be informed of a resident who discharged AMA. When interviewed on 2/26/26 at 1:49 p.m., director of nursing (DON) stated the Ombudsman was to be notified of any resident that was hospitalized or discharged that included residents who had discharged AMA for resident safety. Facility Transfer and Discharge (including AMA) policy dated 2/2025, indicated the facility would provide transfer/discharge notice to the ombudsman.	F0628		
F0656 SS = D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)-	F0656	F0656 – Care Plan Timing and Revision (SS=D) The facility maintains policies and procedures requiring the development and implementation of comprehensive, person-centered care plans for each resident. These care plans include measurable objectives and timeframes to address the resident's medical, nursing, and psychosocial needs as identified through the comprehensive assessment. The policy has been reviewed and remains current. Resident R19's care plan was reviewed and updated to reflect his current individualized and person-centered needs. All residents were assessed for the potential to be affected by the alleged deficient practice. A facility-wide review of care plans was conducted, and updates were made as necessary to ensure accuracy and alignment with current resident needs. Facility staff have been re-educated on the Comprehensive Care Plan policy and procedure, including expectations for person-centered planning and documentation. Education completed by April 3, 2026. To ensure ongoing compliance, the Director of Nursing (DON) or designee will audit care plans within the ARD timeframes to verify that they are current and individualized to resident needs. The DON and/or designee is responsible for maintaining compliance with this requirement. Audit findings will be reviewed during monthly QAPI meetings to determine the need for further action and to monitor sustained	04/20/2026

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F0656 SS = D	Continued from page 21 (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is NOT MET as evidenced by: Based on record review and interview, the facility failed to ensure a resident’s comprehensive care plan was individualized and resident-specific for 1 of 1 resident (R19) reviewed for behavioral care planning. Findings include: R19 R19's quarterly Minimum Data Set (MDS), dated 2/6/26, identified R19 had moderate cognitive impairment and required assistance with activities of daily living (ADLs). R19's diagnoses included non-traumatic brain dysfunction (impaired brain function affecting cognition or behavior not caused by physical injury), Alzheimer's disease (a progressive neurodegenerative disorder that causes memory loss, impaired thinking, and decline in functional abilities), heart failure (a chronic condition in which the heart is unable to pump blood effectively to meet the body’s needs), hypertension (chronically elevated blood pressure), obstructive uropathy (blockage of urine flow that can impair kidney and bladder function), diabetes mellitus (a metabolic disorder characterized by elevated blood glucose levels due to impaired insulin production or use), anxiety disorder (a mental health condition characterized by excessive worry or fear), depression (a mood disorder causing persistent feelings of sadness and loss of interest), insomnia (difficulty falling or staying asleep), constipation (infrequent or difficult bowel movements), other reduced mobility (limited ability to move independently due to physical or medical conditions), long-term use of anticoagulants	F0656	Continued from page 21 compliance. Completion Date: April 10, 2026	

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F0656 SS = D	Continued from page 22 (ongoing use of medications that reduce blood clotting and increase bleeding risk), alcohol abuse (harmful or excessive use of alcohol that may impact physical and mental health), obstructive sleep apnea (a sleep disorder in which breathing repeatedly stops and starts due to airway obstruction during sleep), and atrial fibrillation (an irregular heart rhythm that increases the risk of blood clots and stroke). Review of R19's comprehensive care plan, print date of 2/25/26, included a focus area titled "Substance Use," which indicated: "I have a history of substance use disorder. As evidenced by: (specify) Use of/addiction to {prescription/illegal/alcohol} drugs (specify). My drug(s) of choice is/was: _____." The care plan failed to identify the residents' specific substance use history, triggers, risks, or individualized interventions for staff to follow. Further review of the care plan revealed a focus area titled "Trauma," which indicated: "I have a history of trauma that affects me negatively. (Describe trauma): _____." The care plan failed to describe the resident's trauma history, identify potential triggers, or include individualized trauma-informed care approaches for staff. During interview on 2/26/26 at 12:49 p.m., registered nurse clinical coordinator (CC)-F stated care plans could be updated and revised by nursing staff, including herself, other nurses on the unit, and the social worker. CC-F stated care plans should be developed and updated when there was a change in the resident's condition and reviewed at least quarterly to ensure the information was accurate. CC-F stated the care plan was important so staff were aware of how to care for the resident and so it reflected the overall picture of the resident's care needs. CC-F confirmed the resident's care plan contained several generic areas that were not person-centered and acknowledged the care plan should have been updated. During interview on 2/26/26 at 1:32 p.m., director of nursing (DON) acknowledged the care plan contained templated focus areas and stated the care plan should have been individualized to reflect the resident's specific needs and history. Review of the facility policy titled "Comprehensive	F0656		

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F0656 SS = D	Continued from page 23 Care Plans," dated 9/24, indicated comprehensive care plans were to be individualized and developed based on the residents' assessed needs, preferences, strengths, and goals. The policy further indicated care plans were to include resident-specific problems, measurable goals, and individualized interventions to guide staff in providing person-centered care.	F0656		
F0657 SS = E	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and record review the facility failed to ensure care plans were revised for 6 of 14 residents (R5, R8, R10, R40, R47 and R7) whose care plans were reviewed for accuracy. Findings include:	F0657	F0657 – Comprehensive Care Plans (SS=D) The facility maintains policies and procedures requiring that comprehensive, person-centered care plans are developed, reviewed, and revised in accordance with regulatory timeframes and resident needs. These care plans include measurable objectives and timeframes to address each resident's medical, nursing, and psychosocial needs as identified through the comprehensive assessment. The policy has been reviewed and remains current. Residents R5, R8, R10, R40, R47, and R7 had their care plans reviewed and updated to reflect current, individualized, and person-centered needs. All residents were evaluated for the potential to be affected by the alleged deficient practice. A facility-wide review of care plans was conducted, and updates were made as necessary to ensure care plans are current and reflective of resident needs. Facility staff have been re-educated on the Comprehensive Care Plan policy and procedure, with emphasis on timely review and revision requirements and accurate documentation. Education completed by April 3, 2026. To ensure ongoing compliance, the Director of Nursing (DON) or designee will conduct weekly audits of five care plans to verify that they are current, individualized, and revised in accordance with regulatory requirements. The DON and/or designee is responsible for maintaining compliance with this requirement. Audit findings will be reviewed at monthly QAPI meetings to identify trends, determine if additional interventions are necessary, and ensure sustained compliance. Completion Date: April 10, 2026	04/20/2026

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F0657 SS = E	Continued from page 24 R5 R5's admission Minimum Data Set (MDS) dated 8/5/25, identified R5 had severe cognitive impairment and required assistance with all activities of daily living (ADLs). R5's diagnoses included non-traumatic brain dysfunction, Alzheimer's disease, hypertension (high blood pressure), diabetes mellitus (high blood sugar due to impaired insulin regulation), arthritis (joint inflammation causing pain and stiffness), other fractures (history of bone fractures), anxiety disorder (excessive worry or fear), depression (persistent feelings of sadness), metabolic encephalopathy (altered brain function due to metabolic imbalance) and paroxysmal atrial fibrillation (intermittent irregular heart rhythm). The MDS indicated R5 had experienced one fall with a major injury and was dependent will all transfers. R5's quarterly MDS dated 11/25/25, identified R5 had severe cognitive impairment and required assistance with all ADLs. R5's diagnoses included non-traumatic brain dysfunction, Alzheimer's disease, hypertension, diabetes mellitus, arthritis, other fractures, anxiety disorder, depression, metabolic encephalopathy and paroxysmal atrial fibrillation. The MDS indicated R5 had experienced one fall with a major injury was needed partial to moderate assistance with all transfers. Review of R5's comprehensive care plan, printed 2/24/26, identified R5 was at risk for falls with the following interventions in place: TRANSFERS: R5 requires Stand lift with 2assist for transfers. Date Initiated: 08/05/2025 Additionally, R5's care plan identified R5 needing assistance with ADLs with the following interventions in place: TOILETING: Resident requires LA 1 staff assistance for toileting transfers with a walker, gait belt. Date Initiated: 01/23/2026 TRANSFERS: Resident requires Stand lift with 2 assist	F0657		

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F0657 SS = E	Continued from page 25 for transfers. Date Initiated: 08/05/2025 During interview on 2/25/26 at 12:32 p.m., registered nurse (RN)-G stated R5 required assistance of one staff member with transfers, although R5 sometimes attempted to transfer independently. During interview on 2/26/26 at 10:19 a.m., nursing assistant (NA)-E stated R5 required assistance of one staff member with transfers and reported therapy sometimes walked with R5. During interview on 2/26/26 at 10:48 a.m., NA-A stated R5 required assistance of one staff member with transfers and stated staff notified the nurse when a resident fell. NA-A stated R5 self-transfers herself often and stated that if staff see her self-transferring, they supervise as they don't want to scare R5. R8 R8's quarterly Minimum Data Set (MDS) dated 12/23/25, identified R8 had severe cognitive impairment and required assistance with activities of daily living (ADLs). R8's diagnoses included non-traumatic brain dysfunction (impaired brain function affecting cognition or behavior not caused by physical injury); vascular dementia – severe – without behavioral, psychological, mood, or anxiety disturbances (advanced cognitive decline caused by impaired blood flow to the brain); hypertension (chronically elevated blood pressure); arthritis (joint inflammation causing pain and reduced mobility); chronic obstructive pulmonary disease (COPD) (chronic lung disease causing airflow limitation and breathing difficulty); paroxysmal atrial fibrillation (intermittent irregular heart rhythm that increases the risk of stroke); gastroesophageal reflux disease (GERD) (stomach acid flowing back into the esophagus); insomnia (difficulty falling or staying asleep); chronic idiopathic constipation (long-term constipation without a known cause); pain in the right ankle and joints of the right foot (musculoskeletal pain affecting mobility); and rheumatic tricuspid insufficiency (incomplete closure of the tricuspid valve causing backward blood flow in the heart). R8's order summary report, printed on 2/25/26, included an order for Haloperidol 0.5 milligrams (mg) to be	F0657		

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F0657 SS = E	Continued from page 26 administered sublingually (under the tongue) two times per day for agitation, hallucinations, and delusions. Furthermore, Lorazepam was not included on the order summary report. R8’s comprehensive care plan, with print date of 2/24/26, indicated the following: Wandering behaviors. Interventions included monitoring the resident for wandering behaviors and redirecting the resident when wandering occurred. Use of antianxiety medication, Lorazepam (a medication commonly used to treat anxiety or agitation) with associated monitoring and interventions. However, review of physician orders revealed the resident was no longer prescribed or receiving Lorazepam, and the care plan continued to include interventions related to the medication. R8’s comprehensive care plan failed to include Antipsychotic medication had been initiated on 12/31/25. However, R8's care plan failed to include interventions, monitoring, or care plan revisions related to the newly initiated antipsychotic medication. During an interview on 2/26/26 at 10:19 a.m., NA-E stated R8 did not wander any longer and had not for quite a while, as the resident required total assistance. During an interview on 2/26/26 at 10:24 a.m., RN-G confirmed R8 did not wander and had not for “quite some time.” During an interview on 2/26/26 at 10:48 a.m., NA-A stated R8 had not wandered for a while because the resident was not able to move around independently. During an interview on 2/26/26 at 12:49 p.m., the registered nurse clinical coordinator (CC)-F stated care plans could be updated and revised by herself, nursing staff, or the social worker. CC-F stated the care plan should be updated whenever there was a change	F0657		

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F0657 SS = E	Continued from page 27 in the resident's condition and reviewed at least quarterly to ensure the information was accurate. CC-F stated the care plan was important so staff were aware of how to care for the resident and to provide an overall picture of the resident's care needs. CC-F further stated R8 no longer wandered. CC-F reviewed the R8's care plan and confirmed wandering was still listed and acknowledged the care plan required revision. CC-F also stated the resident was no longer receiving Lorazepam and confirmed the medication was still listed on the care plan and should have been revised. CC-F additionally confirmed the resident was receiving an antipsychotic medication that was not addressed in the care plan. R10 R10's annual MDS dated 12/30/25, identified R10 had severe cognitive impairment and required extensive assistance with ADLs. R10's diagnoses included Alzheimer's disease (a progressive neurodegenerative disorder causing memory loss and impaired thinking), anxiety disorder (a mental health condition characterized by excessive worry or fear), depression (a mood disorder causing persistent feelings of sadness), hypertension (chronically elevated blood pressure), and gastroesophageal reflux disease (GERD) (stomach acid flowing back into the esophagus causing irritation). Record review of R10's EMR, on 2/25/26, revealed R10 utilized a motorized wheelchair for mobility within the resident's room and throughout the facility. However, review of R10's comprehensive care plan revealed the use of a motorized wheelchair, including associated safety considerations or staff interventions, was not addressed in R10's care plan. R10's comprehensive care plan, reviewed on 2/25/26, failed to include R10's use of a motorized wheelchair as well as safety considerations and staff interventions. During an interview on 2/26/26 at 11:28 a.m., the clinical coordinator (CC)-B stated R10 utilized a motorized wheelchair in her room and throughout the facility. CC-B expected R10's use of the motorized wheelchair was included in R10's care plan as part of R10's care needs. CC-B reviewed R10's care plan and confirmed the use of the motorized wheelchair was not	F0657		

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F0657 SS = E	Continued from page 28 included. CC-B further stated the care plan contained information staff needed to appropriately care for the resident and was an ongoing process, as residents' conditions could change. CC-B stated baseline care plans were developed within 24 to 48 hours of admission and could be updated by nursing staff or the clinical coordinator as changes occurred. CC-B stated significant changes, such as skin issues or other care needs, should be added to the care plan when identified by staff aware of the situation. CC-B stated the comprehensive care plan was reviewed in its entirety at least quarterly. During an interview on 2/26/26 at 1:32 p.m., the director of nursing (DON) stated the care plan was intended to reflect each resident's overall status and care needs. The DON expected each resident's care plan was updated whenever there was a change in the resident's condition and reviewed at least quarterly to ensure it accurately reflected the resident's current care needs. Review of the facility policy titled "Care Plan Revisions Upon Status Change," revised 10/2024, indicated the facility was to provide a consistent process for reviewing and revising the care plan for residents experiencing a status change. The comprehensive care plan would be reviewed and revised as necessary when a resident experienced a change in status. R40 R40's care plan with revision date 12/5/25, indicated R40 required the following: Activities of Daily Living (ADLs): Bathing- one staff assist Hygiene/grooming- one staff assist Skin: Repositioning- resident will be repositioned every two hours	F0657		

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F0657 SS = E	Continued from page 29 R40's care plan indicated R40 was receiving antiplatelet medication and included interventions to monitor for side effects. R40's quarterly Minimum Data Set (MDS) dated 12/31/25, indicated R40 was cognitively intact and was independent with transfers, shower/bathing, hygiene and bed mobility. R40 required supervision or touch assist for ambulation. R40 was not taking an anticoagulant. R40's physician orders last signed 1/6/26, did not include an antiplatelet medication. R40's face sheet printed 2/26/26, indicated R40's diagnoses included ataxia (neurological condition characterized by poor muscle control), heart failure and narcolepsy. During interview on 2/25/26 at 1:50 p.m., nursing assistant (NA)-B stated R40 was independent with toileting, bathing, personal hygiene, transfers in his room and repositioning. R47 R47's annual MDS dated 11/13/25, indicated R47 was dependent on staff for eating, oral hygiene and all other ADLs. R47's physician orders last signed 1/6/26, did not include an order for trazadone. R47's care plan with revision date 1/29/26, indicated R47 required the following: ADLs: Eating assistance- staff set up assistance. Use of adaptive equipment, built up handled silverware, cup with lid Oral care- staff set up assistance R47's care plan indicated R47 was receiving trazadone for insomnia. R47's face sheet printed 2/26/26 indicated R47's diagnoses included dementia, insomnia, and weakness. During observation on 2/25/26 at 12:09 p.m., R47 was seated at the table in the dining room. NA-B brought	F0657		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0657 SS = E	Continued from page 30 R47 his food and beverage. NA-B assisted R47 to eat the noon meal and to drink beverages. R47 made no attempt to assist himself with eating or drinking. No adaptive silverware or cups were observed. During interview on 2/25/26 at 1:50 p.m., NA-B stated R47 always required assistance to eat and for all ADLs. R47 made no attempts to use silverware, was not able to eat finger foods on his own and was not able to drink from any type of glass on his own. R47 had not used adaptive equipment, “for a long while.” R7 R7’s quarterly MDS dated 11/28/25, indicated R7 had moderate cognitive impairment and required staff assistance with ADLs included partial/moderate assistance with eating, dependent on staff for transfer to/from toilet, dependent on staff for toileting hygiene, and dependent on staff for lower body dressing. R7’s care plan with revision date 2/16/26, indicated R7 required the following: Nutrition- Eating: Independent after set-up. Resident prefers to eat meals in room. ADLs- Toileting: two staff assist with standing lift Eating Assistance: limited assistance of one staff with eating assistance, set-up meal, cut up food, place utensils on right side Eating: Bring resident to dining room for all meals Transfers: I require ceiling lift for transfers. Elimination- Extensive assist of two and Hoyer (brand of full body mechanical lift) with toileting transfers and extensive assist with hygiene cares and clothing management	F0657		

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F0657 SS = E	Continued from page 31 Skin- lambs wool applied to sling to protect bilateral arms during transfer Wheelchair mobility- Staff to put foot pedals on my wheelchair R7’s face sheet printed 2/26/26, indicated R7’s diagnoses included dementia, multi-system degermation of the autonomic nervous system (causes loss of coordination and balance, also to become slow and stiff) and chronic venous hypertension (high blood pressure within the veins). During observation on 2/24/26 at 4:11 p.m., R7 received assistance to transfer from w/c to toilet with two staff and ceiling lift. No padding was observed on the lift sling straps. Following completion of toilet use, NA-C provided full assistance to R7 for toileting hygiene and to adjust clothing. R7 did not physically participate in these tasks. During observation on 2/25/26 at 11:31 a.m., R7 was assisted in her wheelchair from her room to the dining room. No foot pedals were on R7's wheelchair. R7's feet were sliding on the floor. During observation on 2/25/26 at 11:53 a.m. NA-B was seated next to R7 while assisting another resident to eat. NA-B included R7 in conversation but made no attempt to assist R7 with eating. R7 was eating and drinking independently after set-up. During interview on 2/25/26 at 3:30 p.m., NA-C stated R7 used the standing lift for transfers a long time ago. R7 was not able to support her upper body, so she was changed to a ceiling lift. NA-C was not aware lamb’s wool padding to the transfer sling straps was on R7’s care plan. NA-C stated R7 required physical assistance with eating at every meal, R7 may be able to eat finger foods on her own but required assistance when using silverware. R7 refused to use her foot pedals, NA-C stated, staff were supposed to offer the foot pedals, but R7 always refused so NA-C was not sure all staff offered. During interview on 2/26/26 at 8:37 a.m. registered	F0657		

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F0657 SS = E	Continued from page 32 nurse (RN)-B stated resident care plans are usually updated by the clinical coordinator (CC). The NAs usually let the nurses know if a change needed to be made, the nurse would update the CC. RN-B stated she reviews all resident care plans weekly and will make changes herself if the need is urgent. During interview on 2/26/26 at 9:21 a.m., CC-B stated care plans were reviewed quarterly and with any changes in the resident's needs. She updates the care plan as soon as she is notified a change is needed. The nurses on the floor were also able to update the care plans. CC-B would be notified if changes were made by the nurses on the floor and would review the care plan herself to determine if, "it needs further tweaking or additional work." CC-B did not consider aspirin to be an anticoagulant and stated it should not be on the care plan as such. CC-B verified R40's care plan did not accurately depict R40's physical needs accurately and should have been changed when R40's needs changed. CC-B stated aspirin should not be considered an anticoagulant and should not be on R40's care plan as such. CC-B verified R47's care plan was not up-to-date and stated she did not know why it did not get updated when R47's needs changed. CC-B stated two different transfer methods could be found on the care plan if a resident had increased weakness at different times of day, so required more support to transfer. Upon review of R7's care plan, CC-B verified the inconsistencies and inaccurate information in R7's care plan but was not able to give specific reasons for the inconsistencies and inaccurate information. CC-B stated R7's foot pedals should be noted as, "frequently refused," on the care plan. During interview on 2/26/26 at 10:10 a.m., director of nursing (DON) stated she expected the care plans to be up-to-date with each resident's specific needs. Changes should be completed quarterly and as needed. When interventions were no longer appropriate, DON expected them to be removed from the care plan. DON stated it was important for residents to have updated care plans to ensure each resident received the level of assistance needed to meet their needs and so there was not confusion on what the resident needed.	F0657		
F0677 SS = D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene;	F0677	F0677 – ADL Care Provided for Dependent Residents The facility maintains policies and procedures governing the provision of Activities of Daily Living (ADL) care for dependent residents. These policies guide staff practice to ensure that residents receive necessary assistance with ADLs in order to maintain adequate nutrition, grooming, and personal hygiene. The	04/20/2026

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F0677 SS = D	Continued from page 33 This REQUIREMENT is NOT MET as evidenced by: Based on observation, record review and interview the facility failed to ensure residents who were dependent on others for activities of daily living (ADLs) received the services needed. This affected 1 of 3 residents (R65) observed for partial bathing and nail care and 1 of 3 residents (R47) observed for facial shaving. Findings include: R65 R65's annual MDS dated 1/30/26, indicated R65 was dependent on staff for personal hygiene, oral cares, bathing and all other ADLs. R65 had severe cognitive impairment. R65's care plan with revision date 2/16/26, indicated R65 required total assistance of one staff for bathing and oral cares, extensive assistance of one staff for dressing and hygiene/grooming tasks. R65's face sheet printed 2/26/26, indicated R65's diagnoses included dementia, anxiety, hypertension, chronic pain insomnia and major depression. During observation on 2/23/26 at 1:52 p.m., R65 had long fingernails with an unknown, dark brown/black substance under the nails. During observation on 2/24/26 at 2:56 p.m., R65 had long fingernails with an unknown dark brown/black substance underneath the nails. During observation on 2/25/26 at 3:42 p.m., R65 was sitting at a table in the common area using her hands to eat a snack, R65 had long fingernails with an unknown, dark brown/black substance underneath the nails. During observation on 2/26/26 at 7:55 a.m., NA-A entered R65's room, announced she was there to help R65 to get ready for breakfast. R65 was laying in bed. NA-A applied R65's socks and pants. NA-A assisted R65 to sit on edge of the bed. NA-A removed R65's gown, applied	F0677	Continued from page 33 policy has been reviewed and remains current. For R65, the resident's nail care, hand hygiene, oral care, and partial bathing needs were immediately reviewed with direct care staff. R65's nails were cleaned and trimmed, and staff were re-educated on the expectation to provide partial bathing, nail care, peri-care, and oral care in accordance with the resident's needs, tolerance, and plan of care. The resident's care approach was reviewed with staff to reinforce that refusals or resistive behaviors must be addressed with appropriate cueing, redirection, re-approach, and documentation, rather than omission of necessary ADL care. For R47, the resident's grooming needs and shaving preferences were immediately reviewed. Staff were instructed to provide shaving assistance in accordance with the resident's preference and care needs and not to rely on family to provide routine grooming unless specifically requested by the resident or family. The resident's care plan was reviewed and updated to reflect grooming preferences, including frequency of shaving as appropriate. The Director of Nursing (DON), Clinical Coordinator, or designee will audit all residents who require staff assistance with ADLs, with focus on personal hygiene, oral care, nail care, partial bathing, and grooming/shaving, to identify any residents who may not be receiving needed services in accordance with their assessed needs, care plans, and preferences. This audit will include a review of residents dependent on staff for hygiene and grooming, as well as a review of care plans to ensure resident preferences related to grooming are identified and documented. The facility has implemented the following systemic changes: Nursing staff will be re-educated on facility expectations and policies related to ADL care, including bathing, grooming, oral care, nail care, peri-care, and infection control practices. Education will include expectations for morning and routine care, including washing face, hands, under nails, underarms, under breasts, peri-area, and providing oral care with soap and water as appropriate to the care task.	

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F0677 SS = D	Continued from page 34 deodorant, assisted R65 with applying shirt. NA-A assisted R65 with standing up with use of standing lift, NA-A used a disposable wipe to clean R65's peri-area with one swipe from front to back, applied clean incontinent brief, pulled up pants then place R65 in wheelchair. R65 was assisted to bathroom for oral cares, NA-A provided resident with toothbrush prepared with toothpaste. R65 then brushed hair with toothpaste covered toothbrush. NA-A then rinsed toothbrush, applied fresh toothpaste, handed R65 the prepared toothbrush, R65 again brushed hair with prepared toothbrush. NA-A noticed R65 brushing hair with toothbrush, took toothbrush and stated to R65, "If you don't want to brush your teeth that's fine" Hair was cleaned of toothpaste and brushed. R65 had long fingernails with an unknown, dark brown/black substance underneath the nails. NA-A stated R65 kind of refused to wash her face, frequently refused to brush her teeth. NA-A stated in the mornings she dressed R65 for the day, changed incontinent brief, washed face and brushed teeth. NA-stated they did not usually wash residents underarms, under breasts or clean peri-area with soap and water so that R65 would not "fuss", nail care included cutting and cleaning of nails only happened on bath day. During observation on 2/26/26 at 11:27 a.m., R65 was in common are playing trivia, R65 had long nails with an unknown, dark brown/black substance under the nails. When interviewed on 2/26026 at 11:29 a.m., RN-G stated trimming of nails was expected to be completed during bath day, nails were expected to be cleaned when hands were washed during morning and evening partial bathing. Partial bathing included washing hands, face, underarms, under breasts and peri-area with soap and water. RN-G stated R65 could be, "spicy," at times but nursing assistants should attempt to provide partial bathing. RN-G observed R65's nails, stated they should have been trimmed and definitely should have been cleaned for comfort and infection control. When interviewed on 2/26/26 at 11:53 a.m., CC-F stated when providing morning cares the expectation was oral cares, washing residents face, underarms, hands including nails if needed, under breast using soap and water, when incontinence care was provided expectation was clean with wipes if soiled then follow with soap and water. CC-F stated when a toothbrush was used by a resident for something other than brushing teeth, she would expect that NA to replace it with a new one due	F0677	Continued from page 34 Staff will be re-educated that when a resident is resistive, staff are expected to use person-centered approaches, cueing, redirection, and re-approach, and to document refusals and report concerns to the nurse for follow-up as needed. Staff will be re-educated that routine grooming, including shaving, is the responsibility of the facility when the resident is dependent on staff, unless the resident or family has specifically requested to assume that task. Care plans will be reviewed and updated, as needed, to reflect individualized ADL needs and resident preferences, including grooming and shaving frequency. Licensed nurses and supervisors will reinforce infection control expectations, including replacement of toothbrushes if used for anything other than oral care. Shower/bath schedules and daily ADL assignment expectations will be reviewed with direct care staff to ensure nail care, oral care, and grooming needs are addressed routinely and not deferred inappropriately. The DON, Clinical Coordinator, or designee will complete audits of dependent residents requiring assistance with ADLs to verify: partial bathing is being completed per policy and resident need, oral care is being provided, nails are clean and maintained, grooming and shaving are completed according to resident preference, refusals are documented and appropriately addressed, care plans reflect individualized grooming preferences and ADL needs. Five audits will be completed weekly for four (4) weeks, then monthly for three (3) months. Audit results will be reviewed through the facility's QAPI process, and additional education or corrective action will be implemented if concerns are identified.	

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F0677 SS = D	Continued from page 35 to infection control. When interviewed on 2/26/26 at 12:20 p.m., director of nursing (DON) stated the expectation for morning ADLs the nursing assistants should encourage residents to complete what they are able to do, assist with partial bath that included washed face, hands that included under nails, under arms, under breasts and peri care/bottom with soap and water, and oral cares. Partial bath, nail care and oral cares were important for resident comfort, cleanliness and infection control. Facility Activities of Daily Living (ADLs) policy stated 10/2022, indicated care and services will be provided for the following ADLs bathing, dressing, grooming and oral care; A resident who is unable to carry out ADLs will receive necessary services to maintain good nutrition, grooming and personal and oral hygiene. Facility Nail Care policy dated 10/2022, indicated routine cleaning and inspection of nails would be provided during ADL care on an ongoing basis. R47 R47's annual MDS dated 11/13/25, indicated R47 was dependent on staff for eating, oral hygiene and all other ADLs. R47 had moderate cognitive impairment. R47's care plan with revision date 1/29/26, indicated R47 required total assistance from two staff for hygiene and grooming tasks. Care plan failed to include R47's preference for frequency of grooming. R47's face sheet printed 2/26/26 indicated R47's diagnoses included dementia, insomnia, and weakness. During observation on 2/23/26 at 11:17 a.m., R47 had coarse, white hair approximately 1/4 inch long covering his cheeks, chin, above upper lip, and under chin. During observation on 2/24/26 at 2:01 p.m., R47 had coarse, white hair slightly longer than was observed on 2/23/26, covering his cheeks, chin, above upper lip, and under chin. During interview on 2/24/26 at 4:39 p.m., family member (FM)-A stated there are several times R47's spouse will	F0677	Continued from page 35 Completion Date: 4/20/26 Responsible Person: Director of Nursing / Designee	

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F0677 SS = D	Continued from page 36 assist to shave R47 during visits, but R47's spouse did not visit every day. R47's facial hair is not shaved as frequently as it would be if he was living at home and family would prefer for facility staff to assist R47 with shaving more frequently. FM-A stated they felt facility staff expected family to assist R47 with shaving so staff did not offer or attempt as often as they should. During observation and interview on 2/24/26 at 6:49 p.m., R47's facial hair remained unchanged. Nursing assistant (NA)-C stated they assisted residents with shaving facial hair if there was time, but R47's family provided assist with shaving facial hair. During interview on 2/25/26 at 1:50 p.m., NA-B stated R47 required total assistance from staff, this included shaving facial hair. NA-B was not sure the last time she assisted R47 to shave facial hair. During interview on 2/25/26 at 3:30 p.m., NA-C stated assistance with grooming residents can happen on any shift. NA-C stated she assisted R47 with shaving, "a few days ago." During interview on 2/26/26 at 9:21 a.m., clinical coordinator (CC)-B stated she expected residents, male or female, were assisted to shave facial hair as frequently as they desired. Assistance should be provided by facility staff unless resident or family have requested otherwise. CC-B stated R47's family has not requested to assist R47 with shaving and should not be expected to. During interview on 2/26/26 at 10:10 a.m., director of nursing (DON) stated she expected residents were assisted with shaving daily or according to their personal preference. This was important for each resident's happiness, self-image and dignity. Facility policy, Activities of Daily Living (ADLs) dated January 2023, section: Policy Explanation and Compliance Guidance: number three indicated, "A resident who is unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming and personal oral hygiene.	F0677		
F0679 SS = E	Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1) §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the	F0679	F0679 – Activities (SS=D) Residents R6, R10, R13, and R42 were reassessed by the Community Life Team to evaluate current activity preferences, interests, and needs. Individualized, in-room activities were initiated in	04/20/2026

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F0679 SS = E	Continued from page 37 comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is NOT MET as evidenced by: Based on observation, record review, and interview, the facility failed to ensure residents received an ongoing program of activities designed to meet their assessed needs, interests, and abilities in accordance with their comprehensive care plans for 4 of 5 residents reviewed for activities (R6, R10, R13, and R42). Findings include: R6 R6's quarterly Minimum Data Set (MDS), dated 11/28/25, identified R6 had intact cognition. R6's diagnoses included arthritis (joint inflammation causing pain and stiffness), macular degeneration (loss of central vision), overactive bladder (frequent or urgent need to urinate), cervicalgia (neck pain) and sensorineural hearing loss – bilateral (permanent hearing loss in both ears). Observations of R6 were conducted on multiple occasions during the survey:On 2/23/26 at 11:14 a.m., R6 was observed sitting in her recliner with her legs elevated, eyes closed, and mouth open. No activity materials or staff interaction were present.On 2/24/26 at 11:39 a.m., R6 was observed sitting in her recliner looking around the room. No activity materials or staff interaction were present.On 2/24/26 at 3:00 p.m., R6 was observed sitting in her recliner with her legs elevated. No activity materials or staff interaction were present.On 2/24/26 at 6:21 p.m., R6 was observed sitting in her recliner in her room. During the observation, R6 asked the surveyor if they would be present the following day and stated, “Could you please come and visit with me? It really breaks up my day.” No activity materials or staff interaction were present.On 2/25/26 at 8:35 a.m., R6 was observed sitting up in her recliner while staff delivered breakfast to her room.On 2/25/26 at 8:42 a.m., the Administrator entered the resident’s room and greeted R6 by saying good morning.On 2/25/26 at 12:41 p.m., R6 was observed sitting in her recliner with her eyes closed. No	F0679	Continued from page 37 accordance with each resident’s preferences. These included one-to-one visits, faith-based offerings, music, conversation, reading materials, and sensory-based activities. Each resident’s care plan was reviewed and updated to reflect individualized activity interventions. Activity offers and resident participation are being documented daily. All residents were evaluated to determine the potential to be affected by the alleged deficient practice. A facility-wide review was conducted to ensure that: A current activity assessment is in place Resident preferences are accurately reflected in the care plan Activity offers and participation are appropriately documented The facility has reinforced processes to ensure compliance with activity programming requirements: Staff were re-educated on policies related to activities, including during periods of isolation Community Life staff and nursing leadership were educated on expectations for activity provision and documentation in accordance with F0679 requirements Volunteer-led activities, including worship services, will be documented by Activity staff to ensure completeness of records Education completed by April 3, 2026. To ensure sustained compliance, the Community Life Director or designee will: Conduct weekly audits of activity documentation for four weeks, followed by monthly audits for six months Review findings through the QAPI process Any identified concerns will be addressed promptly through additional staff education and/or corrective	

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F0679 SS = E	Continued from page 38 activity materials or staff interaction were present.On 2/25/26 at 2:28 p.m., R6 was observed sitting in her recliner with her legs extended. R6 asked the surveyor how many residents still had COVID and stated she was “going crazy just sitting in my room all day” and reported she liked to talk to people. R6 asked the surveyor if they would be present the following day and stated, “Oh yes please, now I have something to look forward to. It means so much to me having you stop and talk to me.” No activity materials or staff interaction were present.On 2/26/26 at 7:21 a.m., R6 was observed lying in bed with her eyes closed and the lights off. Review of R6’s activity interests assessment, undated, indicated R6 preferred one-to-one visits, being invited and/or escorted to activities, pastoral care visits, pet visits, Protestant worship services, and watching television or movies. Review of R6’s activity documentation, from 2/12/2026 through 2/25/26, failed to include documented participation in any type of activity despite the resident’s identified preferences. There was no documented evidence R6 was offered individualized or in-room activities during this period. R10 R10’s annual MDS dated 1/29/26, identified R10 had severe cognitive impairment R10’s diagnoses included stroke (brain injury caused by interrupted blood flow), aphasia (difficulty speaking or understanding language), hemiplegia (paralysis on one side of the body), depression (persistent feelings of sadness or loss of interest), Observations of R10 were conducted on multiple occasions during the survey:On 2/24/26 at 11:37 a.m., R10 was observed sitting in her room in her motorized wheelchair watching television. No activity materials or staff interaction were present.On 2/24/26 at 2:59 p.m., R10 was again observed sitting in her room in her motorized wheelchair watching television. No activity materials or staff interaction were present.On 2/24/26 at 6:20 p.m., R10 was observed sitting in her motorized wheelchair near the window looking outside. No activity materials or staff interaction were present.On 2/25/26 at 8:37 a.m., R10 was observed sitting at the table in her room eating breakfast. No activity materials or staff interaction were present.On 2/25/26 at 12:40 p.m., R10 was observed sitting in her wheelchair in her	F0679	Continued from page 38 action as appropriate. The Community Life Director and/or designee is responsible for maintaining compliance with this requirement. Completion Date: April 10, 2026	

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F0679 SS = E	Continued from page 39 room while a nurse obtained the resident's vital signs.On 2/25/26 at 2:25 p.m., R10 was observed sitting in her motorized wheelchair in her room watching television. No activity materials or staff interaction were present.On 2/26/26 at 7:21 a.m., R10 was observed lying in bed with her eyes closed and the door shut. No activity materials or staff interaction were present.On 2/26/26 at 8:12 a.m., R10 was observed sitting in her room in her motorized wheelchair watching television. No activity materials or staff interaction were present. Review of R10's activity interests assessment, undated, indicated R10 preferred adult coloring, baking, balloon volleyball, bean bag toss/cornhole, being outdoors, Bible study, bingo, cardio drumming, Catholic communion, community drum circle, crafts, devotions, dice games, Eucharistic ministry visits, exercise, happy hour, being invited to activities, Mass, music and entertainment, music therapy, painting and drawing, parties and socials, pet visits, resident council, singing, table games, trivia, walking, watching television or movies, and Wii bowling. Review of R10's activity documentation, from 2/12/2026 through 2/25/26, failed to include documented participation in any type of activity despite the resident's identified preferences. There was no documented evidence R10 was offered individualized or in-room activities during this period. R13 R13's annual MDS dated 11/11/25 identified R13 had moderate cognitive impairment R13's diagnoses included non-traumatic brain dysfunction (impaired brain function not caused by injury), unspecified dementia without behavioral, psychological, mood, or anxiety disturbances (decline in memory and thinking without significant behavioral symptoms), anemia (low red blood cell count), and non-Alzheimer's dementia (cognitive decline not caused by Alzheimer's disease). Observations of R13 were conducted on multiple occasions during the survey:On 2/24/26 at 11:39 a.m., R13 was observed sitting in her chair in her room with her eyes closed. No activity materials or staff interaction were present.On 2/24/26 at 3:00 p.m., R13 was observed sitting in her recliner with her legs elevated and her eyes closed. No activity materials or staff interaction were present.On 2/24/26 at 6:28 p.m.,	F0679		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F0679 SS = E	Continued from page 40 R13 was observed sitting in her recliner in her room. No activity materials or staff interaction were present.On 2/25/26 at 8:35 a.m., R13 was observed sitting up in her recliner while staff delivered breakfast to her room. No activity materials or staff interaction were present.On 2/25/26 at 12:42 p.m., R13 was observed sitting in her recliner in her room. No activity materials or staff interaction were present.On 2/25/26 at 2:30 p.m., R13 was again observed sitting in her recliner in her room. No activity materials or staff interaction were present.On 2/26/26 at 7:22 a.m., R13 was observed sitting in her recliner in her room. No activity materials or staff interaction were present.On 2/26/26 at 7:31 a.m., R13 activated her call light and then came to the doorway of her room, looked into the hallway, and asked staff for a cup of coffee.On 2/26/26 at 7:38 a.m., R13 stated she had a good night but reported she was “going stir crazy” because she was not able to leave her room. No activity materials or staff interaction were present Review of R13’s activity interests assessment, undated, indicated R13 preferred baking, being outdoors, Bible study, bingo, card bingo, card games, Catholic communion, devotions, being invited and/or escorted to activities, Eucharistic ministry visits, happy hour, Mass, music and entertainment, music livestream, music therapy, parties and socials, reading, reminiscing, resident council, singing, table games, tenant/resident meetings, and watching television or movies. Review of R13’s activity documentation, from 2/12/2026 through 2/25/26, failed to include documented participation in any type of activity despite the resident’s identified preferences. There was no documented evidence R13 was offered individualized or in-room activities during this period. R42 R42’s quarterly MDS dated 11/24/25 identified R42 had severe cognitive impairment. R42’s diagnoses included non-traumatic brain dysfunction (impaired brain function not caused by injury), unspecified dementia (decline in memory and thinking abilities), arthritis (joint inflammation causing pain and stiffness), non-Alzheimer’s dementia (cognitive decline not caused by Alzheimer’s disease), depression (persistent sadness or loss of interest), and chronic pain (persistent long-term pain).	F0679		

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F0679 SS = E	Continued from page 41 Observations of R42 were conducted on multiple occasions during the survey:On 2/23/26 at 11:16 a.m., R42 was observed sitting in her wheelchair in her room with her eyes closed. The resident was leaning to the left in the wheelchair with her left arm draped over the side.On 2/24/26 at 11:40 a.m., R42 was observed sitting in her wheelchair in her room with her eyes closed.On 2/24/26 at 3:00 p.m., R42 was observed lying in bed with her eyes closed.On 2/24/26 at 6:28 p.m., R42 was observed sitting in her wheelchair in her room with her eyes closed.On 2/25/26 at 8:36 a.m., R42 was observed sitting in her wheelchair with her eyes closed while staff delivered breakfast to her room. Staff remained in the room and sat next to the resident while assisting her with eating.On 2/25/26 at 12:42 p.m., R42 was observed sitting in her wheelchair in her room with her eyes closed. The television was on and the resident was holding a newspaper in her hand.On 2/26/26 at 7:21 a.m., R42 was observed lying in bed with her eyes closed and the lights off. Review of R42's activity interests assessment, undated, indicated the resident preferred one-to-one visits, being outdoors, being invited and/or escorted to activities, Methodist services, newspapers, reading, and watching television or movies. Review of R42's activity documentation, from 2/12/2026 through 2/25/26, revealed no documented participation in any type of activity despite the resident's identified preferences. There was no documented evidence R42 was offered individualized or in-room activities during this period. During interview on 2/26/26 at 9:53 a.m., nursing assistant (NA)-D stated R42 required one-to-one activities and R6, R10, and R13 typically attended activities. NA-D stated activities had not been occurring for the previous several weeks due to COVID. During interview on 2/26/26 at 10:00 a.m., community life director (CLD)-A stated the activity department used a website to document activity participation and complete activity assessments. CLD-A stated they were new to the position. CLD-A reported the facility printed a list of residents interested in attending Mass and utilized volunteers for those services who did not document attendance. CLD-A stated if residents did not have COVID, activity staff utilized a mobile activity cart to provide one-to-one activities. CLD-A stated activity staff had not been entering	F0679		

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F0679 SS = E	Continued from page 42 participation into each resident's record, but expected activity staff should enter notes and document when activities are offered. During interview on 2/26/26 at 10:17 a.m., activity aide (AA)-A stated activity participation was documented in Toolkit (computer software program). Documentation included if the resident participated, declined, or received one-to-one activities, and stated all activities should be documented. During interview on 2/26/26 at 11:28 a.m., registered nurse clinical coordinator (CC)-B stated activities were expected to continue on a smaller scale for residents who did not have COVID. CC-B stated residents who did not have an active COVID diagnosis could attend activities in the living room if they wore a mask and reported activity staff should enter each resident's room individually to check on residents and offer activities. During interview on 2/26/26 at 1:32 p.m., director of nursing (DON) stated the Roadhouse unit had minimal activities occurring due to COVID precautions. DON expected activities were still be occurring with residents independently in their rooms. Review of the facility policy titled “Activities,” dated 6/2024, indicated the facility was to provide an ongoing program of activities to support residents in their choice of activities based on their comprehensive assessment, care plan, and preferences. Facility-sponsored group, individual, and independent activities will be designed to meet the interests of each resident, as well as support their physical, mental, and psychosocial well-being. Activities will encourage both independence and interaction within the community. Activities may be conducted in different ways:One-to-One programsPerson Appropriate – activities relevant to the specific needs, interests, culture, background, etc. for the resident they are developed for.Program of Activities – to include a combination of large and small groups, one-to-one, and self-directed as the resident desires to attend.	F0679		
F0684 SS = D	Quality of Care CFR(s): 483.25	F0684	F0684 – Quality of Care (SS=D) The facility maintains policies and procedures to ensure that residents are comprehensively assessed and	04/20/2026

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F0684 SS = D	Continued from page 43 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is NOT MET as evidenced by: Based on observation, record review and interview the facility failed to identify, assess and monitor a new skin concern for 1 of 1 resident (R47) observed for quality of care. Additionally the facility failed to ensure care and services were provided in accordance with professional standards of practice to prevent avoidable harm when assisting a resident with mobility for 1 of 1 resident (R19) observed for wheelchair mobility. Findings include: R47 R47’s annual MDS dated 11/13/25, indicated R47 was dependent on staff for eating, oral hygiene and all other ADLs. R47 had moderate cognitive impairment. R47’s physician orders last signed 1/6/26, included, “Nurse to complete the Skin Assessment.” This order was scheduled weekly on R47’s bath day. R47’s care plan revision date 1/29/26, failed to instruct staff to observe skin as well as who to report concerns to. No interventions were noted regarding R47’s right thumb. R47’s face sheet printed 2/26/26 indicated R47’s diagnoses included dementia, insomnia, type 2 diabetes mellitus, and weakness. Review of R47’s Skin Assessment dated 2/20/26, indicated, “No new skin alterations.” Assessment did not include dark, round, raised area next to the nail on R47’s right thumb as a previously noted skin alteration. Review of R47’s 2/2026 treatment record (TAR) reviewed 2/1/26 through 2/25/26, did not indicate nurses or other staff were monitoring the dark, round, raised area next to the nail on R47’s right thumb.	F0684	Continued from page 43 receive care and services in accordance with professional standards of practice, individualized person-centered care plans, and resident preferences. The policy has been reviewed and remains current. For R47, the dark, round, raised area on the right thumb was immediately assessed by licensed nursing staff. A risk management report was completed, and the resident’s provider and family were notified. A physician order was obtained for monitoring, and the area was added to the Treatment Administration Record (TAR) for ongoing observation. The resident’s care plan was updated to include monitoring of the skin concern and appropriate interventions. For R19, staff were immediately re-educated on safe wheelchair transport practices. Foot pedals were placed on the resident’s wheelchair, and staff were instructed to ensure proper positioning during all transports. The resident’s care plan was reviewed and updated to include the requirement for foot pedals during wheelchair mobility to prevent injury. The Director of Nursing (DON), Clinical Coordinator, or designee will conduct an audit of all residents: To ensure all skin concerns are properly identified, assessed, documented, and monitored in accordance with physician orders and facility protocols. To verify that any new or existing skin issues are reflected in the TAR, care plans, and communicated to providers and families as appropriate. To ensure all residents requiring wheelchair assistance have appropriate safety devices (including foot pedals) in place and that care plans reflect these needs. The facility has implemented the following systemic changes: Licensed nurses and nursing assistants will be re-educated on expectations for timely identification, reporting, assessment, and documentation of skin concerns, including completion of risk management reports, notification of the provider and family, and initiation of monitoring orders. Education will reinforce the requirement to update the TAR and care plans to reflect all skin concerns and	

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F0684 SS = D	Continued from page 44 Review of nurse notes in R47's electronic health record (EHR) 1/1/26 through 2/25/26 did not indicate assessment or monitoring of the dark, round, raised area next to the nail on R47's right thumb was completed or ordered. Nurse notes also did not indicate R47's physician or nurse practitioner were made aware of the area. During observation on 2/23/26 at 11:19 a.m., noted a dark, round, raised area next to the nail on R47's right thumb. R47 denied pain. During interview on 2/24/26 at 4:39 p.m., family member (FM)-A stated family was aware of the "blood blister," on R47's right thumb but were not aware of how or when it happened. FM-A stated they noticed it, "last week sometime," FM-A did not alert the facility when the area was noticed. During observation on 2/25/26 at 12:07 p.m., dark, round, raised area next to the nail on R47's right thumb was unchanged. R47 denied pain. During interview on 2/25/26 at 1:50 p.m., nursing assistant (NA)-B stated any changes in resident's skin were immediately reported to the nurse. NA-B was not aware of skin changes for R47. During interview on 2/25/26 at 3:30 p.m., NA-C stated new skin concerns are immediately reported to the nurse. NA-C noticed the area on R47's right thumb, "over the weekend. I told the nurse about it and showed it to her." During interview and observation on 2/26/26 at 8:37 a.m., registered nurse (RN)-A stated skin checks are completed weekly on each resident's bath/shower day. If the resident refuses their bath/shower, the skin check is completed while the resident is in bed. When new concerns are noted either when the skin check is completed or when it is reported by staff or family, the clinical coordinator (CC)-B would be made aware. CC-B would put a nursing order in the resident's TAR for the area to be monitored. The resident's provider and family should be updated. RN-A was not aware of the area on R47's right thumb. When observed, RN-A described the area as, "a reabsorbing blood blister." During interview on 2/26/26 at 9:21 a.m., CC-B stated she expected to be alerted to all skin concerns noted. The nurse identifying the new skin concern is expected to complete a, "Risk Management," form in the facilities EHR, the area needed to be assessed, resident's provider and family were expected to be	F0684	Continued from page 44 interventions. The facility will reinforce expectations for weekly skin assessments, including completion even if residents refuse bathing, and documentation of all findings. Nursing staff will be re-educated on professional standards of practice related to communication and escalation of clinical concerns. Staff will be re-educated on safe wheelchair transport practices, including the requirement that foot pedals must be in place during assisted mobility to ensure proper positioning and prevent injury. Care plans will be reviewed and updated to include specific mobility and equipment needs, including wheelchair safety devices. The facility will implement or reinforce a standardized process to ensure all new skin concerns are tracked, communicated, and followed through consistently across disciplines. The DON, Clinical Coordinator, or designee will conduct: Five weekly audits for four (4) weeks, then Monthly audits for three (3) months Audits will include: Verification that skin concerns are identified, assessed, documented, and monitored appropriately Confirmation that provider and family notifications are completed Review of TAR entries and care plan updates related to skin integrity Observation of wheelchair transport to ensure foot pedals are in place and used appropriately Validation that care plans reflect mobility and safety device needs	

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F0684 SS = D	Continued from page 45 updated, and care plan should be updated with instructions to monitor and interventions to prevent. CC-B expected the resident's TAR was also updated with a nursing order to monitor and how to treat if treatment is needed. During interview on 2/26/26 at 1010 a.m., director of nurse (DON) stated she expected all skin concerns to be reported to the nurse working that day and for that nurse to report the concern to the CC. DON expected the nurse to assess the area, complete a risk management form, update the family and the provider, get orders put in place if needed and update the resident's care plan. Depending on the type of skin concern, the resident may need to be placed on would rounds for closer observation and monitoring. DON stated skin concerns need to be properly communicated so they can be assessed and observed properly. This is important to prevent worsening skin breakdown and possible infection. R19 R19's quarterly Minimum Data Set (MDS) dated 2/6/26, identified R19 had moderate cognitive impairment and required assistance with activities of daily living (ADLs). R19's diagnoses included non-traumatic brain dysfunction (impaired brain function affecting cognition or behavior), Alzheimer's disease (progressive disorder causing memory loss and cognitive decline), heart failure (heart unable to pump blood effectively), hypertension (high blood pressure), obstructive uropathy (blockage of urine flow), diabetes mellitus (high blood sugar due to insulin problems), anxiety disorder (excessive worry or fear), depression (persistent sadness or loss of interest), insomnia (difficulty sleeping), constipation (difficulty passing stools), reduced mobility (limited ability to move independently), long-term use of anticoagulants (blood-thinning medications), alcohol abuse (harmful alcohol use), obstructive sleep apnea (breathing repeatedly stops during sleep), and atrial fibrillation (irregular heart rhythm increasing the risk of stroke). During observation on 2/24/26 at 12:18 p.m., nursing assistant (NA)-E assisted R19 to the dining room in a wheelchair without foot pedals in place. R19's feet were observed sliding on the floor while the wheelchair was in motion. During observation on 2/25/26 at 9:13 a.m., NA-A assisted R19 to the dining room for breakfast in a wheelchair without foot pedals in place. R19's feet	F0684	Continued from page 45 Audit findings will be reviewed through the facility's QAPI process, and additional education or corrective action will be implemented as needed to ensure ongoing compliance. Completion Date: 4/20/26 Responsible Person: Director of Nursing / Designee	

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F0684 SS = D	Continued from page 46 were observed bouncing on the floor during transport. Review of R19's care plan, print date of 2/25/26, lacked documentation for the use of wheelchair foot pedals when staff assisted the resident with mobility. During an interview on 2/26/26 at 10:19 a.m., NA-E stated residents should have foot pedals in place if staff were pushing them in a wheelchair. During an interview on 2/26/26 at 10:48 a.m., NA-A stated residents should have foot pedals in place when staff assisted them by pushing the wheelchair. During an interview on 2/26/2026 at 12:49 p.m., registered nurse clinical coordinator (CC)-F stated if a resident required foot pedals, it should be reflected in the care plan. CC-F further stated foot pedals were expected to be used anytime staff assisted a resident with wheelchair mobility to prevent injury. During an interview on 2/26/2026 at 1:32 p.m., the Director of Nursing (DON) stated residents should have foot pedals in place when staff assisted them with wheelchair mobility to ensure proper positioning and prevent injury. Review of facility policy related to wheelchair use and resident transport was requested; however, the facility did not provide the requested policy during the survey.	F0684		
F0686 SS = D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is NOT MET as evidenced by:	F0686	F0686 – Treatment/Services to Prevent or Heal Pressure Ulcers (SS=D) The facility maintains policies and procedures to ensure that residents receive appropriate care and services to prevent the development and recurrence of pressure injuries. The policy has been reviewed and remains current. In response to the survey findings, Resident R6's care plan was reviewed and updated to ensure all appropriate interventions to prevent further skin breakdown were implemented. Staff were informed of the resident's individualized care plan requirements. All residents were evaluated for the potential to be affected by the alleged deficient practice. A facility-wide audit of skin care plans was conducted to ensure that appropriate interventions are in place and implemented for prevention of skin breakdown. Facility staff have been re-educated on the pressure injury prevention policy, including the expectation	04/20/2026

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F0686 SS = D	Continued from page 47 Based on record review and interview, the facility failed to ensure interventions identified in the comprehensive care plan were implemented to prevent the recurrence of pressure ulcers for 1 of 3 residents reviewed for pressure ulcer prevention (R6). Findings include: R6's quarterly Minimum Data Set (MDS) dated 11/28/25, identified R6 had intact cognition and required assistance with all activities of daily living (ADLs). R6's diagnoses included type 2 diabetes mellitus with diabetic neuropathy (high blood sugar causing nerve damage) and arthritis (joint inflammation causing pain and stiffness), Review of R6's electronic medical record (EMR) indicated R6 previously had a stage three pressure ulcer (full-thickness skin loss where fat tissue may be visible) on the left heel which was documented as healed as of 1/23/26. The EMR identified R6 remained at risk for skin breakdown and recurrence of a pressure ulcer. Review of R6's comprehensive care plan printed 2/25/26, included interventions to prevent recurrence of pressure ulcers. Interventions included: • Elevate resident's heels on heel manager when in bed, initiation date of 10/10/25 • Float heels on two pillows when in recliner, initiation date of 10/10/25 During observation on 2/24/26 at 11:39 a.m., R6 was reclined back in a recliner in her room with her legs elevated and eyes closed. No pillows were noted under R6's legs. R6's heels were resting directly on the foot rest of the recliner. During observation on 2/24/26 at 3:00 p.m., R6 was observed reclined back in her recliner with her legs elevated and eyes closed. No pillows were present under R6's legs. R6's heels were resting directly on the foot rest of the recliner. During observation on 2/24/26 at 6:21 p.m., R6 was observed reclined back in a recliner with no pillows	F0686	Continued from page 47 that all care plan interventions are implemented consistently. Education completed by April 3, 2026. To ensure ongoing compliance, residents will be audited weekly during scheduled shower days to verify that care plan interventions for skin integrity are in place and followed. The Director of Nursing (DON) or designee is responsible for maintaining compliance with this requirement. Audit findings will be reviewed at monthly QAPI meetings to identify trends and ensure sustained compliance. Completion Date: April 10, 2026	

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F0686 SS = D	Continued from page 48 under her legs. R6's heels were resting directly on the foot rest of the recliner. A sign posted on the wall near the recliner instructed, "Make sure resident feet are floating on 2 pillows when in recliner." During observation on 2/25/26 at 8:35 a.m., R6 was observed reclined back in a recliner with no pillows under her legs. R6's heels were resting directly on the foot rest of the recliner while staff delivered breakfast. During observation on 2/25/26 at 2:28 p.m., R6 was observed reclined back in her recliner with her legs extended. One pillow was present under her legs; however, R6's heels continued to rest on the foot rest of the recliner despite the placement of the pillow. During interview on 2/26/26 at 9:53 a.m., nursing assistant (NA)-D stated R6 previously had sores on her heels that had healed. NA-D stated when R6 was in the recliner, staff were supposed to place a pillow under her legs to prevent swelling. During interview on 2/26/26 at 11:28 a.m., registered nurse clinical coordinator (CC)-B stated R6 previously had pressure ulcers on her heels that had since resolved. When R6 was in the recliner, her legs were to be elevated on two pillows to ensure her heels were not resting on the foot rest. CC-B stated R6 received weekly skin checks and staff were expected to ensure the resident's heels were floating and not touching the recliner to prevent the pressure ulcers from returning. During interview on 2/26/26 at 1:32 p.m., the director of nursing (DON) stated she expected staff to follow interventions put in place to prevent recurring pressure ulcers. The DON stated the interventions were important because they were intended to prevent skin breakdown. Review of the facility policy titled "Pressure Injury Prevention and Management," dated 10/22, indicated the facility was committed to the prevention of avoidable pressure injuries, unless clinically unavoidable, and to provide treatment and services to heal pressure ulcers/injuries, prevent infection, and prevent the development of additional pressure ulcers/injuries. The policy indicated evidence-based interventions for	F0686		

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F0686 SS = D	Continued from page 49 prevention would be implemented for all residents assessed as at risk or who had a pressure injury present.	F0686		
F0688 SS = D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is NOT MET as evidenced by: Based on observation, record review and interview the facility failed to following therapy recommended ambulation program for 1 of 1 resident (R40) reviewed with scheduled ambulation assistance. Findings include: R40's quarterly Minimum Data Set (MDS) dated 12/31/25, indicated R40's cognition was intact and required supervision or touch assist for ambulation. R40 did not participate in a restorative nursing program. R40's care plan with edit date of 9/2/25, included ambulation recommendation for R40 to ambulate to meals with staff assistance with front wheeled walker. Additional instruction included, supervision- nursing ambulation program with support of front wheeled walker to and from all meals with supervision assistance daily. Can also provide walking assistant with restroom use. R40's nursing progress notes reviewed 1/28/25 through 2/25/26, no notes found to indicate R40 refused when staff offered assistance. R40's face sheet printed 2/26/26, indicated diagnoses included ataxia (poor muscle control), nontraumatic intracerebral hemorrhage (spontaneous bleeding within the brain tissue), and heart failure. During	F0688	F0688 – Increase/Prevent Decrease in Range of Motion/Mobility (SS=D) The facility maintains policies and procedures to ensure that residents who enter the facility without limitations in range of motion do not experience avoidable decline unless clinically unavoidable. The policy has been reviewed and remains current. Resident R40’s care plan was reviewed, and staff were re-educated regarding the resident’s ambulation status and mobility needs. All residents were evaluated for the potential to be affected by the alleged deficient practice. Residents with ambulation or range-of-motion programs were reviewed, and orders were entered into the eTAR to support consistent monitoring and documentation of mobility activities. Residents identified with potential decline will be referred to therapy for further evaluation. Facility staff have been re-educated on mobility and ambulation protocols, including documentation expectations and early identification of decline. Education completed by April 3, 2026. To ensure ongoing compliance, weekly audits will be conducted on a minimum of ten residents with mobility plans to verify adherence to care plans and documentation requirements. The DON and/or designee is responsible for maintaining compliance with this requirement. Audit findings will be reviewed during monthly QAPI meetings to ensure continued compliance. Completion Date: April 10, 2026	04/20/2026

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F0688 SS = D	Continued from page 50 observation on 2/24/26 at 11:33 a.m., R40 propelled self, in wheelchair, from bedroom to the dining room. No attempts were made to ask R40 to ambulate to the dining room, by staff who walked past him. During observation on 2/24/26 at 4:57 p.m., R40 propelled self, in wheelchair, from bedroom to the dining room. During observation and interview on 2/25/26 at 8:46 a.m., R40 propelled self, in wheelchair, from bedroom to the dining room. R40 stated he used to walk to meals, but is not doing it now. R40 did not know why stating, "I'm able to walk but its been a while since I walked to a meal. Staff do still offer, not like they used to." R40 stated he used ask the staff to walk with him to meals, "... they always have a reason not to. Sometimes they're too busy, or they have other residents to take care of. So I quit asking." R40 voiced a desire to walk more, "I would like to walk more. So, if you talk with them and they start walking me again, I'm okay with that." During interview on 2/25/26 at 1:50 p.m., nursing assistant (NA)-B stated assisting residents to ambulate was easily done in the morning. R40 is supposed to get staff assistance to ambulate to and from meals. R40 would only do it if offered. R40 was typically offered to ambulate in the morning, "If I come before he leaves his room." NA-B thought the last time R40 ambulated was sometime the week prior, but NA-B was not certain. During interview on 2/26/26 at 8:37 a.m., registered nurse, clinical coordinator (CC)-B stated if a resident's care plan included ambulation, she expected assistance was offered. If a resident refused, she expected staff to reapproach and alert the nurse if resident continued to refuse. CC-B reviewed R40's nurse progress notes 1/28/26 through 2/25/26. CC-B was not able to locate progress notes to indicate R40 had refused ambulation assistance. CC-B was not sure if resident ambulation notes were being reviewed, CC-B did not review ambulation notes unless something occurred and was brought to her attention. CC-B stated it was important to encourage and offer assistance to residents for ambulation to ensure they do not decline physically. During interview on 2/26/26 at 10:10 a.m., director of nursing (DON) stated residents who receive assistance with ambulation have a sneaker sticker outside their room. DON expected, when therapy gave recommendations for an ambulation program, the resident would be assisted to ambulate according to the instructions in	F0688		

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F0688 SS = D	Continued from page 51 their care plan. If a resident refused ambulation assistance, DON expected the nurse to write a progress note, alert family and therapy of the refusal. Facility policy for ambulation was requested but was not received.	F0688		
F0689 SS = D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is NOT MET as evidenced by: Based on document review, interview and observation, the facility failed to ensure a root cause analysis was completed after a fall to determine interventions to prevent falls, and failed to continue to assess for changes after a head injury per policy, for 1 of 3 (R5) residents reviewed for falls. Findings include: R5's admission Minimum Data Set (MDS) dated 8/5/25, identified R5 had severe cognitive impairment was dependent on staff for all activities of daily living (ADLs) including transfers and bed mobility. R5's diagnoses included non-traumatic brain dysfunction, Alzheimer's disease, hypertension (high blood pressure), diabetes mellitus (high blood sugar due to impaired insulin regulation), arthritis (joint inflammation causing pain and stiffness), other fractures (history of bone fractures), anxiety disorder (excessive worry or fear), depression (persistent feelings of sadness), metabolic encephalopathy (altered brain function due to metabolic imbalance) and paroxysmal atrial fibrillation (intermittent irregular heart rhythm). The MDS indicated R5 had experienced one fall since admission with a injury (except major). Progress note dated 8/5/25 at 2:56 p.m., indicated R5 was attending a musical activity when R5 fell asleep,	F0689	F0689 – Free of Accident Hazards/Supervision/Devices (SS=D) The facility maintains policies and procedures to ensure that the resident environment is as free of accident hazards as possible and that each resident receives adequate supervision and assistive devices to prevent accidents. Resident R5's incidents were reviewed, and a root cause analysis was completed. Appropriate interventions were identified and implemented, and updates were made to both the care plan and staff assignment tools. All residents were evaluated for the potential to be affected by the alleged deficient practice. A facility-wide review of fall risk assessments and care plans was conducted to ensure appropriate interventions are in place based on individual resident needs. Facility staff have been re-educated on fall prevention protocols, including: Completion of fall huddles and root cause analysis Post-fall assessments and neurological monitoring Immediate implementation of interventions based on identified causes Adherence to care plan interventions Education completed by April 3, 2026. To ensure ongoing compliance: All falls will be audited for completion of assessments and appropriate interventions Interdisciplinary Team (IDT) meetings will include review of fall incidents Weekly audits of at least five residents will be conducted to verify adherence to care plans and	04/20/2026

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F0689 SS = D	Continued from page 52 was startled, and slid from a chair onto the carpet, landing on her right side. The note indicated R5 did not hit her head. Documentation indicated the nurse assessed R5 for injuries, cause of the fall, and pain. Range of motion (ROM) was noted to be unchanged for R5. No signs of pain were documented. R5 was assisted off the floor with a Hoyer lift and assistance of two staff and was assisted to bed. The note further indicated therapy was notified and a tilt-in-space wheelchair was delivered. R5's care plan was updated to include anticipating needs, wear gripper socks when up without shoes, staff will remind and reinforce safety awareness by telling Rt5 to lock breaks on bed anc chair, therapy provided new tilt-in-space wheelchair (a wheelchair that tilts back to assist in preventing slipping out of chair). Progress note dated 8/8/25 at 6:12 p.m., indicated staff had assisted R5 out of bed and brought R5 to the common area for dinner. The nurse documented staff left briefly to assist another resident with a bathroom transfer. While staff were assisting the other resident, a third staff member present in the common area observed R5 lying on the floor. The note indicated staff exited the other resident's room and found R5 on the floor at approximately 4:25 p.m. Staff reported they did not witness the fall but observed R5 hit her head on the floor. R5 was lying on her right side approximately three feet away from her wheelchair, which had the leg rest extended. R5 was noted to be wearing gripper socks. R5 was bleeding from the nose and had a laceration on the forehead. Review of the North Memorial Health After Visit Summary, dated 8/8/2025, indicated the reason for the visit was a head injury. Diagnoses included fall, head injury, contusion of the face, neck, or scalp, facial laceration, facial bone fracture, and right hip injury (initial encounter). Discharge instructions included follow-up in five days for suture removal and follow-up with the primary care provider or facility physician within one week. Progress note dated 8/8/25 at 10:32 p.m., indicated R5 returned from the emergency department via North Memorial EMS at approximately 10:00 p.m. Computed tomography (CT) scans of the head, face, pelvis, and spine were completed and reported as normal. An X-ray of the pelvis and hip was also completed. Vital signs	F0689	Continued from page 52 interventions The DON and/or designee is responsible for maintaining compliance with this requirement. Audit findings will be reviewed during monthly QAPI meetings to ensure sustained compliance. Completion Date: April 10, 2026	

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F0689 SS = D	Continued from page 53 were documented as blood pressure 166/81, temperature 97.3°F, pulse 84, oxygen saturation 92% on room air, and respirations 18. R5 received seven stitches to the forehead and top of the nose. R5 received bedtime medications and was documented as stable. Information was reported to the oncoming shift. Progress note dated 8/11/25, indicated interdisciplinary team (IDT) met to review R5's unwitnessed fall on 8/8/2025. R5's diagnoses included cerebrovascular accident (CVA), metabolic encephalopathy, and anxiety disorder. Predisposing physiological factors included confusion, gait imbalance, weakness, and poor safety awareness. Predisposing situational factors included ambulating without assistance and self-transferring. R5 was sent to the emergency department. R5's post-fall assessment dated 9/9/2025 at 4:25 p.m. indicated on 8/8/25 staff had assisted R5 out of bed and brought R5 to the common area for dinner. Staff left the area to assist another resident with a bathroom transfer. A third staff member who remained in the common area observed R5 lying on the floor. Staff exited the other resident's room and found R5 on the floor at approximately 4:25 p.m. Staff did not witness the fall but reported observing R5 strike her head on the floor. R5 was observed lying on her right side approximately three feet away from her wheelchair, which had the footrests in a raised position. R5 was bleeding from the nose and had a laceration to the forehead. R5 was noted to be wearing gripper socks and was unable to describe what had occurred. R5 was oriented to person. Immediate interventions included placing a pillow under R5's head, not moving the resident, and calling 911 at 4:27 p.m. Staff applied pressure to R5's nose to control bleeding. The Director of Nursing (DON), Administrator, and Admissions Specialist responded to assist following the fall. Vital signs at the time of the fall were blood pressure 174/79, pulse 79, temperature 97.2°F, respirations 20, and oxygen saturation 91% on room air. Family member (FM)-B was notified at 4:43 p.m. and provided verbal consent to send R5 to North Memorial and to hold the resident's bed. Emergency medical services (EMS) arrived, and R5 was transported via stretcher to North Memorial at approximately 4:43 p.m. The on-call provider was notified at 6:05 p.m. R5's EHR indicated R5 experienced a fall on 8/8/25. Documentation failed to include root cause analysis of	F0689		

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F0689 SS = D	Continued from page 54 the fall as well as changes to R5's care plan to prevent future falls. Progress note dated 10/20/2025 at 3:09 p.m., indicated R5 was placed on one-to-one (1:1) supervision due to multiple attempts to self-transfer. Staff redirected R5 with activities such as reading the newspaper and caring for a baby doll; however, the interventions were short-lived. R5 remained near the nurse's station when no activities were occurring. Progress note dated 10/23/2025 at 8:02 a.m., indicated R5 was found on the floor during rounds at approximately 7:10 a.m. R5 sustained a skin tear to the right outer eyebrow with ongoing bleeding, and a bandage was applied. R5 was noted to have left-sided weakness and complained of pain in the left hand. The provider was notified and orders were received to send R5 to the emergency department for further evaluation. Review of R5's post-fall assessment, dated 10/23/2025, indicated R5 was found on the floor beside her bed in a prone position with her right hand underneath her body, positioned laterally to the bed. R5's head was facing the window and her legs were toward the door. Blood was noted on the floor, and R5 was calling out for her husband. R5 was assisted to a sitting position and cleaned. An initial neurological assessment was completed. A skin tear was noted to the right outer eyebrow with continued bleeding, a bandage was applied. R5's left hand was noted to be weaker than the right. R5 followed commands and complained of pain in the left hand. A hematoma was noted at the base of the left, fifth finger. R5 was unable to describe what had occurred. Immediate interventions included assisting R5 to bed using a Hoyer lift with assistance of two staff. Vital signs at the time of the fall included blood pressure 145/69, pulse 75, oxygen saturation 95% on room air, respirations 20, and temperature 97.5°F. R5 denied headache or blurred vision. R5 was dressed and brought to the common area. The bed was noted to be in the lowest position. R5 was sent to the emergency department for further evaluation. Physical therapy (PT) and occupational therapy (OT) to assess R5 upon return. The care plan updated to indicate R5 should be first to get up in the morning. R5 was oriented to person. Predisposing physiological factors included confusion, gait imbalance, and poor safety awareness. Predisposing situational factors included self-transfer.	F0689		

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F0689 SS = D	Continued from page 55 Review of a progress note dated 10/23/2025 at 3:47 p.m., indicated R5 returned from the hospital at approximately 2:15 p.m. R5 was restless, confused, and fidgety, and removed the splint from her left hand and refused staff attempts to reapply. Staff attempts at redirection were unsuccessful. R5 was observed sitting at the nurse's station receiving one-to-one supervision. R5 was able to move the affected arm and denied pain at that time. R5 also removed the dressing from the right eye. Family member (FM)-B was notified and was attempting to arrange for a family member to visit. Continued efforts to redirect and maintain R5's safety. Review of the North Memorial Health After Visit Summary, dated 10/23/2025, indicated the reason for the visit was a closed displace fracture of shaft of fifth metacarpal bone of left hand and head injury. Discharge instructions included follow-up with the primary care provider or facility physician within one week and to schedule an appointment with Twin Cities Orthopedics as soon as possible. Facility IDT notes dated 10/24/25, indicated 10/23/25 fall was discussed. Documentation indicated R5 resided on the memory care unit with a diagnosis of Alzheimer's disease and was described as impulsive. R5 was reported to have attempted to self-transfer out of bed, resulting in injury to the right outer eyebrow and a hematoma at the base of the left fifth finger. R5 was sent to the emergency department and returned to the facility the same day at approximately 2:15 p.m. Updated interventions included ensuring R5 was first to get up in the morning and initiating therapy services through OT and PT. The care plan was updated accordingly. R5's quarterly MDS dated 11/25/25, identified R5 had severe cognitive impairment and required partial/moderate staff assistance with transfers and bed mobility. The MDS indicated R5 had experienced one fall after admission with a major injury. During observation on 2/24/26 at 11:34 a.m., R5 was lying sideways in bed with her wheelchair positioned next to the bed. R5 was wearing gripper socks. During observation on 2/24/26 at 2:39 p.m., R5	F0689		

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F0689 SS = D	Continued from page 56 self-propelled her wheelchair from the dining room toward her room. R5's gripper socks had slid down on both feet, with approximately three inches of the socks hanging off the ends of her toes but heels were still partially covered. Activity aide (AA)-A asked R5 if she wanted to join activities; however, R5 continued propelling toward her room. During observation on 2/25/26 at 8:25 a.m., R5 was in the living room propelling herself in her wheelchair toward her room. Registered nurse (RN)-G asked R5 where she was going, and R5 stated she was going to lie down for a while before breakfast. RN-G stated she would come get R5 when breakfast was ready. R5 then entered her room and transferred herself into bed. During observation on 2/25/26 at 2:09 p.m., R5 was lying in bed in her room with the door closed. During interview on 2/25/26 at 12:32 p.m., RN-G stated R5 required assistance of one staff member with transfers, although R5 sometimes attempted to transfer independently. RN-G stated that if staff observed R5 attempting to self-transfer, they would typically watch to ensure she was safe and would assist if able. Staff sometimes avoided immediately intervening because they did not want to startle R5. RN-G confirmed, earlier this morning R5 told RN-G she intended to go to room and lay down. RN-G stated she did not attempt to intervene but should have assisted R5. RN-G stated assisting R5 was important to prevent falls. During interview on 2/26/26 at 9:53 a.m., nursing assistant (NA)-D stated that when a resident fell, staff notified the nurse and remained with the resident to ensure the resident was safe while the nurse completed an assessment. During interview on 2/26/26 at 10:19 a.m., NA-E stated when a resident fell, staff notified the nurse. NA-E stated the nurse completed an assessment and updated the care plan as needed. NA-E stated R5 required assistance of one staff member with transfers and reported therapy sometimes walked with R5. During interview on 2/26/26 at 10:24 a.m., RN-G stated when a resident fell, the nurse completed a fall assessment and communicated the event to other staff.	F0689		

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F0689 SS = D	Continued from page 57 RN-G stated neurological assessments might be completed for unwitnessed falls depending on the circumstances and were followed by vital sign monitoring. RN-G stated multiple staff could update the care plan following a fall. RN-G further stated the focus of care planning was often ensuring tasks for nursing assistants were clearly identified so staff knew how to care for R5. RN-G stated R5 used a tilt-in-space wheelchair when first admitted then transitioned to a regular wheelchair. At the time of the falls she was in the tilt-in-space wheelchair. During interview on 2/26/26 at 10:48 a.m., NA-A stated R5 required assistance of one staff member with transfers and stated staff notified the nurse when a resident fell. NA-A stated R5 self-transfers herself often and stated that if staff see her self-transferring, they supervise as they don't want to scare R5. During interview on 2/26/26 at 12:49 p.m., Clinical Coordinator (CC)-F stated that when a resident fell, the nurse entered the fall into the facility's incident reporting system, and the fall was reviewed by the interdisciplinary team to ensure interventions were implemented to prevent additional falls. CC-F stated R5 experienced a fall on 8/8/25, was sent to the emergency department, and returned the same day. CC-F confirmed an intervention was not implemented following that fall. CC-F stated neurological assessments were expected when a resident hit their head or when a fall was unwitnessed and that neurological monitoring was documented in a neurological assessment. CC-F confirmed neurological assessments were not initiated or completed following R5's falls on 8/8/25 and 10/23/25 and stated neurological monitoring would have been expected following each fall. CC-F stated neurological monitoring was important to detect changes in condition, particularly for memory care residents who might not be able to report symptoms. CC-F stated R5 required assistance of one staff member to stand-by assistance with transfers and stated R5 tended to self-transfer but required staff assistance due to being very unsteady. CC-F stated staff were expected to assist R5 with transfers when aware R5 was attempting to transfer due to R5's fall history and unsteadiness. During interview on 2/26/26 at 1:32 p.m., the Director of Nursing (DON) stated after every fall, whether witnessed or unwitnessed, interventions were expected to be implemented to prevent additional falls and	F0689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245619	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAINT THERESE AT OXBOW LAKE	9751 REGENT AVENUE NORTH , BROOKLYN PARK, Minnesota, 55443

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F0689 SS = D	Continued from page 58 reduce the risk of serious injury. The DON stated fall interventions should be added to the resident's care plan. The DON further stated neurological assessments should be completed when a fall was unwitnessed or when a resident hit their head. The DON stated staff were expected to assist residents who required assistance with transfers and should not allow residents to self-transfer due to the risk of falls. Review of the facility policy titled "Fall Mitigation Program," dated 1/26, indicated each resident would be assessed for fall risk and would receive care and services in accordance with their individualized level of risk to minimize the likelihood of falls.	F0689		
F0880 SS = D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must 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. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;	F0880	F0880 – Infection Prevention and Control (SS=D) The facility maintains an infection prevention and control program consistent with CDC and regulatory guidance. Policies have been reviewed and updated to reflect current standards. In response to the survey findings, the infection control policy was updated to include procedures for the administration of aerosol-generating treatments for residents on COVID-19 precautions. At the time of review, Resident R25 no longer required isolation precautions, and no other residents were receiving aerosol treatments under COVID-19 precautions. Facility staff have been re-educated on infection prevention protocols, including aerosol precautions and appropriate use of personal protective equipment (PPE). Education completed by April 3, 2026. To ensure ongoing compliance, during any period of resident isolation, the Infection Preventionist and/or designee will conduct routine audits to ensure appropriate precautions are in place and followed. Daily audits will be conducted as indicated during outbreak or isolation periods. The DON and/or designee is responsible for maintaining compliance with this requirement. Audit findings will be reviewed during monthly QAPI meetings. Completion Date: April 10, 2026	04/20/2026

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F0880 SS = D	Continued from page 59 (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is NOT MET as evidenced by: Based on observation, record review and interview the facility failed to ensure appropriate infection control practices were followed for 1 of 1 resident (R25) reviewed who was diagnosed with COVID and received an aerosol breathing treatment. Findings include: R25's face sheet printed 2/26/26 included diagnosis	F0880		

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F0880 SS = D	Continued from page 60 COVID-19 (2/18/26) During observation and interview on 2/25/26 at 8:30 a.m., licensed practical nurse (LPN)-A explained she needed to assist R25 with a nebulizer treatment. LPN-A entered R25's room after donning appropriate personal protective equipment (PPE), LPN-A left R25's room door fully open. LPN-A set up the nebulizer, applied the face mask to R25 and turned the machine on. At 8:41 a.m., LPN-A turned off the nebulizer machine, cleaned the face mask and medication container with water, then placed on a towel on the counter in R25's room. LPN-A left R25's room and appropriately removed PPE. During interview on 2/25/26 at 9:36 a.m., LPN-A stated not being aware of special instructions when administering aerosol breathing treatments (i.e. nebulizer) to a resident diagnosed with COVID. During interview on 2/26/26 at 9:21 a.m., clinical coordinator (CC)-B stated not being the, "... best person to answer..." regarding infection control practices when administering an aerosol breathing treatment to a resident diagnosed with COVID. CC-B stated based on previous directions, the resident should be screened to determine if able to self administer the medication. R25 was not assessed, therefore could not self administer the nebulizer. R25 was not residing in an airborne infection isolation room (AIIR), facility did not have those type of rooms. CC-B expected the bedroom door of the COVID positive resident's room was kept closed during the nebulizer treatment. CC-B expected the nurse to also close the door after the nebulizer was finished, for at least 15 minutes. This was important so the virus was not spread to other residents, staff and/or visitors. During interview on 2/26/26 at 10:10 a.m., director of nursing (DON) stated for residents who are COVID positive, she expected the resident's room door was closed prior to starting the nebulizer treatment and remained closed for at least 15 minutes after the nebulizer treatment was finished. This was important because COVID is spread through the respiratory system and use of the nebulizer treatment could carry the virus to other residents and/or staff. DON stated the facility did not have rooms designated as AIIR. Facility policy, COVID-19 Prevention, Response and Reporting dated 1/2025, failed to direct staff how to manage use of a nebulizer during administration. The policy provided the following instructions: 18. Aerosol-generating procedures should be performed	F0880		

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F0880 SS = D	Continued from page 61 cautiously and avoided if appropriate alternatives exist. 19. Aerosol-generating procedures should take place in an airborne infection isolation room (AIIR), if possible, and the number of HCP (health care providers) present during the procedure should be limited to those essential for resident care and support. Visitors should not be present for the procedure.	F0880		
F0883 SS = D	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization;	F0883	F0883 – Influenza and Pneumococcal Immunizations (SS=D) The facility maintains policies and procedures consistent with CDC and MDH guidelines for resident immunizations. The policy has been reviewed and remains current. Resident R5 has been offered the necessary vaccines to being her up to date. A facility-wide audit of resident immunization records was conducted utilizing the Minnesota Immunization Information Connection (MIIC) system to verify compliance with current vaccination guidelines. Residents identified as requiring immunizations will be offered vaccines in accordance with policy and upon obtaining consent. Vaccinations will be administered as appropriate. Facility staff have been re-educated on immunization guidelines and documentation requirements. Education completed by April 3, 2026. To ensure ongoing compliance: Immunization status will be reviewed during care conferences Admission assessments will include verification through MIIC Seasonal vaccination clinics will continue to be offered Ongoing audits will be conducted to ensure compliance The DON and/or designee is responsible for maintaining compliance with this requirement. Audit findings will be reviewed during monthly QAPI meetings. Completion Date: April 10, 2026	04/20/2026

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F0883 SS = D	Continued from page 62 (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to ensure 1 of the 5 residents (R5) reviewed for immunizations was offered and/or provided the pneumococcal vaccination series as recommended by the Centers for Disease Control (CDC) to help reduce the risk of associated infection(s). A CDC Pneumococcal Vaccine Timing for Adults feature, dated 3/2025, identified various tables when each (or all) of the pneumococcal vaccinations should be obtained. This identified when an adult over 50 years old had received no prior pneumococcal vaccine should receive PCV20 or PCV21, those who had received the complete series (i.e., PPSV23 and PCV13; see below) then the patient and provider may choose to administer Pneumococcal 20-valent Conjugate Vaccine (PCV20) for patients who had received Pneumococcal 13-valent Conjugate Vaccine (PCV13) at any age and Pneumococcal Polysaccharide Vaccine 23 (PPSV23) at or after 65 years old. R5’s face sheet dated 2/25/26, indicated R5 was 88 years old. The immunization record, undated, failed to indicate R5 had received any doses of pneumococcal vaccine. R5’s electronic medical record (EMR) identified a signed consent dated 8/6/25 which indicated R5’s family had consented to R5 receiving the pneumococcal vaccine, however, review of R5’s EMR failed to indicate R5 was offered or received	F0883		

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F0883 SS = D	Continued from page 63 pneumococcal vaccine. R5's EMR failed to indicate their Minnesota Immunization Information Connection (MIIC) was reviewed for vaccinations R5 had received prior to admission to the facility. When interviewed on 2/26/26 at 12:28 p.m., director of nursing (DON) stated when a resident was admitted their MIIC was reviewed for received vaccinations If there were vaccinations due, consent for the vaccination(s) was received from the resident or the resident representative after education regarding the vaccinations. The dose(s) would be obtained from the pharmacy and administered once there were received from the pharmacy. DON reviewed R5's EMR, was unable to locate R5's MIIC report or indication that resident had received any doses of pneumococcal vaccines. DON did locate signed consent dated 8/6/25. DON stated pneumococcal vaccine was important for infection control, to help reduce the risk of associated infections. Facility Pneumococcal Vaccine (Series) policy dated 1/2026, indicated each resident would be assessed for pneumococcal immunizations upon admission, each resident would be offered a pneumococcal immunization unless medically contraindicated or the resident had already bee immunized.	F0883		

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

March 20, 2026

Administrator
SAINT THERESE AT OXBOW LAKE
9751 REGENT AVENUE NORTH
BROOKLYN PARK, MN 55443

RE: CCN:245619
Cycle Start Date: February 26, 2026

Dear Administrator:

On February 26, 2026, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within **ten (10) calendar days** after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.

What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.

- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

The state agency may, in lieu of an onsite revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility’s Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by an "F" and/or an "E" tag), i.e., the plan of correction should be directed to:

Nikki Harvey, Regional Operations Supervisor
St. Cloud A District Office
Health Regulation Division
Minnesota Department of Health
4140 Thielman Lane
Saint Cloud, Minnesota 56301-4557
Email: nikki.harvey@state.mn.us
Office: (320) 223-7318 Mobile: (320) 216-5631

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by May 26, 2026 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by August 26, 2026 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

INFORMAL DISPUTE RESOLUTION (IDR)

In accordance with 42 CFR 488.331 and Minnesota Statute 144A.10 subd 15, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:
https://forms.web.health.state.mn.us/form/NHDisputeResolution
This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.
A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. You are required to send your written request, along with the specific deficiencies being disputed, and an

explanation of why you are disputing those deficiencies, to:
https://forms.web.health.state.mn.us/form/NHDisputeResolution

A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

Travis Z. Ahrens
State Fire Safety Supervisor
Health Care & Correctional Facilities
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
Email: travis.ahrens@state.mn.us
Web: www.sfm.dps.mn.gov
Cell: 1-507-308-4189

Feel free to contact me if you have questions.

Sincerely,



Kamala Fiske-Downing
Compliance Analyst | Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Office: 651-201-4112