



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

June 25, 2026

Administrator

Rochester Restorative Care Center

501 Eighth Avenue Southeast

Rochester, MN 55904

Re: Reinspection Results

Event ID: 1E3F48-H2

Dear Administrator:

On June 1, 2026, survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on March 12, 2026. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

A handwritten signature in black ink that reads 'H. Zahler'.

Holly Zahler, Compliance Analyst

Federal Enforcement | Health Regulation Division

Minnesota Department of Health

Office: 651-201-4384

Email: holly.zahler@state.mn.us



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June 25, 2026

Administrator

Rochester Restorative Care Center

501 Eighth Avenue Southeast

Rochester, MN 55904

RE: CCN: 245184

Cycle Start Date: March 12, 2026

Dear Administrator:

On April 29, 2026, we notified you a remedy was imposed.

On June 1, 2026, the Minnesota Departments of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of May 18, 2026.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective May 14, 2026, be discontinued as of May 18, 2026. (42 CFR 488.417 (b))

In our letter of April 29, 2026, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from May 14, 2026. This does not apply to or affect any previously imposed NATCEP loss.

The CMS Location may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

A handwritten signature in black ink, appearing to read 'H. Zahler'.

Holly Zahler, Compliance Analyst

Federal Enforcement | Health Regulation Division

Minnesota Department of Health

Office: 651-201-4384

Email: holly.zahler@state.mn.us



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April 8, 2026

Administrator

Rochester Restorative Care Center

501 Eighth Avenue Southeast

Rochester, MN 55904

RE: CCN:245184

Cycle Start Date: March 12, 2026

Dear Administrator:

On March 12, 2026, a survey was completed at your facility by the Minnesota Department(s) 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 widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), 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:

Jennifer Kolsrud Brown, RN, Regional Operations Supervisor

Rochester District Office

Health Regulation Division

Minnesota Department of Health

3425 40th Avenue NW, Suite 115

Rochester, MN 55901

Email: jennifer.kolsrud@state.mn.us

Office: (507) 206-2727

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 **June 12, 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 **September 12, 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,

A handwritten signature in black ink, appearing to read "H. Zahler".

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
625 Robert Street North
P.O. Box 64975
St. Paul, MN 55164-0899
Office: 651-201-4384 | Email: holly.zahler@state.mn.us



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

April 8, 2026

Administrator

Rochester Restorative Care Center

501 Eighth Avenue Southeast

Rochester, MN 55904

Re: State Nursing Home Licensing Orders

Event ID: 1E3F48-H1

Dear Administrator:

The above facility survey was completed on March 12, 2026, for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a “suggested method of correction” has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The “suggested method of correction” is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction

Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact:

Jennifer Kolsrud Brown, RN, Regional Operations Supervisor

Rochester District Office

Health Regulation Division

Minnesota Department of Health

3425 40th Avenue NW, Suite 115

Rochester, MN 55901

Email: jennifer.kolsrud@state.mn.us

Office: (507) 206-2727

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

Please feel free to call me with any questions.



Holly Zahler, Compliance Analyst

Federal Enforcement | Health Regulation Division
Minnesota Department of Health
625 Robert Street North
P.O. Box 64975
St. Paul, MN 55164-0899
Office: 651-201-4384 | Email: holly.zahler@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245184		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 0... B. WING		(X3) DATE SURVEY COMPLETED 03/10/2026	
NAME OF PROVIDER OR SUPPLIER Rochester Restorative Care Center				STREET ADDRESS, CITY, STATE, ZIP CODE 501 EIGHTH AVENUE SOUTHEAST , ROCHESTER, Minnesota, 55904			
(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	
K0000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 03/10/2026. At the time of this survey, ROCHESTER RESTORATIVE CARE CENTER was found NOT 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, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: If PARTICIPATING IN THE E-POC PROCESS, a paper copy of the plan of correction is not required. Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR		K0000			04/16/2026	

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
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K0000	Continued from page 1 By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: A detailed description of the corrective action taken or planned to correct the deficiency. Address the measures that will be put in place to ensure the deficiency does not reoccur. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. Identify who is responsible for the corrective actions and monitoring of compliance. The actual or proposed date for completion of the remedy. ROCHESTER RESTORATIVE CARE CENTER is a 3-story building with full basement. ROCHESTER EAST HEALTH SERVICES building was constructed in 1968 and was determined to be Type II (222) construction. The facility is fully protected throughout by an automatic sprinkler system and has a fire alarm system with smoke detection in corridors and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 111 beds and had a census of 67 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidence by:		K0000				
K0291 SS = F	Emergency Lighting CFR(s): NFPA 101 Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 This STANDARD is NOT MET as evidenced by:		K0291	The facility has taken the following corrective actions: On 4/13/26, the Maintenance Director conducted a full 90-minute annual test of all emergency lighting throughout the facility. Any malfunctioning emergency lighting units identified during testing were repaired or replaced immediately. A comprehensive emergency lighting log system has been implemented to document all required testing and		04/13/2026	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245184		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 0... B. WING		(X3) DATE SURVEY COMPLETED 03/10/2026	
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K0291 SS = F	Continued from page 2 Based on a review of available documentation and staff interview, the facility failed to maintain, test, and inspect the emergency lighting fixtures per NFPA 101 (2012 edition) Life Safety Code, sections 19.2.9.1, 7.9.3.1. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 03/10/2026 between 9:30 AM to 1:30 PM, it was revealed by a review of available documentation that no documentation was available to confirm 90-minute annual emergency light testing is being completed. An interview with the Maintenance Director verified this deficient finding at the time of discovery.			K0291	Continued from page 2 inspections. 2. How the facility will identify other residents/equipment affected All emergency lighting fixtures throughout the facility were inspected and tested to ensure proper operation. This review ensured that no other areas or residents were at risk due to non-functioning emergency lighting. Any deficient fixtures identified were corrected at the time of testing. 3. Measures put in place to ensure the deficient practice does not recur The facility has implemented the following systemic changes: A preventive maintenance program has been established in accordance with NFPA 101: Monthly 30-second emergency lighting tests Annual 90-minute emergency lighting tests The Maintenance Director (or designee) is responsible for ensuring all testing is completed and documented timely. 4. How the facility will monitor ongoing compliance The Administrator or designee will audit emergency lighting logs for thirty (30) days. Audits will verify: Tests are completed as scheduled Documentation is complete and accurate Any failures are corrected promptly		

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K0291 SS = F			K0291	Continued from page 3 Results of audits will be reviewed in the Quality Assurance (QA) / QAPI program, and corrective actions will be implemented as needed.			
K0321 SS = F	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322)		K0321	5. Completion Date Completion Date: April 13th, 2026 1. How the deficient practice will be corrected On April 2nd, the facility repaired the 1st Floor Medical Gas (O ,) Storage Room to restore the required fire-resistance rating. Repairs included: Sealing all wall penetrations Replacing damaged/missing wall and ceiling materials Ensuring construction meets 1-hour fire-rated barrier requirements in accordance with NFPA 101 The room was inspected after repairs to confirm compliance. 2. How the facility will identify other areas affected On April 1st, the Maintenance Director (or designee) conducted a facility-wide inspection of all hazardous areas, including but not limited to: Medical gas storage rooms Soiled utility/linen rooms Laundry areas Storage rooms over 50 sq. ft. Trash rooms All walls, ceilings, and penetrations were inspected for:		04/02/2026	

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K0321 SS = F	Continued from page 4 This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to maintain areas per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.2.1, 19.3.2.1.5, 8.3, 8.3.1.1, 8.3.1.2. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 03/10/2026 at 11:25 AM, it was revealed by observation that in the 1st Floor – Med Gas (O2) Storage room that portions of the wall and ceiling were damaged and missing, compromising the fire resistance rating of the room. An interview with the Maintenance Director verified this deficient finding at the time of discovery.			K0321	Continued from page 4 Damage Missing materials Unsealed penetrations Any additional deficiencies identified were corrected immediately. 3. Measures put in place to ensure the deficient practice does not recur The facility has implemented the following systemic changes: A work order system is in place to ensure: Immediate repair of any identified damage Tracking of completion Only approved materials and methods will be used for repairs to maintain fire ratings. 4. How the facility will monitor ongoing compliance The Administrator or designee will: Conduct audits for the next thirty (30) days Audits will verify: Walls and ceilings are intact No unsealed penetrations exist Repairs are completed timely Findings will be reviewed through the Quality Assurance (QA/QAPI) Committee, and corrective actions will be implemented as needed.		

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K0321 SS = F			K0321	Continued from page 5 5. Completion Date Completion Date: April 2nd, 2026			
K0345 SS = F	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This STANDARD is NOT MET as evidenced by: Based on a review of available documentation and staff interview, the facility failed to test the fire alarm system per NFPA 101 (2012 edition), Life Safety Code, sections 19.7.1.4, NFPA 25 (2011 edition), Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 5.3.3 This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 03/10/2026 between 9:30 AM to 1:30 PM, it was revealed by a review of available documentation that no documentation was available to confirm that semi-annual inspection of the fire alarm system is being completed. An interview with the Maintenance Director verified this deficient finding at the time of discovery.		K0345	1. How the deficient practice will be corrected On October 21st, 2025 the facility contacted its licensed fire alarm vendor to perform an annual inspection and testing of the fire alarm system in accordance with NFPA 72. The inspection included verification of: Control panel operation Initiating devices (pull stations, smoke detectors) Notification devices (horns/strobes) Supervisory and trouble signals Documentation of the completed inspection has been obtained and is maintained on-site and readily available. Any deficiencies identified during testing were corrected immediately or scheduled for repair. 2. How the facility will identify other systems affected The facility conducted a review of all fire alarm system documentation to ensure: Required inspections (semi-annual and annual) are completed Records are complete and accessible This review confirmed whether any additional missed inspections occurred. Any gaps in documentation or missed testing were immediately addressed with the vendor. 3. Measures put in place to ensure the deficient		04/17/2026	

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K0345 SS = F				K0345	Continued from page 6 practice does not recur The facility has implemented the following system changes: A contracted licensed fire alarm vendor has been scheduled to perform: Annual inspections and testing- by or before October 21st 2026 Semi-annual inspections completed by onsite maintenance The Maintenance Director (or designee) is responsible for: Scheduling inspections Verifying completion Maintaining documentation 4. How the facility will monitor ongoing compliance The Administrator or designee will: Review fire alarm inspection documentation through our work order system every six (6) months Monitoring will ensure: Inspections are completed on schedule Reports are complete and signed Any deficiencies are corrected timely Results will be reported to the Quality Assurance (QA/QAPI) Committee, with corrective actions taken as needed. 5. Completion Date		

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K0345 SS = F			K0345	Continued from page 7 Completion Date: April 17th, 2026			
K0353 SS = F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This STANDARD is NOT MET as evidenced by: Based on observation, a review of documentation and staff interview the facility failed to inspect and maintain the sprinkler system in accordance with NFPA 101 (2012 edition), Life Safety Code, sections 4.6.12, 4.6.12.1, 4.6.12.2, 9.7.5, 9.7.6, NFPA 13 (2010), Standard for the Installation of Sprinkler Systems, section(s) 7.7.1.4, 8.5, 8.5.1.2, 26.1, NFPA 25 (2011 edition) Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, section(s), 4.3, 5.1.1, 5.2.1, 5.2.1.1.1, 5.2.1.1.2(6) These deficient findings could have a widespread impact on the residents within the facility. Findings include: On 03/10/2026 at 11:40 AM, it was revealed by observation in the Basement – Laundry / Dryer area that sprinkler head(s) exhibited of debris loading. On 03/10/2026 between 0930 AM to 1:30 PM, it was revealed by a review of available documentation that no documentation was available to confirm that system		K0353	1. How the deficient practice will be corrected The facility has taken the following corrective actions: On April 2nd, 2026, all sprinkler heads in the Basement Laundry/Dryer area were: Cleaned or replaced to remove debris loading and ensure proper operation The kitchen 6-burner stove was repositioned directly beneath the sprinkler head to ensure proper spray pattern coverage Damaged/missing ceiling tiles in: Basement Old Physical Therapy Area Basement Men/Women Bath/Shower Areas were replaced immediately to ensure proper thermal activation of sprinkler heads On January 26th, 2026, the facility's licensed sprinkler vendor completed: Any missed quarterly inspections/testing for 2025 (Q2 and Q4) and five (5) year test was completed. April 1st another quarterly inspection was completed Verification that the system is fully operational All inspection and testing documentation has been obtained and maintained on-site 2. How the facility will identify other systems/areas affected A facility-wide inspection of the sprinkler system was conducted, including:		04/02/2026	

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K0353 SS = F	Continued from page 8 quarterly testing occurred in Q2 and Q4 of 2025. On 03/10/2026 at 11:30 AM, it was revealed by observation in the Kitchen that the 6-burner stove was skewed from center-line placement below the protecting sprinkler-head, affecting proper and effective pattern coverage. On 03/10/2026 at 11:45 AM, it was revealed by observation in the Basement – Old Physical Therapy Area that areas of the ceiling were damaged / missing – affecting the thermal activation of the sprinkler head(s). On 03/10/2026 at 11:50 AM, it was revealed by observation in the Basement – Men / Women / Bath-Shower areas, that ceiling sections were damaged / missing – affecting the thermal activation of the sprinkler head(s). An interview with the Maintenance Director verified these deficient findings at the time of discovery.			K0353	Continued from page 8 All sprinkler heads for debris, paint, or obstruction Proper clearance below sprinkler heads Ceiling integrity in all sprinklered areas Any additional issues identified were corrected immediately Documentation was reviewed to ensure all required inspections and testing are current 3. Measures put in place to ensure the deficient practice does not recur The facility has implemented the following systemic changes: A contract with a licensed sprinkler vendor ensures completion of: Quarterly inspections Annual inspections 5-year internal inspections (as applicable) The Maintenance Director (or designee) is responsible for: Ensuring sprinkler heads remain clean and unobstructed Maintaining proper clearance (minimum 18 inches below heads) Monitoring ceiling integrity Environmental rounds will now include: Inspection of sprinkler heads for debris/obstruction Verification of ceiling condition 4. How the facility will monitor ongoing compliance		

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K0353 SS = F			K0353	Continued from page 9 The Administrator or designee will: Conduct sprinkler system audit at the next scheduled quarterly inspection for July 26, 2026 Audits will verify: Sprinkler heads are clean and unobstructed Equipment is not blocking spray patterns Ceiling tiles are intact Required inspections/testing are completed and documented Results will be reviewed through the Quality Assurance (QA/QAPI) Committee, with corrective action taken as needed 5. Completion Date Completion Date: April 2nd, 2026			
K0354 SS = C	Sprinkler System - Out of Service CFR(s): NFPA 101 Sprinkler System - Out of Service Where the sprinkler system is impaired, the extent and duration of the impairment has been determined, areas or buildings involved are inspected and risks are determined, recommendations are submitted to management or designated representative, and the fire department and other authorities having jurisdiction have been notified. Where the sprinkler system is out of service for more than 10 hours in a 24-hour period, the building or portion of the building affected are evacuated or an approved fire watch is provided until the sprinkler system has been returned to service. 18.3.5.1, 19.3.5.1, 9.7.5, 15.5.2 (NFPA 25) This STANDARD is NOT MET as evidenced by: Based on available documentation and staff interview, the facility failed to maintain a sprinkler system out		K0354	1. How the deficient practice will be corrected On April 14th 2026, the facility reviewed and revised the Sprinkler System Out-of-Service Policy to ensure full compliance with NFPA requirements. Conflicting policies were rescinded and replaced with one standardized policy. The revised policy clearly defines: When a system is considered impaired Required actions during impairment Fire watch initiation (for impairments exceeding 10 hours in a 24-hour period) Notification procedures (City/State Fire Marshal, management, staff)		05/15/2026	

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K0354 SS = C	Continued from page 10 of service policy per NFPA 101 (2012 edition), Life Safety Code, section 19.3.5.1, 9.7.5, 9.7.6 and NFPA 25 (2011 edition) Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, section 15.5.2(6). This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 03/10/2026 between 09:30 AM to 1:30 PM, it was revealed by a review of available documentation that two documents associated to Fire Sprinkler System Out-of-Service Policy were presented for review – documents conflicted as to when the facility would initiate Fire Watch. An interview with the Maintenance Director verified this deficient finding at the time of discovery.		K0354	Continued from page 10 The updated policy has been implemented facility wide. 2. How the facility will identify other areas affected All fire protection-related policies were reviewed to ensure: Consistency Alignment with NFPA 101 and NFPA 25 requirements Any additional conflicting or outdated policies were updated or removed. Staff responsible for life safety compliance were interviewed to confirm understanding of the revised process. 3. Measures put in place to ensure the deficient practice does not recur The facility has implemented the following systemic changes: A standardized Sprinkler Impairment Procedure has been adopted, including: Immediate assessment of impairment extent and risk Required notifications (fire department, administration, AHJ) Documentation of all impairments Fire watch procedures when required A fire watch log and documentation tool has been implemented The Maintenance Director (or designee) is responsible for: Initiating impairment procedures Ensuring compliance with fire watch requirements			

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K0354 SS = C			K0354	Continued from page 11 Staff (maintenance and leadership) have been educated on the updated policy, including: When to initiate fire watch Required documentation Notification procedures 4. How the facility will monitor ongoing compliance The Administrator or designee will: Review any sprinkler impairment events and associated documentation for thirty (30) days. Monitoring will ensure: Proper implementation of the policy Fire watch initiated appropriately when required Notifications completed and documented Results will be reviewed in the Quality Assurance (QA/QAPI) Committee, with corrective action taken as needed 5. Completion Date Completion Date: May 15th, 2026			
K0355 SS = E	Portable Fire Extinguishers CFR(s): NFPA 101 Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10		K0355	1. How the deficient practice will be corrected On March 17th, 2026, the facility: Completed a annual full inventory and inspection of all portable fire extinguishers Ensured all extinguishers have current monthly inspection tags completed and up to date		03/17/2026	

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K0355 SS = E	Continued from page 12 This STANDARD is NOT MET as evidenced by: Based on observation, review of available documentation and staff interview, the facility failed to properly inspect, and maintain documentation of portable fire extinguishers in accordance with NFPA 101 (2012 edition), Life Safety Code, sections 19.3.5.12, 9.7.4.1, and NFPA 10 (2010 edition), Standard for Portable Fire Extinguishers, section 7.1, 7.2.4, 7.2.4.1, 7.2.4.5, 7.3.2.1, These deficient findings could have a patterned impact on the residents within the facility. Findings include: On 03/10/2026 between 09:30 AM to 1:30 PM, it was revealed by a review of available documentation that annual vendor documentation was not available for review. On 03/10/2026 between 09:30 AM to 1:30 PM, it was revealed by a review of available documentation that inspection records and documentation associated with facility fire extinguishers was generic and not confirming that monthly in occurring for all extinguishers. On 03/10/2026 at 11:45 AM, it was revealed by observation that the fire extinguisher located in the Basement – Old Occupational Therapy area was missing two monthly inspection dates. An interview with the Maintenance Director verified these deficient findings at the time of discovery.		K0355	Continued from page 12 The fire extinguisher located in the Basement – Old Occupational Therapy area was immediately corrected with proper monthly inspection documentation A licensed vendor was contacted and completed the required annual inspection and maintenance of all fire extinguishers on March 17th, 2026 All vendor documentation is now on-site and readily available for review 2. How the facility will identify other areas affected A facility-wide audit of all fire extinguishers was conducted to ensure: Monthly inspections are being completed for each extinguisher Inspection tags are accurate and complete Extinguishers are properly mounted, accessible, and unobstructed Any discrepancies identified were corrected immediately 3. Measures put in place to ensure the deficient practice does not recur The facility has implemented the following systemic changes: The Maintenance Director (or designee) is responsible for: Completing and documenting monthly inspections Scheduling and maintaining annual vendor inspections A contract with a licensed vendor has been secured for annual servicing 4. How the facility will monitor ongoing compliance			

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K0355 SS = E			K0355	Continued from page 13 The Administrator or designee will: Conduct monthly audits of fire extinguisher inspection records for thirty (30) days Monitoring will ensure: Monthly inspections are completed for each extinguisher Documentation is accurate and complete Annual inspections are completed and documented Results will be reviewed through the Quality Assurance (QA/QAPI) Committee, with corrective actions taken as needed 5. Completion Date Completion Date: March 17th, 2026			
K0374 SS = E	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to test, maintain, and inspect the smoke barrier doors per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.7 and 8.5.4 This deficient finding could		K0374	1. How the deficient practice will be corrected On April 2nd, 2026, the 3rd Floor smoke barrier door assembly was adjusted/repared to eliminate the excessive air gap and ensure compliance with NFPA requirements (maximum 1/8-inch clearance). Repairs included: Adjustment of door alignment and hinges Replacement or adjustment of door sweeps/seals as needed Verification that the door fully closes and latches (if applicable) without impediment The door was tested after repair to ensure it effectively resists the passage of smoke. 2. How the facility will identify other areas affected		04/03/2026	

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K0374 SS = E	Continued from page 14 have a patterned impact on the residents within the facility. Findings include: On 03/10/2026 at 11:15 AM, it was revealed by observation that the 3rd Floor - smoke barrier door assemblies, exhibited an air-gap greater than 1/8 inch, which would allow the passage of smoke. An interview with the Maintenance Director verified this deficient finding at the time of discovery.			K0374	Continued from page 14 On April 2nd, 2026, the Maintenance Director (or designee) conducted a facility-wide inspection of all smoke barrier doors, including: Measurement of door gaps Verification of proper closing function Inspection of door hardware and seals Any additional deficiencies identified were corrected immediately. 3. Measures put in place to ensure the deficient practice does not recur The facility has implemented the following systemic changes: Monthly environmental rounds will include: Inspection of door gaps (ensuring "d 1/8 inch) Verification that doors close completely and are not obstructed The Maintenance Director (or designee) is responsible for: Routine inspection and maintenance Timely repair of any deficiencies 4. How the facility will monitor ongoing compliance The Administrator or designee will: Conduct monthly audits of smoke barrier doors for thirty (30) days Audits will verify:		

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K0374 SS = E				K0374	Continued from page 15 Proper door alignment and minimal gaps Doors close fully without obstruction No damage to door surfaces or frames Results will be reviewed through the Quality Assurance (QA/QAPI) Committee, with corrective action taken as needed 5. Completion Date Completion Date: April 3rd, 2026		04/15/2026
K0711 SS = C	Evacuation and Relocation Plan CFR(s): NFPA 101 Evacuation and Relocation Plan There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. Employees are periodically instructed and kept informed with their duties under the plan, and a copy of the plan is readily available with telephone operator or with security. The plan addresses the basic response required of staff per 18/19.7.2.1.2 and provides for all of the fire safety plan components per 18/19.2.2. 18.7.1.1 through 18.7.1.3, 18.7.2.1.2, 18.7.2.2, 18.7.2.3, 19.7.1.1 through 19.7.1.3, 19.7.2.1.2, 19.7.2.2, 19.7.2.3 This STANDARD is NOT MET as evidenced by: Based on a review of available documentation and staff interview, the facility failed to adopt an evacuation and relocation plan per NFPA 101 (2012 edition), Life Safety Code, sections 19.7.1.1. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 03/10/2026 between 09:30 AM to 1:30 PM, it was revealed by review of available documentation that the Emergency Action Plan / Emergency Operations Plan presented for review – identified that the Kitchen Range-Hood Fire Suppression System is of ANSUL type			K0711	1. How the deficient practice will be corrected On April 14th, 2026, the facility revised the Emergency Action Plan (EAP) / Emergency Operations Plan (EOP) to ensure accuracy and compliance with NFPA 101 requirements. Corrections included: Updating the kitchen fire suppression system description to accurately reflect a water-based sprinkler system (removal of incorrect ANSUL system reference) Updating the smoke compartment count to reflect the correct number (eight (8) compartments) per building floor plans The revised plan now accurately reflects the facility's layout, systems, and fire safety features. Updated plans have been distributed and made readily available to staff in required locations. 2. How the facility will identify other areas affected A comprehensive review of the entire Emergency Operations Plan was conducted to ensure: All building systems and fire protection features are accurately described		

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K0711 SS = C	Continued from page 16 system. The system protecting the commercial stove in the Kitchen is water-based - part of the sprinkler system. On 03/10/2026 between 09:30 AM to 1:30 PM, it was revealed by review of available documentation that the Emergency Action Plan / Emergency Operations Plan presented for review – identified that the structure contains a total of six (6) smoke compartments. The structure contains eight (8) – per building floor plan documentation. An interview with the Maintenance Director verified this deficient finding at the time of discovery.		K0711	Continued from page 16 Floor plans and compartmentation are correct Evacuation procedures align with the actual building configuration Any discrepancies identified were corrected immediately 3. Measures put in place to ensure the deficient practice does not recur The facility has implemented the following systemic changes: The Emergency Operations Plan will be reviewed at least annually and after any building/system changes A multidisciplinary review process (Administration, Maintenance, Nursing) has been established to ensure accuracy The Maintenance Director (or designee) will verify: Fire protection systems descriptions are accurate Smoke compartment layouts match current floor plans Staff have been educated on the updated evacuation and relocation procedures, including: Horizontal evacuation between smoke compartments Roles and responsibilities during emergencies Updated plans are maintained in readily accessible locations per regulatory requirements 4. How the facility will monitor ongoing compliance The Administrator or designee will: Review the Emergency Operations Plan annually and during QAPI meetings			

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K0711 SS = C				K0711	Continued from page 17 Fire drills and exercises will be used to: Validate staff understanding of evacuation procedures Ensure plans align with actual building layout Any identified issues will be addressed through the Quality Assurance (QA/QAPI) Committee 5. Completion Date Completion Date: May 15th, 2026		
K0712 SS = F	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This STANDARD is NOT MET as evidenced by: Based on a review of available documentation and staff interview, the facility failed to document and conduct fire drills per NFPA 101 (2012 edition), Life Safety Code, sections 4.7, 19.7.1. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 03/10/2026 between 09:30 AM to 1:30 PM, it was revealed by a review of available documentation that no documentation was available to confirm that fire drills were completed for: 1st shift in Q1 and Q2; 2sn shift in Q2 and Q3.			K0712	1. Corrective Action for Identified Deficiency Upon discovery, the facility immediately reviewed the fire drill schedule and documentation records. Missing fire drills for: 1st shift (Q1 and Q2) 2nd shift (Q2 and Q3) were identified. The facility conducted all overdue fire drills on to ensure compliance. 2. How Other Potentially Affected Areas Were Identified and Corrected An audit of all fire drill records for the previous 12 months was conducted by the Maintenance Director/designee to identify any additional gaps in compliance. Any missing or incomplete documentation was addressed, and all required fire drills were verified to be completed for each shift per quarter. No additional discrepancies were identified. 3. Measures Put in Place to Prevent Recurrence The facility has implemented the following measures: A fire drill schedule has been established to ensure		05/15/2026

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K0712 SS = F	Continued from page 18 An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K0712	Continued from page 18 drills are conducted quarterly on each shift, as required. The Maintenance Director (or designee) is responsible for scheduling, conducting, and documenting all drills. Education was provided to the Maintenance Director and applicable staff regarding fire drill requirements and documentation expectations under NFPA 101. 4. Monitoring Plan (Quality Assurance) The Maintenance Director or designee will review the fire drill log monthly to ensure drills are completed as scheduled. The Administrator (or designee) will conduct quarterly audits of fire drill documentation for completeness and compliance. Results will be reported to the facility's Quality Assurance and Performance Improvement (QAPI) committee quarterly. Any identified issues will be corrected immediately, and re-education will be provided as needed. 5. Completion Date All corrective actions were completed by: May 15th, 2026	
K0741 SS = F	Smoking Regulations CFR(s): NFPA 101 Smoking Regulations Smoking regulations shall be adopted and shall include not less than the following provisions: (1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking. (2) In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that	K0741	1. How the deficient practice will be corrected On, the facility immediately enforced its no-smoking policy on campus: The resident observed smoking at the entrance was educated and redirected to comply with facility policy The flowerpot used as a cigarette receptacle at the main entrance was removed immediately "No Smoking" signage was installed/reinforced at all main entrances and designated areas The facility smoking policy was:	05/15/2026

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K0741 SS = F	Continued from page 19 prohibits smoking shall not be required. (3) Smoking by patients classified as not responsible shall be prohibited. (4) The requirement of 18.7.4(3) shall not apply where the patient is under direct supervision. (5) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. (6) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted. 18.7.4, 19.7.4 This STANDARD is NOT MET as evidenced by: Based on observation, a review of available documentation and staff interview, the facility failed to maintain and have available for review the facility smoking policy per NFPA 101 (2012 edition), Life Safety Code, section 19.7.4. This deficient finding could have a widespread impact on the residents within the facility. Findings include:On 03/10/2026 between 09:30 AM to 1:30 PM, it was revealed by a review of available documentation that the facility has a smoking policy that prohibits on-campus smoking. On 03/10/2026 at 9:30 AM, it was observed at time of arrival for survey, a wheelchair resident was observed at the entrance door of the facility - smoking. On 03/10/2026 at 11:25 AM, it was revealed by observation that the flowerpot, located at the building entrance, is being used as a smoker cigarette butt receptacle. An interview with the Maintenance Director verified this deficient finding at the time of discovery.			K0741	Continued from page 19 Reviewed Updated (if needed for clarity and enforcement) To be reviewed at Resident Council in May 2. How the facility will identify other areas affected A facility-wide assessment was conducted to ensure: No unauthorized smoking areas exist No improper receptacles (e.g., flowerpots, containers) are being used All entrances and exterior areas were inspected to ensure compliance with the no-smoking policy Any additional concerns identified were corrected immediately 3. Measures put in place to ensure the deficient practice does not recur The facility has implemented the following systemic changes: The smoking policy has been reinforced and communicated to: All staff Residents Visitors Staff have been educated on enforcement responsibilities, including: Monitoring entrances and common areas Redirecting residents/visitors who attempt to smoke on campus to the designated smoking area on our campus		

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K0741 SS = F			K0741	Continued from page 20 The facility will ensure: Smoking is not permitted in prohibited areas Residents requiring supervision are managed per policy 4. How the facility will monitor ongoing compliance The Administrator or designee will: Conduct weekly audits of entrance areas for 4 weeks Monitoring will ensure: No evidence of smoking (e.g., cigarette butts, ash containers) Results will be reviewed through the Quality Assurance (QA/QAPI) Committee, with corrective action taken as needed 5. Completion Date Completion Date: May 15th, 2026			
K0761 SS = F	Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101 Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are maintained and are available for review.		K0761	How the deficient practice will be corrected On March 20th, 2026, the facility maintenance completed the annual inspection and testing of all fire door and smoke barrier door assemblies. The inspection included: Verification of door operation and closure Inspection of hinges, latching (if applicable), and hardware Assessment of door gaps and alignment Confirmation that doors are free of damage or impediments		03/20/2026	

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K0761 SS = F	Continued from page 21 19.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (2010 NFPA 80) This STANDARD is NOT MET as evidenced by: Based on a review of available documentation and staff interview, the facility failed to inspect and test doors per NFPA 101 (2012 edition), Life Safety Code, sections 19.2.2.2, 7.2.1.15 and NFPA 80 (2010 edition), sections 5.2.1. This deficient condition could have a widespread impact on the residents within the facility. Findings include: On 03/10/2026 between 09:30 AM to 1:30 PM, it was revealed by a review of available documentation that annual smoke / fire door inspection was last completed 02/27/2025. An interview with the Maintenance Director verified this deficient finding at the time of discovery.			K0761	Continued from page 21 Any deficiencies identified during inspection were repaired or scheduled for correction immediately Documentation of the completed inspection has been maintained on-site and is readily available 2. How the facility will identify other areas affected A facility-wide review of all door assemblies was conducted to ensure: All required fire and smoke barrier doors are included in the inspection program No additional doors were missed in prior inspections Documentation records were reviewed to confirm compliance with annual inspection requirements Any gaps in inspection or documentation were corrected immediately 3. Measures put in place to ensure the deficient practice does not recur The facility has implemented the following systemic changes: The Maintenance Director (or designee) is responsible for: Scheduling inspections Verifying completion Maintaining documentation Routine environmental rounds will include: Observation of door functionality (closing, latching, gaps) 4. How the facility will monitor ongoing compliance		

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K0761 SS = F				K0761	Continued from page 22 The Administrator or designee will: Review door inspection documentation when due March 2027 Monitoring will ensure: Annual inspections are completed on time Documentation is complete and accurate Deficiencies are corrected promptly Results will be reviewed through the Quality Assurance (QA/QAPI) Committee, with corrective action taken as needed 5. Completion Date Completion Date: March 20th, 2026		
K0781 SS = C	Portable Space Heaters CFR(s): NFPA 101 Portable Space Heaters Portable space heating devices shall be prohibited in all health care occupancies, except, unless used in nonsleeping staff and employee areas where the heating elements do not exceed 212 degrees Fahrenheit (100 degrees Celsius). 18.7.8, 19.7.8 This STANDARD is NOT MET as evidenced by: Based on a review of available documentation and staff interview, the facility failed to maintain a portable space heater policy NFPA 101 (2012 edition), Life Safety Code, section 19.7.8. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 03/10/2026 between 0930 AM to 1:30 PM, it was			K0781	1. How the deficient practice will be corrected On April 10th, 2026, the facility developed and implemented a Portable Space Heater Policy in accordance with NFPA 101 requirements. The policy includes: Prohibition of portable space heaters in all resident care and sleeping areas Allowable use only in non-sleeping staff areas, if applicable Requirements that any permitted heaters: Have heating elements not exceeding 212°F (100°C) Be UL-listed and in good working condition The policy has been made readily available on-site for staff and surveyor review.		05/15/2026

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K0781 SS = C	Continued from page 23 revealed by a review of available documentation that the facility portable space heater policy was unavailable for review. An interview with the Maintenance Director verified this deficient finding at the time of discovery.		K0781	Continued from page 23 2. How the facility will identify other areas affected A facility-wide sweep was conducted to ensure: No unauthorized portable space heaters are in use Any heaters present meet NFPA requirements Any non-compliant devices identified were removed immediately 3. Measures put in place to ensure the deficient practice does not recur The facility has implemented the following systemic changes: The Portable Space Heater Policy has been communicated to all staff Staff have been educated on restrictions, including: Prohibited areas Safe use requirements (if allowed in staff areas) The Maintenance Director (or designee) is responsible for: Approving any use of portable heaters Ensuring compliance with NFPA standards Routine environmental rounds will include: Monitoring for unauthorized heaters 4. How the facility will monitor ongoing compliance The Administrator or designee will:			

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K0781 SS = C				K0781	Continued from page 24 Conduct environmental audits for thirty (30) days Monitoring will ensure: No unauthorized heaters are present Policy is being followed Results will be reviewed through the Quality Assurance (QA/QAPI) Committee, with corrective actions implemented as needed 5. Completion Date Completion Date: May 15th, 2026		
K0914 SS = F	Electrical Systems - Maintenance and Testing CFR(s): NFPA 101 Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99) This STANDARD is NOT MET as evidenced by: Based on observation, a review of available documentation and staff interview, the facility failed			K0914	1. How the deficient practice will be corrected By April 30th, 2026, the facility will complete an electrical receptacle testing in all required resident care areas in accordance with NFPA 99. Testing included: Verification of grounding integrity Polarity testing Physical integrity of receptacles All deficiencies identified during the previous testing dated 03/03/2025 were: Reviewed Corrected, including repair or replacement of deficient outlets Documentation of: Current testing results		05/15/2026

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K0914 SS = F	Continued from page 25 maintain and test electrical receptacle(s) in resident rooms per NFPA 99 (2012 edition), Health Care Facilities Code, section(s) 6.3.3.2, 6.3.4, 6.3.4.1.3, 6.3.4.2. These deficient findings could have a widespread impact on the residents within the facility. Findings include:On 03/10/2026 between 0930 AM to 1:30 PM, it was revealed by review of available documentation that electrical outlet testing was last completed 03/03/2025. On 03/10/2026 between 0930 AM to 1:30 PM, it was revealed by review of available documentation that no documentation was presented for review to confirm that corrective action(s) had been completed associated to the deficiencies noted in the 03/03/2025 outlet testing record. An interview with the Maintenance Director verified these deficient findings at the time of discovery.		K0914	Continued from page 25 Completed corrective actions has been maintained on-site and is readily available for review 2. How the facility will identify other areas affected A facility-wide review of all receptacle testing records was conducted to ensure: Required testing intervals were met All identified deficiencies had documented corrective actions Any missing documentation or unresolved deficiencies were immediately addressed and corrected 3. Measures put in place to ensure the deficient practice does not recur The facility has implemented the following systemic changes: A preventive maintenance program (TELS) has been established to ensure: Annual testing of non-hospital-grade receptacles Testing of hospital-grade receptacles at required intervals The Maintenance Director (or designee) is responsible for: Scheduling testing Ensuring completion of repairs Maintaining documentation of all testing and corrective actions 4. How the facility will monitor ongoing compliance			

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K0914 SS = F			K0914	Continued from page 26 The Administrator or designee will: Review electrical testing documentation annually to ensure compliance Monitoring will ensure: Testing is completed within required timeframes All deficiencies have documented corrective actions Records are complete and readily available Results will be reviewed through the Quality Assurance (QA/QAPI) Committee, with corrective actions implemented as needed 5. Completion Date Completion Date: May 15th, 2026			
K0920 SS = D	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5		K0920	1. How the deficient practice will be corrected On April 2nd, 2026 the relocatable power tap (power strip) observed in Room 209 at the bed headwall was repositioned to ensure compliance with NFPA requirements. Medical devices were plugged directly into approved wall receptacles or into properly approved power strips, if applicable. The power strip was removed from the floor and repositioned in accordance with manufacturer guidelines and safety standards. The area was re-evaluated to ensure no further hazards or non-compliant usage existed. 2. How the facility will identify other areas affected A facility-wide inspection of all resident rooms and patient care areas was conducted to ensure:		05/15/2026	

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K0920 SS = D	Continued from page 27 This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to manage usage of electrical devices in accordance with NFPA 99 (2012 edition), Health Care Facilities Code, section 10.2.3.6, 10.2.4, 10.5.2.3 and NFPA 70, (2011 edition), National Electrical Code, sections 110.3(B), 400.8 (1) and UL 1363 / 1363A. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 03/10/2026 at between 11:20 AM, it was revealed by observation that in RM 209, in location of the bed headwall, that medical device(s) were connected to a relocatable power tap positioned on the floor. An interview with the Maintenance Director verified this deficient finding at the time of discovery.			K0920	Continued from page 27 No power strips are placed on the floor Power strips are used appropriately and only for allowed equipment No extension cords are used as permanent wiring Any additional non-compliant power strip or extension cord usage identified was corrected immediately 3. Measures put in place to ensure the deficient practice does not recur The facility has implemented the following systemic changes: A policy for power strip and extension cord usage has been implemented in accordance with NFPA 99 and NFPA 70 The policy includes: Proper use of relocatable power taps Prohibition of floor placement in patient care vicinity Restrictions on extension cord use The Maintenance Director (or designee) is responsible for: Monitoring compliance Approving appropriate equipment use Staff have been educated on proper electrical safety practices, including: Appropriate use of power strips Prohibited practices in resident care areas Routine environmental rounds will include: Monitoring for improper use of power strips and cords		

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K0920 SS = D			K0920	Continued from page 28 4. How the facility will monitor ongoing compliance The Administrator or designee will: Conduct monthly environmental audits for thirty (30) days Monitoring will ensure: Power strips are used appropriately No cords or strips are on the floor in patient care areas No extension cords are used improperly Results will be reviewed through the Quality Assurance (QA/QAPI) Committee, with corrective actions implemented as needed 5. Completion Date Completion Date: May 15th, 2026			
K0921 SS = F	Electrical Equipment - Testing and Maintenanc CFR(s): NFPA 101 Electrical Equipment - Testing and Maintenance Requirements The physical integrity, resistance, leakage current, and touch current tests for fixed and portable patient-care related electrical equipment (PCREE) is performed as required in 10.3. Testing intervals are established with policies and protocols. All PCREE used in patient care rooms is tested in accordance with 10.3.5.4 or 10.3.6 before being put into service and after any repair or modification. Any system consisting of several electrical appliances demonstrates compliance with NFPA 99 as a complete system. Service manuals, instructions, and procedures provided by the manufacturer include information as required by 10.5.3.1.1 and are considered in the development of a program for electrical equipment maintenance. Electrical equipment instructions and maintenance		K0921	1. How the deficient practice will be corrected By May 15th, 2026, the facility will have developed and implemented Patient Care-Related Electrical Equipment (PCREE) Testing and Maintenance Program in accordance with NFPA 99. The program includes: Testing of all PCREE prior to initial use and after any repair or modification Scheduled ongoing testing based on manufacturer recommendations and risk-based intervals Evaluation of: Physical integrity		05/15/2026	

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K0921 SS = F	Continued from page 29 manuals are readily available, and safety labels and condensed operating instructions on the appliance are legible. A record of electrical equipment tests, repairs, and modifications is maintained for a period of time to demonstrate compliance in accordance with the facility's policy. Personnel responsible for the testing, maintenance and use of electrical appliances receive continuous training. 10.3, 10.5.2.1, 10.5.2.1.2, 10.5.2.5, 10.5.3, 10.5.6, 10.5.8 This STANDARD is NOT MET as evidenced by: Based on a review of available documentation and staff interview, the facility failed initiate an electrical equipment – testing and maintenance program in accordance with NFPA 99 (2012 edition), Health Care Facilities Code, section 10.3, 10.5.2.1, 10.5.2.1.2, 10.5.2.5, 10.5.3, 10.5.6, 10.5.8. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 03/10/2026 between 0930 AM to 1:30 PM, it was revealed by a review of available documentation that no documentation was presented to confirm that a PCREE program is in place. An interview with the Maintenance Director verified this deficient finding at the time of discovery.			K0921	Continued from page 29 Grounding resistance Leakage current and touch current A complete inventory of all PCREE will be conducted, and all equipment: Tested Labeled to indicate compliance status Documentation of testing and corrective actions is maintained on-site and readily available 2. How the facility will identify other areas affected A facility-wide inventory and assessment of all electrical equipment used in patient care areas was conducted to ensure: All applicable equipment is included in the program No equipment was previously omitted from testing Any equipment identified as not tested or out of compliance will be removed from service until tested and approved 3. Measures put in place to ensure the deficient practice does not recur The facility has implemented the following systemic changes: The Maintenance Director (or designee) is responsible for: Maintaining the equipment inventory Scheduling and ensuring completion of testing Maintaining all records of testing, repairs, and modifications		

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K0921 SS = F				K0921	Continued from page 30 Manufacturer guidelines are incorporated into maintenance procedures Preventative maintenance program- TELS Service manuals and instructions are maintained and accessible 4. How the facility will monitor ongoing compliance The Administrator or designee will: Review PCREE program documentation annually for compliance Monitoring will ensure: Equipment is tested per required intervals Documentation is complete and accurate Deficient equipment is removed from service and repaired timely Results will be reviewed through the Quality Assurance (QA/QAPI) Committee, with corrective actions implemented as needed 5. Completion Date Completion Date: May 15th, 2026		
K0923 SS = F	Gas Equipment - Cylinder and Container Storag CFR(s): NFPA 101 Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or			K0923	1. How the deficient practice will be corrected On April 6th, the 1st Floor Medical Gas (O ,) Storage Room was reorganized to ensure proper storage and segregation of cylinders. Corrections included: Establishing clearly designated and labeled areas for: Full cylinders		04/06/2026

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K0923 SS = F	Continued from page 31 within an enclosed interior space of non- or limited-combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to maintain proper medical gas storage and management per NFPA 99 (2012 edition), Health Care Facilities Code, sections 11.6.5. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 03/10/2026 at 11:25 AM, it was revealed by observation that the 1st Floor - Med Gas (O2) Storage Room, had no identifiable location for placement / storage of full cylinders. An interview with the Maintenance Director verified this deficient finding at the time of discovery.		K0923	Continued from page 31 Empty cylinders Installation of appropriate racks, chains, or securing devices to prevent tipping Implementation of a labeling system to clearly identify full vs. empty cylinders Signage was installed on the storage room door stating: “CAUTION: OXIDIZING GAS(ES) STORED WITHIN – NO SMOKING” The storage area was reviewed to ensure compliance with NFPA 99 requirements. 2. How the facility will identify other areas affected A facility-wide inspection of all medical gas storage locations was conducted to ensure: Proper segregation of full and empty cylinders Cylinders are secured and properly stored Required signage is present Any additional deficiencies identified were corrected immediately 3. Measures put in place to ensure the deficient practice does not recur The facility has implemented the following systemic changes: A medical gas storage policy has been developed/updated in accordance with NFPA 99 The policy includes: Proper segregation and labeling of cylinders			

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K0923 SS = F			K0923	Continued from page 32 Safe storage practices and securing methods Inventory rotation (first-in, first-out) The Maintenance Director (or designee) is responsible for: Monitoring compliance with storage requirements Ensuring proper organization of storage areas Routine environmental rounds will include: Inspection of cylinder storage areas for compliance 4. How the facility will monitor ongoing compliance The Administrator or designee will: Conduct audits for the next thirty (30) days Monitoring will ensure: Full and empty cylinders are clearly separated and labeled Cylinders are secured properly Required signage is present Results will be reviewed through the Quality Assurance (QA/QAPI) Committee, with corrective actions implemented as needed 5. Completion Date Completion Date: Apri 6th, 2026			
K0926 SS = F Bldg. 01	Gas Equipment - Qualifications and Training CFR(s): NFPA 101 Gas Equipment - Qualifications and Training of		K0926	1. How the deficient practice will be corrected The facility has set up a Medical Gas Training Program for all staff responsible for handling, storage, and		05/15/2026	

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K0926 SS = F Bldg. 01	Continued from page 33 Personnel Personnel concerned with the application, maintenance and handling of medical gases and cylinders are trained on the risk. Facilities provide continuing education, including safety guidelines and usage requirements. Equipment is serviced only by personnel trained in the maintenance and operation of equipment. 11.5.2.1 (NFPA 99) This STANDARD is NOT MET as evidenced by: Based on review of available documentation and staff interview, the facility failed to provide documentation of education and staff training per NFPA 99 (2012 edition), Health Care Facilities Code, sections 11.5.2.1, 11.5.2.1.1, 11.5.2.1.2, 11.5.2.1.3 This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 03/10/2026 between 09:30 AM to 1:30 PM, it was revealed by a review of available documentation that no documentation presented for review to confirm that staff are receiving initial and continuing education on safety / risks associated with of Med Gas (O2) – Liquid Oxygen (LOX) cylinders and transfill. An interview with the Maintenance Director verified this deficient finding at the time of discovery.		K0926	Continued from page 33 maintenance of medical gas systems (including O , and Liquid Oxygen (LOX) systems). Training included: Safe handling and storage of oxygen cylinders Risks associated with oxidizing gases Proper use of transfill systems Emergency procedures related to medical gas systems All applicable staff received initial training, and documentation of completion has been maintained on-site and is readily available for review. 2. How the facility will identify other areas affected A review of all staff roles and responsibilities was conducted to identify: Personnel involved in medical gas handling, storage, or maintenance Training records were reviewed to ensure: All applicable staff have documented initial and ongoing education 3. Measures put in place to ensure the deficient practice does not recur The facility has implemented the following systemic changes: A formal medical gas training policy and program has been established in accordance with NFPA 99 The program includes: Initial training upon hire or assignment Annual refresher training			

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K0926 SS = F Bldg. 01				K0926	Continued from page 34 Documentation of all training activities The Maintenance Director (or designee) is responsible for: Ensuring staff are trained prior to performing related duties Maintaining training records Only qualified and trained personnel are permitted to: Handle medical gas systems Perform maintenance or transfill operations Staff have been educated on safety protocols and risks associated with medical gases 4. How the facility will monitor ongoing compliance The Administrator or designee will: Review medical gas training records for the next 30 days Monitoring will ensure: All applicable staff have completed required training Training is current and documented Results will be reviewed through the Quality Assurance (QA/QAPI) Committee, with corrective actions implemented as needed 5. Completion Date Completion Date: May 15th, 2026		

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E0000	Initial Comments On 3/9/26-3/12/26, 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			04/17/2026	
F0000	INITIAL COMMENTS On 3/9/26-3/12/26, 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:H51847801C (2793857), H51847942C (2612067), H51847874C (MN00111412/1073210), H51847875C (MN00111170/1073209), H51847973C (MN00112661/1073214), H51848020C (2796479). NO deficiencies were cited. 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			04/17/2026	
F0554 SS = D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by		F0554	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: R4 had self-administration of medication assessment		05/18/2026	

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
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F0554 SS = D	Continued from page 1 §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and record review, the facility failed to ensure residents were assessed to self-administer medications for 1 of 1 resident (R4) reviewed for self-administration of medication (SAM). Findings include: R4's quarterly Minimum Data Set (MDS) assessment, dated 2/23/26 indicated R4 was cognitively intact, had no upper body impairment, was independent with personal hygiene, and required set-up to supervision for upper and lower body dressing. R4's diagnoses list included diabetes, end-stage kidney disease, heart failure, and morbid obesity. R4's self-administration care plan dated 11/20/25 lacked self-administration of nystatin powder (medication used to treat fungal infections). R4's provider orders included: Nystatin powder 1 application to affected areas under right breast and skin folds topically twice a day and as needed. R4's medical record lacked a self-administration assessment for applying Nystatin powder. During observation and interview on 3/10/26 at 3:45 p.m., R4 stated she keeps her nystatin powder locked up in the canvas bag located on her bed. During interview on 3/11/26 at 9:43 a.m., licensed practical nurse (LPN)-A stated R4 administers own injections and completes blood sugar check with nursing supervision and performs her own vitals. LPN-A stated R4 refuses the nystatin powder however it is kept in the medication cart. LPN-A looked in the medication and treatment cart however could not find R4's nystatin powder. During observation and interview on 3/11/25 at 10:12 a.m., R4 indicated she puts the nystatin powder on herself twice a day. R4 stated she feels the area under her abdomen has improved however confirmed she is unable to see what the area looks like. R4 opened the locked canvas bag on her bed that contained a bottle of nystatin powder dated November of 2025. R4 stated she likes that particular bottle because it is easier to use. When she runs out, she has the nursing staff order	F0554	Continued from page 1 completed on 4/30/2026. IDT reviewed results of assessment and resident was deemed safe to self-administer medication (Nystatin) MD was notified of assessment results and order was obtained for resident to self-administer Nystatin on 4/30/2026 How will you identify other residents having potential to be affected by the same deficient practice and what corrective action will be taken: All residents have the potential to be affected Ad-Hoc resident council was held on 4/30/2026 with self-administration of medication policy reviewed with residents An audit was completed of resident rooms to determine if residents had medications at bedside – any found to have medications stored at bedside had self – administration of medication assessment completed and reviewed with IDT. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur; and: Education was initiated by DON/Designee with licensed clinical staff on self-administration of medication policy and medication administration policy was initiated on 3/26/2026 by DON with all staff being licensed clinical staff being educated by 4/24/2026 anyone not being educated by (DATE) will not be allowed to work until they receive education Random audits will be conducted on 5 rooms weekly x 8 weeks or until substantial compliance is met to ensure medications aren't stored at bedside. Describe the Quality Assurance and Process Improvement Program that will be put into place. QAPI was held on 4/28/2026 to review results of survey and approve the plan of correction. Results of audits will be reviewed at QAPI meeting monthly x 3 months or until substantial compliance is maintained	

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F0554 SS = D	Continued from page 2 a new bottle and dump the contents of the new bottle into the bottle she likes. R4 stated the nurses do not offer to put the nystatin powder on. During observation and interview on 3/11/26 at 11:05 a.m., LPN-A arrived to perform R4's dressing change. After the dressing change, LPN-A asked permission to wash under R4's abdominal folds and apply the nystatin powder. R4 stated "then I'll have to unlock my bag" and proceeded to unlock her canvas bag and hand the nystatin powder to LPN-A. LPN-A then washed and dried under R4's abdomen, applied the nystatin powder, and handed the powder back to R4 to lock in her bag. After leaving the room, LPN-A stated R4 has never allowed her to wash the area or apply the nystatin powder. When asked if R4 keeps the nystatin powder in her room, LPN-A stated "I'm going to say yes since I couldn't find it in the cart." LPN-A stated residents who want to self-administer a medication are "assessed for it" and "have to have something in the orders or care plan." LPN-A stated she has never done a self-administration assessment for R4. During an interview on 3/11/26 at 3:18 p.m., registered nurse (RN)-A stated a self-administration assessment is performed to determine a resident is able to safely administer medications. The assessment involves resident's ability to identify what the medication is, what it is for, and the correct dosage. Residents also must be able to demonstrate safe storage of the medication and have the manual dexterity to administer the medication safely. When the assessment is completed the nursing staff, director of nursing, and nurse practitioner meet to discuss if self-administration is appropriate. If the resident is deemed appropriate, the medical provider or nurse practitioner will sign off allow the resident to administer the medication. RN-A stated there was a time R4 was able to administer a lot of the prescribed medications however the facility has "dialed back" what R4 is allowed to do as they were finding oral medications on the floor. Currently R4 is able to check blood sugar and administer some injectable medications with staff set up and supervision as well as independently administer inhaled medications. RN-A verified R4 did not have a self-administration assessment completed for the nystatin powder. During an interview on 3/12/26 at 9:31 a.m., the director of nursing stated self-administration assessments are required to determine if a resident is able to determine the purpose of safely administering, and store medications.		F0554	Continued from page 2 Facility alleges substantial compliance on 5/18/2026			

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F0554 SS = D	Continued from page 3 A policy titled Resident Self-Administration of Medication revised January 2026 indicated "A resident may only self-administer medications after the facility's interdisciplinary team has determined which medications may be self-administered safely."	F0554		
F0580 SS = D	Notify of Changes (Injury/Delirium/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the	F0580	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Skin check was completed on R4 by (PERSON) on (DATE) with no adverse finding noted. R4 MD notified of findings from skin check and R4 documented refusals with order obtained to DC Nystatin on 4/30/2026 How will you identify other residents having potential to be affected by the same deficient practice and what corrective action will be taken: All residents have the potential to be affected An audit was completed on 4/30/2026 by DON/Designee for refused medications in last 30 days with MD notified of refusals Education was provided by the Regional Clinical Consultant on 4/22/2026 with the IDT on the Medication Administration policy with instruction on expectations when resident refuses medication. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur; and: Education with licensed clinical staff on the Medication Administration policy with instruction on expectations when resident refuses medication was initiated on 3/26/2026 by the DON/Designee with all licensed clinical staff being educated by end of business on 4/24/2026 with any staff not receiving education by 4/24/2026 not being allowed to work until they receive education. The medication not administered report will be reviewed Monday – Friday as part of the daily clinical standup to ensure refusals have appropriate follow up with anything occurring on the weekend being reviewed on the	05/18/2026

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F0580 SS = D	Continued from page 4 resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and record review, the facility failed to update the provider timely of ordered medication refusals for 2 of 2 residents (R4, R44) reviewed for medication administration. Findings include: R4: R4's face sheet indicates R4 was readmitted to the facility on 11/17/25 after a 12-day hospital stay for a below the knee amputation. R4's quarterly Minimum Data Set (MDS) assessment, dated 2/23/26, indicated R4 was cognitively intact, had no upper body impairment, was independent with personal hygiene, and required set-up to supervision for upper and lower body dressing. R4's diagnoses list included diabetes, end-stage kidney disease, heart failure, and morbid obesity. R4's care plan indicated R4 is resistive/noncompliant with treatments/cares related to manipulative behaviors, loss of independence and control with a goal of understanding the consequences of refusal/noncompliance. R4's provider orders dated 11/18/25 indicated: Nystatin powder (medication used to treat fungal infections) 1 application to affected areas under right breast and skin folds topically twice a day and as needed. R4's medication administration record (MAR) indicated the following refusals of the Nystatin powder: Nov. 2025: 21 of 26 possible administrations			F0580	Continued from page 4 Monday following the weekend. Describe the Quality Assurance and Process Improvement Program that will be put into place. QAPI was held on 4/28/2026 to review results of survey and approve the plan of correction. Results of audits will be reviewed at QAPI meeting monthly x 3 months or until substantial compliance is maintained Facility alleges substantial compliance on 5/18/2026		

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F0580 SS = D	Continued from page 5 Dec. 2025: 54 of 62 possible administrations Jan. 2026: 49 of 62 possible administrations Feb. 2026: 43 of 56 possible administrations During an interview on 3/11/26 at 9:43 a.m., licensed practical nurse (LPN)-A stated R4 "has yet to allow me to put it [nystatin powder] on her". During an observation and interview on 3/11/26 at 11:05 a.m., LPN-A entered R4's room to perform a dressing change. After performing the dressing change, R4 allowed LPN-A to wash under her abdominal folds and apply the nystatin powder R4 kept in a locked bag on her bed. Upon leaving R4's room, LPN-A stated R4 has never allowed her to wash under the abdominal folds and apply the powder. LPN-A stated R4's abdominal folds looked "a little red" and "did not look like it had any powder on it." During an interview on 3/11/26 at 2:52 p.m., the facility nurse practitioner stated R4 has a history of refusing medications and treatments however was not notified R4 has consistently refused the nystatin powder since November 2025. The nurse practitioner stated she would expect to be notified so she can speak to the resident about the refusal and have an interdisciplinary team meeting regarding the refusal. During an interview on 3/11/26 at 3:01 p.m., registered nurse (RN)-G stated if a resident consistently refuses a medication or treatment, the clinical manager is notified. RN-G would also notify the provider if they were in the facility to speak to the resident about either discontinuing the order or changing it to "as needed". During an interview on 3/11/26 at 3:18 p.m., RN-A stated residents who consistently refuse a medication/treatment are educated why the medication is important and what may happen they continue to refuse it. If the resident still refuses, the provider is notified and asked to discontinue the order. RN-A stated she was not aware R4 was consistently refusing the nystatin powder therefore she was "guessing they didn't notify" the provider either. During an interview on 3/12/26 at 8:39 a.m., licensed practical nurse (LPN)-B stated if a resident consistently refuses a medication or treatment, she would let the clinical manager know and send a message to the provider. LPN-A stated R4 is known to refuse		F0580				

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F0580 SS = D	Continued from page 6 treatments, medications, and cares when offered, preferring to do things on "her time". LPN-A stated R4 refuses to allow nursing staff to put on nystatin powder. During an interview on 3/12/26 at 9:31 a.m., the director of nursing stated if a resident consistently refuses a medication/treatment, the provider is updated so order can be discontinued so the staff are not consistently documenting refusals. The director of nursing stated the provider was notified of the refusals February 2026. Documentation provided by the director of nursing indicated notification sent to the provider on 2/20/26 of R4 refusing all medications and treatments specifically on 2/20/26. The documentation provided also indicated on 2/28/26 communication was sent to the provider regarding R4 refusing the treatment to her surgical wound. Neither notification mentioned R4 had consistently refused the nystatin powder since November 2025. R44: R44's Admission MDS assessment, dated 2/20/26, indicated intact cognition, R44 required partial/moderate assistance with toileting hygiene. R44's diagnoses included chronic respiratory failure with hypoxia, dependence on supplemental oxygen, acute kidney failure, hypertensive heart and chronic kidney disease with heart failure, Type2 diabetes mellitus, Chronic Pulmonary edema, moderate persistent asthma, dependence of renal dialysis. R44's was admitted On 02/5/26 and orders dated 2/05/25 included: oxygen 2 liters via nasal cannula continuously. During observation on 03/10/26 11:11 a.m., R44 came down the unit hallway on her motorized scooter with no oxygen in use. R44 stated, the portable oxygen tank was empty and was in search of staff to have the tank filled. The director of nursing (DON) filled in the portable oxygen tank for R44 at 11:115 a.m. R44 took the oxygen tank from the DON and passed RN-B in the hallway and went back to her room with no oxygen in use. During observation on 03/10/26 11:23 a.m., and 11:28 a.m., oxygen tank was filled but not in used by R44.	F0580		

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F0580 SS = D	Continued from page 7 During an interview on 03/10/26 1:38 p.m., RN-B stated they had seen R44 at times with no oxygen in use, was not sure if R44 oxygen order was continuous or as needed and had told R44 at times to put the oxygen back on. During an interview on 03/10/26 2:28 p.m., the DON stated they had seen R44 with no oxygen in use. DON stated R44 declined oxygen use and stated, "I don't need it", when DON had offered to turn on the portable oxygen tank after the tank was filled. DON also stated, "I have never seen her with her oxygen in use". R44's oxygen order of 2 liters via nasal cannula continuous was communicated to DON and DON stated, "I will call the provider to get an order to wean her off oxygen". Based on communication with R44's primary care provider, medical doctor (MD) on 03/12/26 at 2:00 p.m., MD expected the facility to have sent an SBAR (situation, background, assessment, recommendation) and an updated vital sign for ongoing need for supplemental oxygen. Review of an undated facility policy titled, Notification of changes, indicates, circumstances requiring notification include Circumstances that require a need to alter treatment.		F0580				
F0584 SS = E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft.		F0584	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Staff working 3/9/2026 7/3 on 3rd floor were provided education on the Serving a Meal policy on 4/30/2026 by DON/Designee Staff working 3/9/2026 3/11 on 2nd floor were provided education on the Servings a Meal Policy on 4/30/2026 by DON/Designee Staff working 3/10/2026 7/3 shift on 3rd floor were provided education on the Serving a Meal Policy on 4/30/2026 by DON/Designee Staff working 3/11/2026 7/3 shift on 3/11/2026 on 3rd floor were provided education on the Serving a Meal policy on 4/30/2026 by DON/Designee How will you identify other residents having potential to be affected by the same deficient practice and what corrective action will be taken:		05/18/2026	

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F0584 SS = E	Continued from page 8 §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interviews, and document review, the facility failed to provide a home like dining experience in 2 dining rooms when meals were left served to residents on a plastic food tray. Findings include: During an observation on 3/9/26 at 12:44p.m., of the 3rd floor dining room, lunch trays were brought up in a cart, the staff passed out the trays and left food items on plastic trays in front of residents. During an observation on 3/9/26 at 6:03p.m., of the 2nd floor dining room, dinner trays were brought up in a cart, the staff passed out the trays and left food items on plastic trays in front of the residents. During observation on 3/10/26 at 12:33 p.m., of the 3rd floor dining room, lunch trays were brought up in a cart, the staff passed out the trays to the residents and left food items on the plastic trays. During observation on 3/11/26 at 8:48 a.m., of the 3rd floor dining room, breakfast trays were brought up in a cart, staff passed out the trays and left food items on	F0584	Continued from page 8 All residents have the potential to be affected Education was provided to the IDT on 4/22/2026 by Regional Clinical Consultant on the Serving a Meal Policy What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur; and: Education was initiated on 3/26/2026 by DON/Designee on the Serving a Meal policy with clinical staff with all clinical staff receiving education by 4/24/2024 not being allowed to work until receiving education Random audits will be conducted on meal service to ensure meals are not being served on a tray to residents 3/week for 8 weeks or until substantial compliance is obtained Describe the Quality Assurance and Process Improvement Program that will be put into place. QAPI was held on 4/28/2026 to review results of survey and approve the plan of correction. Results of audits will be reviewed at QAPI meeting monthly x 3 months or until substantial compliance is maintained Facility alleges substantial compliance on 5/18/2026	

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F0584 SS = E	Continued from page 9 the plastic trays in front of the residents. During an interview on 3/10/26 at 1:15p.m. licensed practical nurse (LPN)-A stated the residents had always been served their food on the trays and placed in front of them. During interview on 3/11/26 at 9:00a.m., certified nursing assistant (can)-F stated the residents had always had their food served on trays and placed in front of them. During interview on 3/11/26 at 10:00 a.m., R40 stated he would like the meals served on time, and not on trays and added it was not home. During interview on 3/11/26 at 11:00a.m., R45 stated feeling like the dining experience was being in school in a juvenile setting when the food is set in from of us on trays during mealtime. In addition, the staff place the hot foods next to the cold foods on the tray. R45 indicated asking staff to separate the food. A policy entitled, Serving a Meal dated 3/23, included to serve nutritional meals that met the needs of the residents. Additionally, arrange the dishes and silverware so the residents can reach them easily. It was often helpful to take dishes off tray.	F0584		
F0655 SS = D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders.	F0655	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: R77 had a baseline care plan provided to him on 4/30/2026 by MDS director How will you identify other residents having potential to be affected by the same deficient practice and what corrective action will be taken: All new admissions have the potential to be affected Education was provided to the IDT on the Baseline Care Plan policy by the Regional Clinical Consultant on 4/22/2026 An audit was conducted by DON/Designee on admissions for the past 30 days to ensure a baseline care plan was developed and provided to the resident per the regulations	05/18/2026

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F0655 SS = D	Continued from page 10 (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to complete baseline care plan within 48 hours of admission for 1 of 1 resident (R77) reviewed for care plans. Findings include: R77's admission Minimum Data Set (MDS) assessment was not available at time of survey. A facility document title Nursing-Admissions/Readmission Observation dated 3/5/26, noted R77 was alert and oriented to person, place, time, and situation. R77's cognition was intact. R77 requires transfer assistance, assistance with activities of daily living (ADL), and assistance		F0655	Continued from page 10 What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur; and: Education was initiated on 3/26/2026 with licensed clinical staff by DON/Designee on the Baseline Care Plan policy with all licensed clinical staff receiving education by 4/24/2026 with any licensed clinical staff not receiving education by 4/24/2026 not being allowed to work until education is received. New admission charts will be reviewed Monday – Friday as part of the daily clinical standup process with any weekend admissions being reviewed on the following Monday to ensure the baseline care plan policy has been followed. Describe the Quality Assurance and Process Improvement Program that will be put into place. QAPI was held on 4/28/2026 to review results of survey and approve the plan of correction. Results of audits will be reviewed at QAPI meeting monthly x 3 months or until substantial compliance is maintained Facility alleges substantial compliance on 5/18/2026			

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F0655 SS = D	Continued from page 11 managing new colostomy, (a surgical opening in the colon that allows stool to e xit the body through a stoma into an external pouch). R77's diagnoses included intestinal obstruction requiring a new colostomy, Parkinson's, urinary retention, and generalized muscle weakness. R77's electronic health record (EHR) indicated R77 was admitted to the facility on 3/5/26 at approximately 2 p.m. EHR lacked evidence a baseline care plan had been initiated within 48 hours of admission. During an interview on 3/10/26 at 1:49 p.m., physician assistant (PA)-A stated it is his expectation that the baseline care plan be created in the first 48 hours after admission. PA-A stated the baseline care plan is important, so staff know how to provide basic cares such as hygiene, ambulation, skin concerns, fall interventions, and any resident-specific concerns. PA-A stated the baseline care plan for R77 was especially important due to the complexity of his hospital stay prior to admission to facility. During an interview on 3/10/26 at 2:00 p.m., director of nursing (DON) stated the process for admitting a resident included: the health unit coordinator (HUC) transcribed admission orders based on the hospital dismissal summary or after visit summary the facility received, a nurse reviewing those orders, and loading the orders into the medication admission record (MAR) and treatment admission record (TAR) in the EMR. Additionally, the nurse would enter a baseline care plan based on those orders. The comprehensive care plan would be completed after the facility could evaluate all areas of resident care in the coming weeks. The DON stated the HUC had transcribed the orders, however, the nurse had not reviewed the orders and uploaded the orders to the MAR and TAR and no baseline care plan was completed. The DON stated the baseline care plan is important so staff can care for the residents' basic needs, establish likes and dislikes, and make sure the residents are safe. An undated facility policy titled Baseline Care Plan, the baseline care plan will be developed within 48 hours of a resident's admission.		F0655				
F0657 SS = D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans		F0657	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: R33 smoking care plan was updated by the MDS		05/18/2026	

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F0657 SS = D	Continued from page 12 §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 document review, the facility failed to revise and update a care plan for 1of 1 resident (R33) reviewed for care plan timing and revision. Findings include: R33's Minimum Data Set (MDS) assessment, dated 12/3/25, /indicated intact cognition, /R33 /was independent with transfers, w/c mobility and required limited assist with bed mobility. R33 's diagnoses included chronic systolic and diastolic (congestive) heart failure (a serious condition of the heart's ability to pump blood efficiently), Chronic obstructive pulmonary diseases (an ongoing lung condition caused by damage to the lungs), generalized osteoarthritis. R33's care plan dated 11/19/25 indicated R33 was allowed to smoke independently in designated smoking			F0657	Continued from page 12 coordinator on 4/30/2026 to reflect the recommendations of the smoking assessment with those recommendations flowing to the resident Kardex R33 TAR was updated on 4/30/2026 for nursing staff to retrieve smoking paraphernalia and keep secured at nurses station. R33 was educated on the Smoking Policy and requirement to follow the recommendations from her Safe Smoking Assessment to continue smoking. How will you identify other residents having potential to be affected by the same deficient practice and what corrective action will be taken: All residents who smoke are at risk A Safe Smoking Assessment was completed on all residents who smoke with care plan, Kardex, and TARs updated appropriately Education was provided to all residents who smoke on the facility policy and the requirement to follow the policy and recommendations from the safe smoking assessments to continue to be allowed to smoke. An Ad Hoc resident council meeting was held on 4/30/2026 to review the smoking policy What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur; and: Education was initiated with the clinical staff on the Smoking Policy and the need to complete Safe Smoking Assessments on all individuals who smoke and maintain possession of all smoking paraphernalia except when resident is smoking by the DON on 3/26/2026 with all staff receiving education by 4/24/2026 any staff not receiving education by 4/24/2026 will not be allowed to work until education is received. Residents who smoke will be reviewed weekly as part of the weekly At Risk meeting to ensure that care plan is accurate and residents are compliant with the recommendations and facility policy. A care conference will be scheduled for any resident found not to be compliant with the recommendations and policy.		

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F0657 SS = D	Continued from page 13 areas, needed reminders and assistance to use smoking apron, and smoking materials needed to be secured at the nurses' station or other designated areas for storage. R33's Smoking Assessment completed on 2/20/26, indicated R33 was safe to smoke without supervision, demonstrated safe smoking practices, no indication of smoking apron use, and facility stored lighter and cigarettes. R33's care plan was not updated to reflect the changes noted in the 2/20/26 smoking assessment. R33's MAR/TAR (medications administration/ treatments administration record) dated 3/10/26 lacked smoking assessment recommendations/interventions. R33's Task Description list (task assigned to nursing assistants) dated 3/1/26 lacked smoking tasks. During an observation on 3/9/26 at 6:46 p.m., R33 took her smoking materials from her room and continued to go out to the designated smoking area. R33 did not use a smoking apron. R33 demonstrated safe smoking practices. During an interview on 3/09/26 3:03 p.m., R33 stated, she kept her smoking materials locked in her room, smoked 1-2 cigarettes a day, and reported no smoking apron use while smoking. During an interview 3/10/26 10:49 a.m., registered nurse (RN-B) stated was not sure if R33 went out to smoke or was getting some fresh air. RN-B stated, "that information will be on the MAR/TAR, and a staff member would have been assigned to R33, if R33 was a smoker". During an interview on 3/10/26 11:20 a.m., nursing assistant (NA-E)stated, R33 used to smoke, and had not seen R33 smoke today. NA-E stated, "I will ask the nurse, the DON or look at Task Description list". During an interview on 3/10/26 at 2:27 p.m., the director of nursing (DON), explained the process of assessment to care planning and updates. DON stated, "after the Smoking Assessment was completed, nursing was responsible for updating the care plan, staff was notified, and information was available on the Task List and in the care plan. DON stated, "no point of care notification is sent out to notify staff of updates, staff are expected to review care plan for updates". During an interview on 3/12/26 at 8:45 a.m., DON		F0657	Continued from page 13 Describe the Quality Assurance and Process Improvement Program that will be put into place. QAPI was held on 4/28/20526 to review results of survey and approve the plan of correction. Results of audits will be reviewed at QAPI meeting monthly x 3 months or until substantial compliance is maintained Facility alleges substantial compliance on 5/18/2026			

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F0657 SS = D	Continued from page 14 stated, R33 stored smoking materials in her room, R33 was safe to smoke independently and R33 needed no smoking apron.	F0657		
F0658 SS = D	Facility policy on care plan revision and update requested and not provided. Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review the facility failed to provide professional standards of practice when staff completed treatments without a provider order, failed to request orders for treatment, and failed to document treatment completion for 1 of 1 resident (R77) reviewed for ostomy cares. Findings Include: R77's admission Minimum Data Set (MDS) assessment was not available at time of survey. A facility document title Nursing-Admissions/Readmission Observation dated 3/5/26, noted R77 was alert and oriented to person, place, time, and situation. R77's cognition was intact. R77 requires transfer assistance, assistance with activities of daily living (ADL), and assistance managing new colostomy (a surgical procedure that creates an opening (stoma) in the abdomen, allowing stool to exit the body when the colon cannot function normally),. R77's diagnoses included intestinal obstruction requiring a new colostomy, Parkinson's, urinary retention, and generalized muscle weakness R77's care plan dated 3/6/26, lacked direction or interventions of how to care for the colostomy. R77's admission orders included empty bag every shift and record amount; the admission orders and baseline care plan lacked specific appliance change instructions (i.e., bag type, bag size, skin protectants, skin barriers, and bag removal).	F0658	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: MD of R77 was contacted orders were received on 4/30/2026 to reflect instructions on colostomy changes LPN-A was provided education by DON/Designee on the standards of practice that we do not provide medical services without an order How will you identify other residents having potential to be affected by the same deficient practice and what corrective action will be taken: All residents with colostomy have the potential to be affected Education was provided to the IDT on 4/22/2026 by the Regional Clinical Consultant on the expectations that we ensure that residents have appropriate orders and that services aren't provided without a physician order An audit was conducted on 4/30/2026 to ensure that all residents with colostomy have appropriate orders and care plans by DON/Designee What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur; and: Education was initiated on 3/26/2026 by DON/Designee with licensed clinical staff on the need to obtain physician orders prior to providing a medical treatment with all licensed clinical staff being educated by 4/24/2026 any resident not receiving education by 4/24/2026 not being allowed to work until education is received All admission and readmission charts will be reviewed Monday – Friday as part of the daily clinical standup with any admissions/readmissions being reviewed on the	05/18/2026

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F0658 SS = D	Continued from page 15 During observation on 3/9/26 at 2:11 p.m., R77 was waiting in his room for facility staff to assist him to the bathroom; while waiting R77 pulled off the colostomy bag and tossed it into the garbage can in his room. Facility staff arrived, closed room door, and assisted resident with changing his clothing and applying a new colostomy bag. According to the American Nurses Association (ANA) an RN's scope of practice is to implement orders, not to create them. The authority to create orders rests with authorized prescribers like physicians and nurse practitioners. Further, RN's need a provider's order to provide medical treatment, such as colostomy site care. During an interview on 3/10/26 at 10:37 a.m., licensed practical nurse (LPN)-A stated R77's colostomy care information should be in his admission orders or his baseline care plan. LPN-A confirmed R77 did not have colostomy care orders and did not have a colostomy care plan. LPN-A stated since the colostomy care information was not in the orders or care plan, she would look at R77's hospital dismissal instructions to verify what colostomy supplies R77 required. LPN-A stated she was unsure what colostomy supplies were used for R77's current colostomy bag. LPN-A stated the last colostomy bag change was not documented appropriately because the colostomy orders had not been entered so staff would not have a place to chart the colostomy bag change. LPN-A stated staff could have also done a progress note to document the last colostomy bag change; LPN-A verified this was also not completed. LPN-A stated staff should have requested a provider order after changing the colostomy bag; LPN-A verified this was also not completed. During an interview on 3/10/26 at 10:41 a.m., director of nursing (DON) stated R77 should have had colostomy care admission orders and a baseline colostomy care plan. DON stated the baseline care plan for R77 was incomplete; with no colostomy care information entered. DON further stated the current colostomy orders lacked specific care information such as bag type and size, skin protectants, and frequency of changes. The DON stated treatments such as colostomy care would require a provider order. The DON stated any treatment provided to residents should be documented in the residents' chart. The DON stated if a treatment is needed and completed urgently, the staff providing the treatment should immediately request an order from the provider for the treatment. Further, the DON stated it is an expectation any time a treatment is provided, with or without an order, be documented in the resident chart.	F0658	Continued from page 15 following Monday to ensure that orders have been obtained for colostomy care Describe the Quality Assurance and Process Improvement Program that will be put into place. QAPI was held on 4/28/2026 to review results of survey and approve the plan of correction. Results of audits will be reviewed at QAPI meeting monthly x 3 months or until substantial compliance is maintained Facility alleges substantial compliance on 5/18/2026	

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F0658 SS = D	Continued from page 16 The DON confirmed a treatment was performed without an order, an order was not subsequently requested, and the treatment was not documented. During an interview on 3/10/26 at 1:49 p.m., physician assistant (PA)-A stated it was his expectation admission orders, and baseline care plan be entered immediately so staff know how to care for and provide treatment to the resident with a colostomy. Additionally, if staff did not have an order for treatment, they should reach out to the provider immediately to obtain an order. Further, PA-A stated he expected all treatments to be documented so facility staff knew about the treatments the resident was receiving. A document titled Registered Nurse Job Description dated 8/2/23, registered nurses provide professional nursing care to residents in accordance with physician orders and facility policies.	F0658		
F0689 SS = E	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 observation, interview, and document review, the facility failed to comprehensively assess transfers with a mechanical lift or develop and implement policies to ensure safety and supervision for 7 of 7 residents (R6, R36, R2, R8, R51, R60, R62) reviewed for accidents. Additionally, the facility failed to identify fall risk resulting in two falls for 1 of 1 resident (R77) reviewed for repeated falls. Findings include: R6's quarterly Minimum Data Set (MDS) assessment dated 1/21/26, identified severely impaired cognition and required maximal assistance for mobility. R6's diagnoses included Parkinson's, dementia, major	F0689	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: R6 was evaluated by therapy for safety with bathroom transfers and use of EZ stand mechanical lift with careplan and kardex updated R36 was evaluated by therapy for safety with bathroom transfers and use of EZ stand mechanical lift with careplan and kardex updated R2 was evaluated by therapy for safety with bathroom transfers and use of EZ stand mechanical lift with careplan and kardex updated R8 was evaluated by therapy for safety with bathroom transfers and use of EZ stand mechanical lift with careplan and kardex updated R51 was evaluated by therapy for safety with bathroom transfers and use of EZ stand mechanical lift with careplan and kardex updated R60 was evaluated by therapy for safety with bathroom transfers and use of EZ stand mechanical lift with careplan and kardex updated R62 was evaluated by therapy for safety with bathroom transfers and use of EZ stand mechanical lift with careplan and kardex updated	05/18/2026

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F0689 SS = E	Continued from page 17 depressive disorder and lack of coordination. R6's care plan (CP) created on 9/14/24, identified mobility was an area of concern, indicated was not ambulatory and needed transfer assistance of 2 and mechanical lift (EZ stand). Furthermore, the CP identified an area of concern, indicated was at risk for falls due to dementia, impaired coordination and mobility, medications, impulsiveness and safety awareness. R36's MDS comprehensive assessment dated 3/14/25, identified moderate cognitive impairment and left sided weakness in upper and lower extremities. R36's diagnoses included dementia, hemiplegia (left side affected), and congestive heart failure. R36's care plan created on 3/14/24, identified mobility was an area of concern, indicated transfers with assist of 2 and (sit to stand lift) EZ stand. Furthermore, the care plan identified was at risk of falls due to impaired mobility, left side weakness and dementia. R2's MDS quarterly assessment dated 2/10/26, identified severely impaired cognition and dependent mobility. R2's diagnoses included anxiety, dementia and cardiorespiratory issues. R2's care plan revised on 10/27/25, identified activities of daily living was an area of concern related to mobility status and dementia. The care plan indicated transfers with the assistance of two and EZ stand lift for all transfers. Furthermore, the care plan identified was at risk for falls due to impaired mobility, dementia and medications. R8's MDS quarterly assessment dated 2/6/26, identified severely impaired cognition and substantial/maximal assistance with transfers. R8's diagnoses included non-traumatic brain dysfunction, dementia and seizure disorder. R8's care plan was created on 6/4/23, identified activities of daily living were an area of concern, due to dementia, leg pain, decrease mobility and resistance to assistance. Perform cares in pairs, transfer with assist of 2 and an EZ stand. R51's MDS quarterly assessment dated 2/24/26, identified severely impaired cognition and dependent on all areas of mobility. R51's diagnoses included atrial fibrillation, type II diabetes, depression and dementia.			F0689	Continued from page 17 R77 kardex was updated to include transfer, ambulation status, and fall risk interventions NA-I, NA-H, NA-J, and RN-D were educated by DON/Designee on 4/30/2026 on maintaining resident safety and supervision while toileting and using the EZ Stand How will you identify other residents having potential to be affected by the same deficient practice and what corrective action will be taken: All residents have the potential to be affected All residents using the EZ stand were evaluated for safety and supervision requirements during toileting by therapy All admissions for the past 30 days were reviewed to ensure there was a Kardex in place and it accurately reflected the transfer, ambulation status, and fall risk interventions Education was provided to the IDT on ensuring the Comprehensive Care Plan policy to include ensuring the Kardex contains the resident transfer status, ambulation status, and fall risk interventions by the Regional Clinical Consultant on 4/22/2026 What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur; and: Education was initiated on 3/26/2026 by the DON/Designee with clinical staff on safe transfer procedure using the EZ Stand lift with understanding validated by a competency. Any clinical staff not receiving education by 4/24/2026 will not be allowed to work until education received. Education was initiated on 3/26/2026 by the DON/Designee with clinical staff on accessing and referencing the Kardex for cares and to notify the UM/DON if there are questions or changes in the resident status that would necessitate the Care Plan/Kardex being updated 5 random observations will be completed weekly x 8 weeks will be completed to ensure that safe transfer procedures are followed when using the EZ stand lift		

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F0689 SS = E	Continued from page 18 R51's care plan created on 3/8/23, identified activities of daily living were an area of concern, due to weakness, stroke and cognitive impairment. Assist of two and EZ stand with transfers. Furthermore, identified falls were an area of concern, due to weakness, dementia and cognitive deficits. R60's MDS quarterly assessment dated 3/3/26, identified severely impaired cognition and dependent on all areas of mobility. R60's diagnoses included dementia, psychotic and mood disturbances and anxiety. R60's care plan revision on 10/7/24, identified activities of daily living was an area of concern, due to the disease process of Alzheimer's. Transfer with assistance of two and EZ stand. Furthermore, an area of concern was at risk for falls due to being unaware of safety needs and history of falls. R62's MDS comprehensive assessment on 2/20/26, identified severely impaired cognition and dependent on mobility. R62's diagnoses included osteoporosis, hemiplegia and dementia. R62's care plan revision on 6/9/25, identified activities of daily living was an area of concern, due to disease process, physical limitations, cognitive losses with spastic hemiplegia. Transfer assist of two and sit to stand lift. Furthermore, an area of concern was at risk for falls related to cognition, unaware of safety needs, incontinence, history of traumatic brain injury and cerebral vascular accident with spastic hemiplegia (type of cerebral palsy that affected one side of body, muscle weakness and stiffness). During observation on 3/10/26 at 11:02 a.m., R6 was in room, sitting in wheelchair repeating the word, "help". Registered nurse (RN)-D-went into room and asked if R6 needed anything. RN-D wheeled R6 to shower room. Nursing assistant (NA)-F and NA-G hooked up the sling to EZ stand, elevated R6, moved the stand over the toilet lowered her down at 11:13 a.m. Staff left R6 attached to the stand and staff left room. At 11:17a.m., the staff returned to the shower room. There was a large amount of urine on the floor, the EZ stand and R6. RN-D left and returned with clean bottoms and socks, while NA-G and NA-F cleaned the floor, EZ stand, and R6. During observation on 3/12/26 at 2:30 p.m., R2 was wheeled into shower room, hooked up to the EZ stand by NA-I and NA-H elevated and brought to toilet and lowered her down, remained hooked up to EZ stand on the toilet. NA-I stayed with resident except when she left	F0689	Continued from page 18 Kardexes will be reviewed and updated as indicated by changes in status Monday – Friday as part of the daily clinical stand up process Describe the Quality Assurance and Process Improvement Program that will be put into place. QAPI was held on 4/28/2026 to review results of survey and approve the plan of correction. Results of audits will be reviewed at QAPI meeting monthly x 3 months or until substantial compliance is maintained Facility alleges substantial compliance on 5/18/2026	

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F0689 SS = E	Continued from page 19 to go find assistance, for approximately 2 minutes. The staff provided cares and transferred her back into wheelchair. During interview on 3/12/26 at 11:28 a.m., NA-J stated residents that use the EZ stand for transfers to the toilet were brought into the shower room, since the bathrooms in their rooms were too small to use. She stated the process for EZ stand was to explain to resident what was happening, as cares were being provided. The EZ stand remained connected to the resident on the toilet because it was safer, kept the resident from falling forward. It was common practice for staff not to stay in shower room with resident. During interview on 3/12/26 at 12:35 p.m., RN-D stated the process for using the EZ stand was to have two staff members when doing transfers. The residents remained hooked in sling connected to EZ stand while on the toilet. The residents were left alone in the shower room. During interview on 3/12/26 at 1:54 p.m., physical therapist assistant (PTA)-A stated it was not acceptable for residents to be hooked up to the EZ stand and left alone. There was an assessment for safety of being left alone on the toilet and the resident had to be independent. However, the residents that used the EZ stand on that floor needed continuous supervision. The EZ stand should be removed while resident is on the toilet. During interview on 3/12/26 at 4:38p.m., director of nursing (DON) stated the expectations for use of shower room to toilet residents with the use of the EZ stand was to follow the transfer status lift, it required two staff members, hook up the resident, position properly and safely, bring them as close to the toilet as possible and lower. The EZ stand remained attached to the resident while using the toilet. A staff member needed to be in the line of sight of resident. DON stated he was not aware that staff were leaving residents unattended and hooked up to the EZ stand while in the shower room. The manual for the Drive EZ Sit to Stand lift indicated: How to transfer the Patient to the desired surface 1. Have the wheelchair, bed or commode ready: If transfer the patient to a commode, position the patient over the commode.	F0689		

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F0689 SS = E	Continued from page 20 2. Press the (M1) DOWN button and lower the patient onto the desired surface. 3. Lock the rear swivel casters of lift. 4. Unhook the sling from all attachment points on the lift. 5. Instruct the patient to lift their feet off the footplate. 6. Remove the sling from around the patient. 7. Pull the lift away from the wheelchair, bed or commode. The policy Safe Resident Handling/Transfers dated 2023 stated: It is the policy of this facility to ensure that residents are handled and transferred safely to prevent or minimize risks of injury and provide and promote a safe, secure and comfortable experience for the resident while keeping the employees safe in accordance with current standards and guidelines. Staff will perform mechanical lifts/transfers according to the manufacturer's instructions for use of the device. Staff members are expected to maintain compliance with safe handling/transfer practices. R77: R77's admission Minimum Data Set (MDS) was not available at time of survey. A facility document title Nursing-Admissions/Readmission Observation dated 3/5/26, noted R77 was alert and oriented to person, place, time, and situation. R77's cognition was intact. R77 requires transfer assistance, assistance with activities of daily living (ADL), and assistance managing new colostomy. R77's diagnoses included intestinal obstruction requiring a new colostomy (a surgical procedure that creates an opening (stoma) in the abdomen, allowing stool to exit the body when the colon cannot function normally), Parkinson's, urinary retention, and generalized muscle weakness. R77 was admitted to the facility on 3/5/26 at approximately 2:00 p.m. R77's baseline care plan dated 3/6/26 contained only information about resident socialization and activities. The baseline care plan lacked information about fall risk, how to minimize falls, how to minimize injuries related to falls, and resident-specific fall interventions.		F0689				

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F0689 SS = E	Continued from page 21 R77's electronic medical record (EMR) lacked a fall assessment. Review of R77's progress notes revealed: -Fall 3/8/26 at 11:09 p.m. R77 was found sitting up on the floor with his back against the bed, legs extended, with grippy socks. R77 sustained a bruise on his left buttock. Resident stated he was reaching for his urinal. -Fall 3/8/26 at 8:32 a.m. R77 was found on the floor between his bed and the bathroom door. No injuries were noted. Resident stated he was trying to get to bathroom. During an observation on 3/9/26 at 2:09 p.m., R77 was in his wheelchair in his room, stated he wanted to get up and needed help with his ostomy. R77's roommate encouraged him to wait for staff assistance. R77 kept stating he needed to get up and use the restroom and get this thing in his abdomen taken care of. During an observation on 3/9/26 at 2:11 p.m., nursing assistant (NA)-A entered R77's room to assist resident to the bathroom and change his clothing. R77 stood up with assistance from NA-A and appeared unsteady on his feet. During an interview on 3/9/26 at 3:07 p.m., NA-A stated each resident should have a Kardex (documentation system that enables nurses to write, organize, and freely reference key resident data). However, NA-A stated R77 did not have a completed Kardex. NA-A stated if a resident didn't have a Kardex, they would get information about a resident during shift change report. NA-A was unable to verbalize the information that was given about R77 during shift change report. Additionally, NA-A could only state R77 required assistance with ambulation but could not state how R77 ambulated. NA-A couldn't state whether R77 was a fall risk or if he had any fall interventions. During an interview on 3/9/26 at 3:10 p.m., NA-B stated R77 did not have a Kardex yet. NA-B stated she would look at R77's care plan since he didn't have a Kardex. NA-B stated she was unsure if R77 was a fall risk since he didn't have a care plan. NA-B couldn't state any resident-specific fall interventions for R77. During an interview on 3/10/26 at 10:37 a.m., licensed practical nurse (LPN)-A stated each resident should have a Kardex and a care plan indicating if they are a			F0689			

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F0689 SS = E	Continued from page 22 fall risk and what interventions work to prevent falls. LPN-A confirmed R77 did not have a Kardex or a resident-specific fall care plan. LPN-A confirmed R77 had fallen twice in less than 12 hours. LPN-A stated it is important to have both a Kardex and fall care plan because staff need to know how to care for each resident and prevent injuries if the resident falls. During an interview on 3/10/26 at 10:41 a.m., director of nursing (DON) stated the resident was admitted to the facility in the afternoon on 3/5/26. The DON stated the resident should have a completed baseline care plan completed in the first 48 hours after admission. The DON stated the baseline care plan should contain information about fall risk, how to prevent falls, and resident-specific interventions to prevent falls. The DON confirmed that the R77 did not have a Kardex, and the baseline care plan had not been completed within 48 hours after admission. The DON confirmed R77's falls were due to him reaching for something. The DON stated R77 should have a care plan entry for fall risk with resident specific interventions to include bed in lowest position, appropriate footwear, and commonly used items within reach. The DON stated it is important to have a completed Kardex and fall care plan to ensure residents are safe. A facility policy titled Fall Prevention Program dated 11/2025, each resident will be assessed for fall risk and will receive care and services in accordance with their individualized level of risk to minimize the likelihood of falls.		F0689				
F0691 SS = D	Colostomy, Urostomy, or Ileostomy Care CFR(s): 483.25(f) §483.25(f) Colostomy, urostomy,, or ileostomy care. The facility must ensure that residents who require colostomy, urostomy, or ileostomy services, receive such care consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to ensure physician orders were in place to provide treatment and monitoring for a colostomy (opening to allow waste to exit the body and be collected in a pouch) for 1 of 1 resident (R77) reviewed for ostomy care.		F0691	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: MD of R77 was contacted orders were received on 4/30/2026 to reflect instructions on colostomy changes LPN-A was provided education by DON/Designee on the standards of practice that we do not provide medical services without an order on 4/30/2026 How will you identify other residents having potential to be affected by the same deficient practice and what corrective action will be taken: All residents with colostomy have the potential to be affected		05/18/2026	

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F0691 SS = D	Continued from page 23 Findings Include: R77 was admitted to the facility on 3/5/26 R77's admission Minimum Data Set (MDS) assessment was not available at time of survey. A facility document titled Nursing-Admissions/Readmission Observation dated 3/5/26, noted R77 was alert and oriented to person, place, time, and situation. R77's cognition was intact. R77 requires transfer assistance, assistance with activities of daily living (ADL), and assistance managing new colostomy (a surgical procedure that creates an opening (stoma) in the abdomen, allowing stool to exit the body when the colon cannot function normally). R77's diagnoses included intestinal obstruction requiring a new colostomy, Parkinson's, urinary retention, and generalized muscle weakness R77's care plan dated 3/6/26, lacked direction or interventions of how to care for the colostomy. R77's admission orders included empty bag every shift and record amount; the admission orders lacked specific appliance change instructions (i.e., bag type, bag size, skin protectants, skin barriers, and bag removal). During observation and interview on 3/9/26 at 2:09 p.m., R77 was wheeling himself down the hall, his colostomy bag on the outside of his body, was visible since his shirt was not covering it. R77 stated he does not like it when his colostomy bag is visible and pulled his shirt down over the colostomy bag and pulled his flannel shirt together to cover the shirt. During observation on 3/9/26 at 2:11 p.m., R77 was waiting in his room for facility staff to assist him to the bathroom; while waiting R77 pulled off the colostomy bag and tossed it into the garbage can in his room. Facility staff arrived, closed room door, and assisted resident with changing his clothing and applying a new colostomy bag. During an interview on 3/10/26 at 10:37 a.m., licensed practical nurse (LPN)-A stated R77's colostomy care information should be in his admission orders and/or his baseline care plan. LPN-A confirmed R77 did not have colostomy care orders and did not have a colostomy care plan. During an interview on 3/10/26 at 10:41 a.m., director of nursing (DON) stated R77 should have colostomy care	F0691	Continued from page 23 Education was provided to the IDT on 4/22/2026 by the Regional Clinical Consultant on the expectations that we ensure that residents have appropriate orders and that services aren't provided without a physician order An audit was conducted on 4/30/2026 to ensure that all residents with colostomy have appropriate orders and care plans What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur; and: Education was initiated on 3/26/2026 by DON/Designee with licensed clinical staff on the need to obtain physician orders prior to providing a medical treatment with all licensed clinical staff being educated by 4/24/2026 any resident not receiving education by 4/24/2026 not being allowed to work until education is received All admission and readmission charts will be reviewed Monday – Friday as part of the daily clinical standup with any admissions/readmissions being reviewed on the following Monday to ensure that orders have been obtained for colostomy care Describe the Quality Assurance and Process Improvement Program that will be put into place. QAPI was held on 4/28/2026 to review results of survey and approve the plan of correction. Results of audits will be reviewed at QAPI meeting monthly x 3 months or until substantial compliance is maintained Facility alleges substantial compliance on 5/18/2026	

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F0691 SS = D	Continued from page 24 admission orders and a baseline colostomy care plan. DON stated the baseline care plan for R77 was incomplete; with no colostomy care information entered. DON further stated the current colostomy orders lacked specific care information such as bag type and size, skin protectants, and frequency of changes. DON stated it is important for colostomy care orders and colostomy care plan to be entered upon admission so staff can provide appropriate colostomy care. An undated facility policy titled Ostomy Care – Colostomy, Urostomy, and Ileostomy was received, ostomy care will be provided by licensed nurses and under the orders of the attending physician. Further, the frequency of pouch changes and the products required for changing ostomy devices will be noted on the resident's person-centered care plan.	F0691		
F0695 SS = D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and record review, the facility failed to provide oxygen therapy as ordered for 1 of 1 resident (R44) reviewed for respiratory care. Findings include: R44's Admission Minimum Data Set (MDS) assessment, dated 2/20/26, indicated intact cognition, R44 required partial to moderate assistance with toileting hygiene. R44's diagnoses included chronic respiratory failure with hypoxia, dependence on supplemental oxygen, chronic pulmonary edema, moderate persistent asthma, and dependence of renal dialysis. R44's was admitted on 2/5/26 with including, oxygen 2 liters via nasal cannula continuously. During an observation on 3/09/26 at 7:24 p.m., R44 was	F0695	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: R44 MD was contacted with orders received to make oxygen PRN to maintain oxygen saturation >90% on 3/11/2026 How will you identify other residents having potential to be affected by the same deficient practice and what corrective action will be taken: All residents on Oxygen have the potential to be affected Education was provided by the Regional Clinical Consultant on 4/22/2026 to the IDT on the Oxygen Administration policy An audit was conducted on 4/30/2026 by the DON/Designee to ensure that residents are receiving on-going assessment of the resident's condition warranting oxygen and the resident response to Oxygen What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur; and: Education was initiated on 3/26/2026 by DON/Designee on the Oxygen Administration policy and the need for residents receiving oxygen to receive on-going	05/18/2026

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F0695 SS = D	Continued from page 25 on the oxygen concentrator with a flow rate of 3 liters. During observation on 3/10/26 11:11 a.m., R44 came down the unit hallway on her motorized scooter with no oxygen in use. R44 stated, the portable oxygen tank was empty and was in search of staff to have the tank filled. R44 searched for staff for 4 minutes. The director of nursing (DON) filled the portable oxygen tank for R44 at 11:15 a.m. R44 took the oxygen tank and went back to her room with no oxygen in use. During observation on 3/10/26 11:23 a.m., and 11:28 am oxygen tank was not in use. During observation on 3/10/26 at 11:49 a.m., R44 was in her room, and was using the oxygen concentrator, on 3 liters via nasal cannula. At 11:50 a.m., registered nurse, (RN)-B entered R44's room, had a conversation with R44 and exited at 11:52 a.m. During observation on 3/10/26 12:03 p.m., R44 came out of the room, the portable oxygen tank in use via nasal cannula on 2 liters and stated was going to the dining room for lunch. During an interview with RN-B on 3/10/26 1:38 p.m., RN-B stated, had seen R44 at times with no oxygen in use, and was not sure if R44 oxygen order was continuous or as needed. During an interview with nursing assistant (NA)-E on 3/10/26 at 1:39 p.m., NA-E stated had seen R44 without oxygen in use. NA-E stated had seen R44 down the hallway and needed the portable oxygen tank filled. During an interview on 3/10/26 2:28 p.m., the DON verified filling the tank for R44. DON stated, "I have never seen her with her oxygen in use". During an interview on 3/12/26 at 2:00 p.m., medical doctor, (MD) expected the facility to have sent an SBAR (situation, background, assessment, recommendation) and updated vitals for ongoing need for supplemental oxygen. An undated facility provided policy indicated staff shall document ongoing assessment of the resident's condition warranting oxygen and the response to oxygen therapy.	F0695	Continued from page 25 assessment of the resident's condition warranting oxygen and the resident response to Oxygen with all staff receiving education by 4/24/2026. Any staff not receiving education by 4/24/2026 will not be allowed to work until education is received An audit will be completed weekly x 8 weeks on residents receiving oxygen to ensure on-going assessment of the resident's condition and the resident's response to Oxygen is being documented appropriately and an SBAR is completed with MD notification with changes in resident condition changes. Describe the Quality Assurance and Process Improvement Program that will be put into place. QAPI was held on 4/28/2026 to review results of survey and approve the plan of correction. Results of audits will be reviewed at QAPI meeting monthly x 3 months or until substantial compliance is maintained Facility alleges substantial compliance on 5/18/2026	
F0698 SS = D	Dialysis	F0698	What corrective action(s) will be accomplished for those residents found to have been affected by the	05/18/2026

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F0698 SS = D	Continued from page 26 CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and record review, the facility failed to complete ongoing assessment of the resident's condition and monitoring complications before and after dialysis treatments received at a certified dialysis facility for 1 of 1 resident (R44) reviewed for dialysis. Findings include: R44's Admission Minimum Data Set (MDS) assessment, dated 2/20/26, indicated intact cognition, R44 required partial/moderate assistance with toileting hygiene. R44's diagnoses included acute kidney failure, dependence of renal dialysis hypertensive heart and chronic kidney disease with heart failure, type2 diabetes mellitus, Pulmonary edema, moderate persistent asthma, dependence on supplemental oxygen, Chronic respiratory failure with hypoxia. R44's was admitted On 02/5/26 and orders dated 2/19/25 included: dialysis pre and post assessment every Tuesday, Thursday and Saturday. Print and send assessment with resident to dialysis, place returned paperwork in manager box. Review of R44's MAR/TAR (medications administration/ treatments administration record) dated 2/5/26 to 2/28/26 and 3/1/26 to 3/10/26, indicated pre and post dialysis assessments were completed 2/24/2026, 2/27/26, 3/3/26. R44's record lacked other days completed. During an interview on 3/9/26 at 7:20 p.m., the director of nursing (DON) verified R44's dialysis pre-assessment form had not been sent consistently. DON was unable to provide completed dialysis pre or post assessment when requested. During an interview on 3/10/26 at 10:44 a.m., registered nurse RN-(B) stated R44 was leaving at 12:15 p.m., and the dialysis pre- assessment will be completed and sent with R44 to the dialysis center.	F0698	Continued from page 26 deficient practice: Education was provided to RN-B on the Hemodialysis policy and the requirement to complete pre/post dialysis assessment on the resident by DON/Designee on 4/30/2026. How will you identify other residents having potential to be affected by the same deficient practice and what corrective action will be taken: All residents receiving hemodialysis have the potential to be affected. Education was provided on 4/22/2026 by the Regional Nurse Consultant to the IDT on the Hemodialysis policy and need to ensure that pre/post dialysis assessments are completed and collaborative care is maintained with the dialysis center An audit was completed on residents receiving hemodialysis to ensure that pre/post dialysis assessments have been completed and collaborative care is maintained with the dialysis center Care plans of residents receiving hemodialysis updated to include need for post treatment monitoring on 4/30/2026 by MDS coordinator What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur; and: Education was initiated on 3/26/2026 by the DON/Designee on the Hemodialysis policy and the need for completing pre/post dialysis assessment and maintaining collaborative care with the dialysis center with all licensed clinical staff receiving education by 4/24/2026. Any licensed clinical staff not receiving education by 4/24/2026 will not be allowed to work until education is received Residents receiving dialysis will be reviewed as part of the clinical morning stand up process to ensure pre/post dialysis assessments are completed and collaborative care with the dialysis center is maintained.	

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F0698 SS = D	Continued from page 27 During an interview on 03/10/26 2:09 p.m., RN-B was unable to provide a copy of the dialysis pre-assessment form sent with R44. During an interview 03/12/26 at 2:00 p.m., medical doctor (MD) expected the facility to have completed the pre and post dialysis assessments and notified them and the dialysis center of any changes in R44's weight and status. An undated facility provided policy indicated, an ongoing assessment of the resident's condition and monitoring for complications before and after dialysis treatments received at a certified dialysis facility.	F0698	Continued from page 27 Describe the Quality Assurance and Process Improvement Program that will be put into place. QAPI was held on 4/28/2026 to review results of survey and approve the plan of correction. Results of audits will be reviewed at QAPI meeting monthly x 3 months or until substantial compliance is maintained Facility alleges substantial compliance on 5/18/2026	
F0732 SS = C	Posted Nurse Staffing Information CFR(s): §483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements.	F0732	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Education provided to facility clinical leadership on requirements of staffing information being posted at all nursing stations at eye level of residents by Regional Clinical Consultant on 4/22/2026 How will you identify other residents having potential to be affected by the same deficient practice and what corrective action will be taken: All residents have the potential to be affected. Staffing information is posted daily at each nurse station at eye level of residents What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur; and: Education was initiated by the DON/Designee with licensed clinical staff on the requirement for nurse staffing information to be posted in a prominent place readily accessible to residents and visitors on 3/26/2026 with all licensed clinical staff receiving education by 4/24/2026. Any staff not receiving education by 4/24/2026 will not be allowed to work until education is received. DON/Designee will audit postings 5/week x 4 weeks, then 3/week x 4 weeks, then weekly x 4 weeks or until substantial compliance is obtained	05/18/2026

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F0732 SS = C	Continued from page 28 (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents, staff, and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interviews, and documents review, the facility failed to include the daily census and actual hours worked by nursing staff groups on the daily staffing data document. This deficient practice had the potential to affect all residents who resided in the facility and/or any visitors who may have wanted to view the information. Findings include: During observation on 3/9/26 at 11:30 a.m., upon entry of the survey, the staff posting for 03/09/26 did not show the daily census and actual hours worked by nursing staff groups. During documents review on 3/10/26, daily schedule reports (daily staffing data document) provided by facility for 03/9/26 to 3/13/26 all lacked the daily census and actual hours worked by nursing staff groups. During an interview on 03/12/26 at 10:11 a.m., the scheduler stated there was a change in template in September and the daily census and actual hours worked by nursing staff groups has been missing from the daily staffing data document. During an interview on 03/12/26 11:51 am, the facility	F0732	Continued from page 28 Describe the Quality Assurance and Process Improvement Program that will be put into place. QAPI was held on 4/28/2026to review results of survey and approve the plan of correction. Results of audits will be reviewed at QAPI meeting monthly x 3 months or until substantial compliance is maintained Facility alleges substantial compliance on 5/18/2026	

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F0732 SS = C	Continued from page 29 administrator acknowledged the daily census and actual hours worked by nursing staff groups was not shown on the facility daily staffing data document.	F0732		
F0755 SS = E	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(f). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is NOT MET as evidenced by: Based on observation and interview, the facility failed to dispose of discontinued, expired, and discharged residents' medications. This had the potential to affect any resident who received medication from all facility medication rooms. Findings include:	F0755	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: R81 medications were destroyed on 4/30/2026 R15 medications were destroyed on 4/30/2026 R42 medications were destroyed on 4/30/2026 R52 medications were destroyed on 4/30/2026 R48 medications were destroyed on 4/30/2026 R78 medications were destroyed on 4/30/2026 R30 medications were destroyed on 4/30/2026 R2 medications were destroyed on 4/30/2026 R13 medications were destroyed on 4/30/2026 R6 medications were destroyed on 4/30/2026 R51 medications were destroyed on 4/30/2026 R34 medications were destroyed on 4/30/2026 R13 medications were destroyed on 4/30/2026 R22 medications were destroyed on 4/30/2026 R6 medications were destroyed on 4/30/2026 R78 medications were destroyed on 4/30/2026 R31 medications were destroyed on 4/30/2026 R62 medications were destroyed on 4/30/2026 R80 medications were destroyed on 4/30/2026 How will you identify other residents having potential to be affected by the same deficient practice and what corrective action will be taken: All residents have the potential to be affected	05/18/2026

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F0755 SS = E	Continued from page 30 On 03/11/2026 10:00 a.m., 1st floor medication storage had 23-40 medication cards from discharged residents awaiting destruction and several bottles of over-the-counter expired bottles awaiting disposal. Registered nurse (RN)-B confirmed the medications on the counter were awaiting destruction and was unsure of the process of medication destruction. RN-B stated, “the nurse manager took care of it, and we do not have one right now”. The 1st floor med room storage had the following current resident medications awaiting destruction. R 81 -Flomax capsule 0.4mg (Tamsulosin HCL) Take 0.4 milligrams (mg) by mouth daily -Inderal LA oral capsule Extended Release 24 hours (Propranolol HCL), Take 1 cap my mouth in the evening. - Lipitor oral tablet (Atorvastatin Calcium), take 10 mg by mouth at bedtime -Synthroid Oral tablet (levothyroxine Sodium), take 112 micrograms (mcg) by mouth in the morning. -Venlafaxine HCL ER oral capsule extended release 24 hours (venlafaxine HCL), take 37.5 mg by mouth one time a day every other day -Zyloprim oral tablet (Allopurinol), take 300 mg by mouth one time a day. -Methocarbamol oral tablet, Take 1000 mg by mouth 4 times a day. -Allegra Allergy oral tablet (Fexofenadine HCL), take 180 mg by mouth every 24 hours as needed. R15 - Allegra Allergy oral tablet (Fexofenadine HCL), take 180 mg by mouth on time a day -Crestor oral tablet (Rosuvastatin Calcium), take 10 mg by mouth at bedtime. -Lasix oral tablet (Furosemide) take 40 mg by mouth one time a day. -Rozerem oral tablet (Ramelteon), take 8 mg by mouth at bedtime.	F0755	Continued from page 30 An audit of all med rooms was completed by DON/Designee on 4/30/2026 to ensure there were no medications that needed to be destroyed or returned A contract was obtained to have a Med Safe provided for the facility for all medications requiring destruction What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur; and: Education was initiated on 3/26/2026 by DON/Designee with licensed clinical staff on medication destruction and returns with all staff being educated by 4/24/2026. Any staff not receiving education by 4/24/2026 will not be allowed to work until education is received. Med rooms will be reviewed and cleaned weekly by the 11/7 shift on Sunday to ensure medications are destroyed or returned as required An audit of med rooms will be completed weekly by the UM to ensure medication room is clean and free of medications requiring destruction Describe the Quality Assurance and Process Improvement Program that will be put into place. QAPI was held on 4/28/2026 to review results of survey and approve the plan of correction. Results of audits will be reviewed at QAPI meeting monthly x 3 months or until substantial compliance is maintained Facility alleges substantial compliance on 5/18/2026	

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F0755 SS = E	Continued from page 31 - Synthroid Oral tablet (levothyroxine Sodium), take 125 mcg by mouth in the morning. - Lopressor oral tablet (Metoprolol Tartate) Take 12.5 mg by mouth 2 times a day - Omeprazole oral tablet, take 20 mg by mouth 2 times a day. - Zylprim oral tablet (Allopurinol), take 100 mg by mouth 2 times a day. - Neurontin oral capsule (Gabapentin), take 300 mg by mouth 3 times a day. Tegretol oral tablet (carbamazepine), take 200 mg by mouth 4 times a day. - Benzonatate oral capsule, take 100 mg by mouth every 4 hours as needed for cough - Carafate oral tablet 1 gram, take 1 gram by mouth as needed 2 times a day as needed. - Melatonin Oral tablet, give 6 mg by mouth at bedtime as needed. - Ondansetron HCL oral tablet, take 1 mg by mouth every 8 hours as needed. On 03/11/2026 10:42 a.m., the 2nd floor medication storage room had 6 medications on the counter. Licensed practical nurse (LPN)-A acknowledged the 6 medication cards were from discontinued medications orders and discharged residents. LPN-A stated was unsure of the medication destruction process and stated that the night shift was responsible for medications destruction. The 2nd floor medication storage room had 6 medication cards belonging to R42 and R52 awaiting destruction. During observation on 03/11/2026 at 11:51 a.m., registered nurse, (RN)-F, RN-F confirmed, medication cards kept on the counter were from discontinued orders, and discharged patients awaiting destruction. RN-F was unsure of facility medication destruction process and who was responsible for medication destruction. The 3rd floor medication room storage had following current resident medications awaiting destruction. R48			F0755			

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F0755 SS = E	Continued from page 32 -Atorvastatin 10 mg 1 tab started, 2/26 R78 -Escitalopram 20 mg, started 3/31/25 -Metoprolol 25 mg, 3 cards -Bupropion hcl 159 mg, tab started 10/29/25 R30 -Clindamycin 150 mg caps started 1/23/26- -Torsemide 20 mg 2 tabs daily for 3 days then continue 1 tab daily R2 -Hyoscyamine 0.125 mg tab, started 4/22/25 R13 - Ondansetron hcl 4 mg tab, started 11/26/2 R6 -Famotidine 20mg, give 1 tablet R51 - Eliquis 5 mg, give 1 tablet by mouth twice a daily R34 -Trazodone 50-gram tablet, give 1.2 tablet by mouth at bedtime as needed sleep R13 - Sertraline 25 mg, give 1 tablet by mouth daily take with 50 mg for total dose of 75 mg R22 -Ondansetron 4 mg tablet, give one tablet by mouth every 8 hrs. as needed for up to 7 days R6 Benzonatate 100 mg capsule, give one capsule by mouth three times daily as needed			F0755			

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F0755 SS = E	Continued from page 33 R78 -Quetiapine 25 mg, give 1.2 tablet by bedtime R31 -Iprat-albut 0.5 (2.5) mg/3ml inhale 3mL vial ben three times daily for SOB. R62 -Paxlovid 300-100mg dose R80 - Cyanocobalamin 1000mcg/ml inject 1 milliliter (ml) intramuscular (IM) weekly It also contained 1 bottle of OTC acetaminophen 325 mg open 11/6/2024 exp on bottle 2/2026, 1 bottle of aspirin over the counter 81 mg, expired 2/26/2026, and 1 canister of inhaler -Formoterol Fumarate 20mcg/2ml. During an interview on 3/11/2026 at 1:34p.m., the director of nursing (DON) stated, medication destruction was to be completed by 2 nurses, 1 nurse logged the medications, and the 2nd nurse completed the destruction by disposing of the tablets in a Stericycle water activated solution. DON expected medications destruction to be completed as soon as possible. During an interview with the facility pharmacist on 03/11/2026 at 2:34 p.m., pharmacist reported being unfamiliar with the current medication destruction process for the facility and advised to refer to the facility policy. A policy for medication storage was requested but not received prior to the end of the survey.		F0755				
F0757 SS = D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or		F0757	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: R33 had a sleep study assessment completed on 4/30/2026 How will you identify other residents having potential to be affected by the same deficient practice and what corrective action will be taken:		05/18/2026	

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F0757 SS = D	Continued from page 34 §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is NOT MET as evidenced by: Based on interview and record review, the facility failed to monitor effectiveness of a medication prescribed for sleep by not completing sleep monitoring for 1 of 1 resident (R33) reviewed for unnecessary medications. Findings include: R33's Minimum Data Set (MDS) assessment, dated 12/3/25, /indicated intact cognition, /R33 /was independent with transfers, w/c mobility and required limited assist with bed mobility. R33 diagnoses included chronic systolic and diastolic (congestive) heart failure (a serious condition of the heart's ability to pump blood efficiently), Chronic obstructive pulmonary diseases (an ongoing lung condition caused by damage to the lungs), generalized osteoarthritis. R33's medication orders included: Melatonin 5 milligrams (mg), oral at bedtime: start date:12/01/25 for insomnia. R33's Medication Administration Record (MAR) record review from 02/1/26 to 3/11/26 reviewed lacked sleep tracking or monitoring. R33' s progress note reviewed from 02/1/25 to 3/11/26 had no reference to R33 sleep monitoring. During an interview on 3/11/2026 at 4:05 p.m., registered nurse (RN)-C, RN-C stated, "yes, resident is			F0757	Continued from page 34 All residents on Melatonin have the potential to be affected An audit of was completed on residents taking Melatonin was conducted and any requiring a sleep study assessment had one scheduled What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur; and: Education was initiated by the DON/Designee on 3/26/2026 with the licensed clinical staff on the Sleep Study assessment and the need to ensure this is completed with the initiation of Melatonin, quarterly and with any significant change on any resident taking Melatonin with all licensed clinical staff receiving education by 4/24/2026. Any staff not receiving education by 4/24/2026 will not be allowed to work until education is received. An audit will be completed quarterly on any resident taking Melatonin as part of their care plan process to ensure a sleep study is completed with any resident not having the sleep study completed having the sleep study scheduled Describe the Quality Assurance and Process Improvement Program that will be put into place. QAPI was held on 4/28/2026 to review results of survey and approve the plan of correction. Results of audits will be reviewed at QAPI meeting monthly x 3 months or until substantial compliance is maintained Facility alleges substantial compliance on 5/18/2026		

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F0757 SS = D	Continued from page 35 taking a sleep aid, melatonin 5 mg, we usually do a sleep monitoring, but there is no sleep monitoring in place in the assessment for that resident and I do not know why". During an interview on 3/11/2026 4:55 p.m., the director of nursing (DON) stated, "I will not track sleep with Melatonin use due to Melatonin being an over-the-counter medication". The facility policy titled: Gradual Dose Reduction of Psychotropic Drugs reviewed 3/5/2025 indicates, "Psychotropic drug" or "psychotropic medication" is defined as any drug that affects brain activities associated with mental processes and behavior. Psychotropic drugs include, but are not limited to the following categories: antipsychotics, antidepressants, anxiety, and hypnotics (a class of drugs used preliminary to induce sleep and treat insomnia)		F0757				
F0812 SS = F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and record review, the facility failed to ensure food stored in the		F0812	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Expired sliced ham was disposed of by the CDM on 3/12/2026 Lettuce was disposed of by the CDM on 3/12/2026 Box of food on the floor was placed on shelf on 3/12/2026 Box of food touching the freezer fan blade was moved away from the fan on 3/12/2026 How will you identify other residents having potential to be affected by the same deficient practice and what corrective action will be taken: All residents have the potential to be affected Education was provided to Cook-C by CDM on the Food Safety Requirement policy on 4/30/2026 What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur; and: Education was initiated by CDM on 3/26/2024 on the Food		05/18/2026	

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F0812 SS = F	Continued from page 36 refrigerator were labeled, dated and free of expired foods. This deficient practice had the potential to affect all residents, staff and visitors who received food from facility kitchen. Findings include: During the initial kitchen tour on 3/9/26 at 10:34 a.m., cook (C)-A greeted surveyor inside the kitchen. The following items were observed in the fridge expired and undated food: -Sliced Ham, expired on 3/2/26 -no date on lettuce, browning and wilting Additionally, the following items were observed in the freezer: -box of food sitting directly on the freezer floor -box on top shelf of freezer touching freezer fan blade During the follow up kitchen tour on 3/12/26 at 12:25 p.m., district manager (DM) stated the expired sliced ham, and undated lettuce had been thrown out. DM confirmed the box on the floor of the freezer had been placed on a shelf. DM confirmed the box touching the freezer fan blade had been pushed back away from the fan blade. DM stated undated items should be thrown out immediately and foods in the fridge longer than 3 days should be thrown out. DM stated it is important to use expiration dates to ensure palatability and to prevent food borne illnesses. DM stated it is important to keep food boxes correctly place to ensure freezer equipment continues to work as intended. A facility policy was requested and not received.			F0812	Continued from page 36 Safety Requirements policy with all staff being educated by 4/24/2026 any staff not receiving education by 4/24/2026will not be allowed to work until they receive education Food storage will be audited by CDM weekly x 8 weeks Describe the Quality Assurance and Process Improvement Program that will be put into place. QAPI was held on 4/28/2026 to review results of survey and approve the plan of correction. Results of audits will be reviewed at QAPI meeting monthly x 3 months or until substantial compliance is maintained Facility alleges substantial compliance on 5/18/2026		
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.			F0880	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Education was provided to CNA-G on the Enhanced Barrier Precautions policy on 4/30/2026 by DON/Designee Education was provided to CNA-F on the Enhanced Barrier Precautions policy on 4/30/2026 by DON/Designee		05/18/2026

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F0880 SS = D	Continued from page 37 §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; (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.	F0880	Continued from page 37 Education was provided to CNA-K on the Enhanced Barrier Precautions policy on 4/30/2026 by DON/Designee Education was provided to CNA-L on the Enhanced Barrier Precautions policy on 4/30/2026 by DON/Designee Education was provided to LPN-A on the Enhanced Barrier Precautions policy on 4/30/2026 by DON/Designee How will you identify other residents having potential to be affected by the same deficient practice and what corrective action will be taken: All residents requiring Enhanced Barrier Precautions have the potential to be affected Education was provided by the Regional Clinical Consultant on 4/24/2026 to the IDT on the Enhanced Barrier Precautions Policy What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur; and: Education was initiated by the DON/Designee on 3/26/2026 with clinical staff on the Enhanced Barrier Precautions policy with all clinical staff being educated by 4/24/2026. Any clinical staff member not being educated by 4/24/2026 will not be allowed to work until education is received. A random audit will be conducted on 5 staff members weekly x 8 weeks to ensure compliance with the Enhanced Barrier Precautions policy. Describe the Quality Assurance and Process Improvement Program that will be put into place. QAPI was held on 4/28/2026 to review results of survey and approve the plan of correction. Results of audits will be reviewed at QAPI meeting monthly x 3 months or until substantial compliance is maintained Facility alleges substantial compliance on 5/18/2026	

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F0880 SS = D	Continued from page 38 §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, interview, and record review, the facility failed to ensure proper personal protective equipment (PPE) usage for 3 of 3 residents (R6, R4, R14) reviewed for enhanced barrier precautions (EBP) who receive tube feeding (R6, R14) and dialysis care (R4). Findings include: R6: R6's Minimum Data Set (MDS) quarterly assessment dated 1/21/26, identified severely impaired cognition and required maximal assistance for mobility. R6's diagnoses included Parkinson's, dementia, major depressive disorder and lack of coordination. R6's physician orders dated 4/24/25, Enhanced Barrier Precautions (EBP) for tube feeding. R6 had a percutaneous endoscopic gastrostomy (PEG) tube for enteral nutrition and medication. Cleanse surrounding skin with warm water using soft cloth, then pat dry. Apply barrier cream to skin under PEG tube disk to prevent moisture related skin redness. R6's care plan (CP) created on 1/27/25, identified R6 was at risk for infection related to indwelling medical device (PEG) tube. EBP when cares are provided to R6. Furthermore, alternation in cognition forgetfulness and confusion related to dementia. Additionally, had impaired swallowing related to Parkinson's, administer tube feedings, medication and flushes per order. R14: R14's MDS comprehensive assessment dated 12/29/25,		F0880				

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F0880 SS = D	Continued from page 39 identified severely impaired cognition and independent with ambulation. R6's diagnoses included non-traumatic brain dysfunction, renal insufficiency, and Alzheimer's disease. R14's physician orders dated 7/19/24, Enhance Barrier Precautions (EBP) for supra-pubic catheter for long term urinary retention. Supra-pubic foley catheter cares clean daily and as needed, empty bag every shift and record results. Educate on importance of risk of infection. R14's CP created on 4/1/24, identified R14 was at risk for infection related to indwelling medical device, supra-pubic catheter, EBP when providing cares. Additionally, R14 had alteration in urinary elimination related to obstructive uropathy, treated with a supra-pubic catheter. During observation on 3/10/26 at 11:13 a.m., certified nursing assistants (CNA)-G and CNA-F performed peri cares and toileting in shower room. There was a large amount of urine on floor, both staff members were not wearing proper EBP while cleaning floor, EZ stand and R6. During observation on 3/11/26 at 8:34a.m., CNA-K attempted to reattach leg bag on R14, bag was hanging out of pants, dragging on the floor while walking to dining room. They walked back to his room, he sat down, CNA-K put on gloves emptied out urine and reattached bag to leg, CNA-K was not wearing proper EBP when cares were performed. During interview on 3/9/26 at 3:30p.m., CNA-L stated EBP was used for the safety of the residents decrease the risk of infection. During interview on 3/10/26 at 11:46 a.m., CNA-G stated standard for infection control was hand washing, before and after cares of residents. EBP, gloves and gown to be worn when cares were done on residents with wounds, catheters, and feeding tubes. During interview on 3/10/26 at 12:00 p.m., RN-D stated EBP protected staff and residents from infections. EBP was to wear gloves and gown, hand washing before and after cares. During interview on 3/11/26 at 9:07a.m., CNA-F stated the importance of EBP was to prevent infection, the only time to wear EBP was when manipulating catheters, feeding tubes or wounds. The only time CNA-F wore EBP was when a resident had COVID. She was not an RN, they	F0880		

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F0880 SS = D	Continued from page 40 did the specific treatments, not the nursing assistants, so EBP wasn't required. R4: R4's quarterly MDS assessment, dated 2/23/26, indicated R4 was cognitively intact, had no upper body impairment, was independent with personal hygiene, and required set-up/supervision for upper and lower body dressing. It also indicated R4 received dialysis care (mechanical filtering of blood), had a surgical wound, and received surgical wound care. R4's diagnoses list included diabetes, end-stage kidney disease, heart failure, left leg amputation, and dependence on renal dialysis. R4's care plan dated 1/29/26 indicated R4 receives dialysis 3 times/week, has a dialysis catheter (a tube inserted in the chest or neck used for mechanical filtering of blood), and is at risk for infection related to a dialysis catheter requiring EBP when performing high-contact care activities. R4's provider orders dated 11/17/25 included: dialysis Monday, Wednesday, Friday, post dialysis assessment, monitor dialysis catheter daily for signs of infection, dressing changes to surgical wound, and EBP due to dialysis catheter. R4's nursing assistant care sheet dated 3/12/26 indicated "enhanced barrier precautions when performing high-contact care activities" During an observation and interview on 3/9/26 at 12:52 p.m., R4 stated staff do not wear gowns because she does not have an infection. An orange sign indicating "enhanced barrier precautions" was noted outside R4's room. During observation and interview on 3/11/26 at 11:05 a.m., licensed practical nurse (LPN)-A entered R4's room to perform a scheduled dressing change to R4's surgical site. LPN-A stated she washed her hands prior to entering the room and applied gloves. Without donning a gown, LPN-A performed the dressing change to R4's left lower extremity. LPN-A then washed and dried under R4's abdomen, applied powder to R4's abdominal folds. After disposing garbage, removing gloves, and washing hands, LPN-A reviewed the EBP sign on R4's door. LPN-A stated it indicated "barrier precautions and to gown up and glove." When asked what tasks would requiring gowning and gloving, LPN-A stated she was		F0880				

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED

OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245184	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/12/2026
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F0880 SS = D	Continued from page 41 “drawing a blank.” When asked why R4 was on EBP, LPN-A stated it “might be for her PICC line [referring to the central line dialysis catheter], but I don’t do anything with that.” LPN-A stated staff are only required to wear PPE if they are providing care “for the reason they are on the precautions.” LPN-A stated staff receive infection control training upon hire and have online education. During interview on 3/11/26 at 11:53 a.m., LPN-A confirmed R4 is on EBP due to having a dialysis catheter. During interview on 3/12/25 at 9:31 a.m., the director of nursing stated residents are placed on EBP if they have indwelling medical devices, chronic rounds, and MDROs (bacteria resistant to multiple treatments). An order is placed on the medication administration record, care plan is updated, and signage is placed on the door. The director of nursing stated staff are expected to read the signage on the door for instruction regarding precautions. He stated gown and gloves are required for all high-contact cares. A policy titled “Enhanced Barrier Precautions” dated 3/24/25 indicated “It is the policy of this facility to implement enhanced barrier precautions for the prevention of transmission of multidrug-resistant organisms.” The policy also indicated, in part, an order for enhanced barrier precautions will be obtained for residents with chronic wounds and/or indwelling medical devices (e.g., central lines, urinary catheters, feeding tubes, etc.). Implementation of enhanced barrier precautions included “PPE for enhanced barrier precautions is only necessary when performing high-contact care activities”. High-contact resident care activities included: device care or use: central lines (tubes in the neck or chest providing access to large vessels), PICC lines (tubes placed in the upper arm allowing access to veins) , hemodialysis catheters, and wound care involving any skin opening requiring a dressing.	F0880		
F0919 SS = D	Resident Call System CFR(s): 483.90(g)(1)(2) §483.90(g) Resident Call System The facility must be adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area from-	F0919	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Call light was repaired in shower room on 3rd floor by Maintenance Director on 4/30/2026 How will you identify other residents having potential to be affected by the same deficient practice and what	05/18/2026

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F0919 SS = D	Continued from page 42 §483.90(g)(1) Each resident's bedside; and §483.90(g)(2) Toilet and bathing facilities. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review the facility failed to ensure a bathroom call light was functioning for the shower room on the 3rd floor having the potential to affect all residents that use the toilet in the shower room, 7 of 7 (R6, R36, R2, R8, R51, R60, R62) residents were brought to and used an EZ stand for toileting. Findings include: R6's Minimum Data Set (MDS) quarterly assessment dated 1/21/26, identified severely impaired cognition and required maximal assistance for mobility. R6's diagnoses included Parkinson's, dementia, major depressive disorder and lack of coordination. R6's care plan (CP) created on 9/14/24, identified mobility was an area of concern, indicated was not ambulatory and needed transfer assistance of 2 and mechanical lift (EZ stand). Furthermore, the CP identified an area of concern, indicated was at risk for falls due to dementia, impaired coordination and mobility, medications, impulsiveness and safety awareness. R36's MDS comprehensive assessment dated 3/14/25, identified moderate cognitive impairment and left sided weakness in upper and lower extremities. R36's diagnoses included dementia, hemiplegia (left side affected), and congestive heart failure. R36's care plan created on 3/14/24, identified mobility was an area of concern, indicated transfers with assist of 2 and (sit to stand lift) EZ stand. Furthermore, the care plan identified was at risk of falls due to impaired mobility, left side weakness and dementia. R2's MDS quarterly assessment dated 2/10/26, identified severely impaired cognition and dependent mobility. R2's diagnoses included anxiety, dementia and cardiorespiratory issues. R2's care plan revised on 10/27/25, identified activities of daily living was an area of concern related to mobility status and dementia. The care plan indicated transfers with the assistance of two and EZ	F0919	Continued from page 42 corrective action will be taken: All residents have the potential to be affected An audit was conducted on all other call lights in the facility on 4/30/2026 by the maintenance director – all were found to be functional What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur; and: Education was initiated with the DON/Designee on reporting items in need of repairs via TELS with clinical staff on 3/26/2026 any clinical staff not receiving education by 4/24/2026 will not be allowed to work until education is received. An audit will be completed by the maintenance director of 5 resident care areas weekly x 8 weeks to ensure call lights are functioning properly Describe the Quality Assurance and Process Improvement Program that will be put into place. QAPI was held on 4/28/2026 to review results of survey and approve the plan of correction. Results of audits will be reviewed at QAPI meeting monthly x 3 months or until substantial compliance is maintained Facility alleges substantial compliance on 5/18/2026	

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F0919 SS = D	Continued from page 43 stand lift for all transfers. Furthermore, the care plan identified was at risk for falls due to impaired mobility, dementia and medications. R8's MDS quarterly assessment dated 2/6/26, identified severely impaired cognition and substantial/maximal assistance with transfers. R8's diagnoses included non-traumatic brain dysfunction, dementia and seizure disorder. R8's care plan was created on 6/4/23, identified activities of daily living were an area of concern, due to dementia, leg pain, decrease mobility and resistance to assistance. Perform cares in pairs, transfer with assist of 2 and an EZ stand. R51's MDS quarterly assessment dated 2/24/26, identified severely impaired cognition and dependent on all areas of mobility. R51's diagnoses included atrial fibrillation, type II diabetes, depression and dementia. R51's care plan created on 3/8/23, identified activities of daily living were an area of concern, due to weakness, stroke and cognitive impairment. Assist of two and EZ stand with transfers. Furthermore, identified falls were an area of concern, due to weakness, dementia and cognitive deficits. R60's MDS quarterly assessment dated 3/3/26, identified severely impaired cognition and dependent on all areas of mobility. R60's diagnoses included dementia, psychotic and mood disturbances and anxiety. R60's care plan revision on 10/7/24, identified activities of daily living was an area of concern, due to the disease process of Alzheimer's. Transfer with assistance of two and EZ stand. Furthermore, an area of concern was at risk for falls due to being unaware of safety needs and history of falls. R62's MDS comprehensive assessment on 2/20/26, identified severely impaired cognition and dependent on mobility. R62's diagnoses included osteoporosis, hemiplegia and dementia. R62's care plan revision on 6/9/25, identified activities of daily living was an area of concern, due to disease process, physical limitations, cognitive losses with spastic hemiplegia. Transfer assist of two and sit to stand lift. Furthermore, an area of concern was at risk for falls related to cognition, unaware of safety needs, incontinence, history of traumatic brain injury and cerebral vascular accident with spastic	F0919		

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F0919 SS = D	Continued from page 44 hemiplegia (type of cerebral palsy that affected one side of body, muscle weakness and stiffness). During observation on 3/10/26 at 11:13 a.m., the shower room had a call light which was a small switch on back wall by the toilet, no cord seen. During observation and interview on 3/10/26 at 12:00, registered nurse (RN)-D went and found a cord, tied it around the call light switch in the shower room by the toilet for residents to use, at that time, the light did turn on outside of door when cord was pulled. RN-D stated things were falling through the cracks on the 3rd floor, they didn't have an RN manager, to educate and facilitate any concerns or issues. During interview on 3/12/26 at 11:28 a.m., CNA-J stated if the call light in the shower room wasn't working, they would hear a resident yelling or banging for assistance. During observation and interview on 3/12/26 at 12:17p.m., the call light was not lit up in hallway nor ringing at the nurse's station for the shower room. CNA-F and director of nursing (DON) were at the nurse's desk filling out the a maintenance report. The DON stated it was the 1st time he was told there was a problem with the call light. During interview on 3/12/2026 at 4:47 p.m., RN-E and RN-F verified that call light was not working. RN-E asked to pull call light, red light came on, there was no sound to alert staff, the light on the board in nurses' station also came on with no sound, Both nurses present, confirmed call light not working. Maintenance called, he came and verified that the call light was not working, and he had a call out to have call light fixed. Record review a document entitled, Building Tasks dated 9/25-3/26, Conduct a Test of the Nurse Call System was marked at completed on 2/20/26. The steps were: 1. For each department, notify the appropriate person in charge that the call system is being tested 2. Check all devices transmitting to, and received from nurse call system, to include pullcords, pendants and pagers. Repair as necessary 3. Check call cords in bathrooms and shower rooms. Ensure call cord length is no more than 6" from the		F0919				

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F0919 SS = D	Continued from page 45 floor. Repair as necessary 4. Notify the appropriate person in charge that the test has been completed and has been returned to operational status 5. Check call light clips 6. If system is capable, run report to identify equipment alerts, such as low battery The Call Lights: Accessibility and Timely response Policy, revised 1/26, indicated The purpose of this policy is to assure the facility is adequately equipped with a call light at each residents' bedside, toilet, and bathing facility to allow residents to call for assistance. Call lights will directly relay to a staff member or centralized location to ensure appropriate response. Staff will ensure the call light is within reach of resident and secure, as needed. The call system must be accessible to the resident at each toilet and bath or shower facility. The call system should be accessible to a resident lying on the floor. Staff will report problems with a call light or the call system immediately to the supervisor and/or maintenance director and will provide immediate or alternative solutions until the problem can be remedied. (Examples include replace "call light", provide a bell or whistle, increase frequency of rounding, etc.)		F0919				

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20000	Initial Comments *****ATTENTION***** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 3/9/26-3/12/26, a standard licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Nursing Home Licensure and the following correction orders are issued. Please indicate in your electronic plan of correction you have reviewed these orders, and identify the date when they will be completed.		20000			04/17/2026	

Office of Primary Care and Health Systems Management

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE		TITLE	(X6) DATE
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Minnesota State Department of Health

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20000	Continued from page 1 The following complaints were reviewed: H51847801C (2793857), H51847942C (2612067), H51847874C (MN00111412/1073210), H51847875C (MN00111170/1073209), H51847973C (MN00112661/1073214), H51848020C (2796479). NO licensing orders were issued. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor's findings are the Suggested Method of Correction and Time period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin https://www.health.state.mn.us/facilities/regulation/infbulletins/ib14_1.html. The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.		20000				
20270	Use of Oxygen CFR(s): MN Rule 4658.0090 A nursing home must develop and implement policies and procedures for the safe storage and use of oxygen. This LICENSURE REQUIREMENT is NOT MET as evidenced by:		20270	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: R44 MD was contacted with orders received to make oxygen PRN to maintain oxygen saturation >90% on 3/11/2026		05/18/2026	

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20270	Continued from page 2 Based on observation, interview, and record review, the facility failed to provide oxygen therapy as ordered for 1 of 1 resident (R44) reviewed for respiratory care. Findings include: R44's Admission Minimum Data Set (MDS) assessment, dated 2/20/26, indicated intact cognition, R44 required partial to moderate assistance with toileting hygiene. R44's diagnoses included chronic respiratory failure with hypoxia, dependence on supplemental oxygen, chronic pulmonary edema, moderate persistent asthma, and dependence of renal dialysis. R44's was admitted on 2/5/26 with including, oxygen 2 liters via nasal cannula continuously. During an observation on 3/09/26 at 7:24 p.m., R44 was on the oxygen concentrator with a flow rate of 3 liters. During observation on 3/10/26 11:11 a.m., R44 came down the unit hallway on her motorized scooter with no oxygen in use. R44 stated, the portable oxygen tank was empty and was in search of staff to have the tank filled. R44 searched for staff for 4 minutes. The director of nursing (DON) filled the portable oxygen tank for R44 at 11:15 a.m. R44 took the oxygen tank and went back to her room with no oxygen in use. During observation on 3/10/26 11:23 a.m., and 11:28 am oxygen tank was not in use. During observation on 3/10/26 at 11:49 a.m., R44 was in her room, and was using the oxygen concentrator, on 3 liters via nasal cannula. At 11:50 a.m., registered nurse, (RN)-B entered R44's room, had a conversation with R44 and exited at 11:52 a.m. During observation on 3/10/26 12:03 p.m., R44 came out of the room, the portable oxygen tank in use via nasal cannula on 2 liters and stated was going to the dining room for lunch. During an interview with RN-B on 3/10/26 1:38 p.m., RN-B stated, had seen R44 at times with no oxygen in use, and was not sure if R44 oxygen order was continuous or as needed. During an interview with nursing assistant (NA)-E on 3/10/26 at 1:39 p.m., NA-E stated had seen R44 without	20270	Continued from page 2 How will you identify other residents having potential to be affected by the same deficient practice and what corrective action will be taken: All residents on Oxygen have the potential to be affected Education was provided by the Regional Clinical Consultant on 4/22/2026 to the IDT on the Oxygen Administration policy An audit was conducted on 4/30/2026 by the DON/Designee to ensure that residents are receiving on-going assessment of the resident's condition warranting oxygen and the resident response to Oxygen What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur; and: Education was initiated on 3/26/2026 by DON/Designee on the Oxygen Administration policy and the need for residents receiving oxygen to receive on-going assessment of the resident's condition warranting oxygen and the resident response to Oxygen with all staff receiving education by 4/24/2026. Any staff not receiving education by 4/24/2026 will not be allowed to work until education is received An audit will be completed weekly x 8 weeks on residents receiving oxygen to ensure on-going assessment of the resident's condition and the resident's response to Oxygen is being documented appropriately and an SBAR is completed with MD notification with changes in resident condition changes. Describe the Quality Assurance and Process Improvement Program that will be put into place. QAPI was held on 4/28/2026 to review results of survey and approve the plan of correction. Results of audits will be reviewed at QAPI meeting monthly x 3 months or until substantial compliance is maintained Facility alleges substantial compliance on 5/18/2026	

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20270	Continued from page 3 oxygen in use. NA-E stated had seen R44 down the hallway and needed the portable oxygen tank filled. During an interview on 3/10/26 2:28 p.m., the DON verified filling the tank for R44. DON stated, "I have never seen her with her oxygen in use". During an interview on 3/12/26 at 2:00 p.m., medical doctor, (MD) expected the facility to have sent an SBAR (situation, background, assessment, recommendation) and updated vitals for ongoing need for supplemental oxygen. An undated facility provided policy indicated staff shall document ongoing assessment of the resident's condition warranting oxygen and the response to oxygen therapy. SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON) or designee could review and revise policies for oxygen use including assessment, implementation, and staff education. The DON or designee could audit oxygen use for residents affected and take that information to QAPI to ensure compliance and determine the need for further education/monitoring/compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.		20270				
20570	Comprehensive Plan of Care; Revision CFR(s): MN Rule 4658.0405 Subp. 4 Subp. 4. Revision. A comprehensive plan of care must be reviewed and revised by an interdisciplinary team that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, with the participation of the resident, the resident's legal guardian or chosen representative at least quarterly and within seven days of the revision of the comprehensive resident assessment required by part 4658.0400, subpart 3, item B. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review, the facility failed to revise and update a care plan for 1of 1 resident (R33) reviewed for care plan timing and revision. Findings include:		20570	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: R33 smoking care plan was updated by the MDS coordinator on 4/30/2026 to reflect the recommendations of the smoking assessment with those recommendations flowing to the resident Kardex R33 TAR was updated on 4/30/2026 for nursing staff to retrieve smoking paraphernalia and keep secured at nurses station. R33 was educated on the Smoking Policy and requirement to follow the recommendations from her Safe Smoking Assessment to continue smoking. How will you identify other residents having potential to be affected by the same deficient practice and what corrective action will be taken: All residents who smoke are at risk		05/18/2026	

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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	
20570	Continued from page 4 R33's Minimum Data Set (MDS) assessment, dated 12/3/25, /indicated intact cognition, /R33 /was independent with transfers, w/c mobility and required limited assist with bed mobility. R33 's diagnoses included chronic systolic and diastolic (congestive) heart failure (a serious condition of the heart's ability to pump blood efficiently), Chronic obstructive pulmonary diseases (an ongoing lung condition caused by damage to the lungs), generalized osteoarthritis. R33's care plan dated 11/19/25 indicated R33 was allowed to smoke independently in designated smoking areas, needed reminders and assistance to use smoking apron, and smoking materials needed to be secured at the nurses' station or other designated areas for storage. R33's Smoking Assessment completed on 2/20/26, indicated R33 was safe to smoke without supervision, demonstrated safe smoking practices, no indication of smoking apron use, and facility stored lighter and cigarettes. R33's care plan was not updated to reflect the changes noted in the 2/20/26 smoking assessment. R33's MAR/TAR (medications administration/ treatments administration record) dated 3/10/26 lacked smoking assessment recommendations/interventions. R33's Task Description list (task assigned to nursing assistants) dated 3/1/26 lacked smoking tasks. During an observation on 3/9/26 at 6:46 p.m., R33 took her smoking materials from her room and continued to go out to the designated smoking area. R33 did not use a smoking apron. R33 demonstrated safe smoking practices. During an interview on 3/09/26 3:03 p.m., R33 stated, she kept her smoking materials locked in her room, smoked 1-2 cigarettes a day, and reported no smoking apron use while smoking. During an interview 3/10/26 10:49 a.m., registered nurse (RN-B) stated was not sure if R33 went out to smoke or was getting some fresh air. RN-B stated, "that information will be on the MAR/TAR, and a staff member would have been assigned to R33, if R33 was a smoker". During an interview on 3/10/26 11:20 a.m., nursing assistant (NA-E)stated, R33 used to smoke, and had not seen R33 smoke today. NA-E stated, "I will ask the nurse, the DON or look at Task Description list".		20570	Continued from page 4 A Safe Smoking Assessment was completed on all residents who smoke with care plan, Kardex, and TARs updated appropriately Education was provided to all residents who smoke on the facility policy and the requirement to follow the policy and recommendations from the safe smoking assessments to continue to be allowed to smoke. An Ad Hoc resident council meeting was held on 4/30/2026 to review the smoking policy What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur; and: Education was initiated with the clinical staff on the Smoking Policy and the need to complete Safe Smoking Assessments on all individuals who smoke and maintain possession of all smoking paraphernalia except when resident is smoking by the DON on 3/26/2026 with all staff receiving education by 4/24/2026 any staff not receiving education by 4/24/2026 will not be allowed to work until education is received. Residents who smoke will be reviewed weekly as part of the weekly At Risk meeting to ensure that care plan is accurate and residents are compliant with the recommendations and facility policy. A care conference will be scheduled for any resident found not to be compliant with the recommendations and policy. Describe the Quality Assurance and Process Improvement Program that will be put into place. QAPI was held on 4/28/20526 to review results of survey and approve the plan of correction. Results of audits will be reviewed at QAPI meeting monthly x 3 months or until substantial compliance is maintained Facility alleges substantial compliance on 5/18/2026			

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20570	Continued from page 5 During an interview on 3/10/26 at 2:27 p.m., the director of nursing (DON), explained the process of assessment to care planning and updates. DON stated, “after the Smoking Assessment was completed, nursing was responsible for updating the care plan, staff was notified, and information was available on the Task List and in the care plan. DON stated, “no point of care notification is sent out to notify staff of updates, staff are expected to review care plan for updates”. During an interview on 3/12/26 at 8:45 a.m., DON stated, R33 stored smoking materials in her room, R33 was safe to smoke independently and R33 needed no smoking apron. Facility policy on care plan revision and update requested and not provided. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and revise policies and procedures related to revision of the care plan as needed to meet the needs of each individual resident. The director of nursing or designee could develop a system to educate staff and develop a monitoring system to ensure individual care plans are revised as necessary. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.		20570				
21100	Food Supplies; Storage of Perishable food CFR(s): MN Rule 4658.0650 Subp. 5 Subp. 5. Storage of perishable food. All perishable food must be stored off the floor on washable, corrosion-resistant shelving under sanitary conditions, and at temperatures which will protect against spoilage. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and record review, the facility failed to ensure food stored in the refrigerator were labeled, dated and free of expired foods. This deficient practice had the potential to affect all residents, staff and visitors who received food from facility kitchen. Findings include: During the initial kitchen tour on 3/9/26 at 10:34 a.m., cook (C)-A greeted surveyor inside the kitchen.		21100	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Expired sliced ham was disposed of by the CDM on 3/12/2026 Lettuce was disposed of by the CDM on 3/12/2026 Box of food on the floor was placed on shelf on 3/12/2026 Box of food touching the freezer fan blade was moved away from the fan on 3/12/2026 How will you identify other residents having potential to be affected by the same deficient practice and what corrective action will be taken: All residents have the potential to be affected		05/18/2026	

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21100	Continued from page 6 The following items were observed in the fridge expired and undated food: -Sliced Ham, expired on 3/2/26 -no date on lettuce, browning and wilting Additionally, the following items were observed in the freezer: -box of food sitting directly on the freezer floor -box on top shelf of freezer touching freezer fan blade During the follow up kitchen tour on 3/12/26 at 12:25 p.m., district manager (DM) stated the expired sliced ham, and undated lettuce had been thrown out. DM confirmed the box on the floor of the freezer had been placed on a shelf. DM confirmed the box touching the freezer fan blade had been pushed back away from the fan blade. DM stated undated items should be thrown out immediately and foods in the fridge longer than 3 days should be thrown out. DM stated it is important to use expiration dates to ensure palatability and to prevent food borne illnesses. DM stated it is important to keep food boxes correctly place to ensure freezer equipment continues to work as intended. A facility policy was requested and not received. SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON) or designee could review and revise policies for oxygen use including assessment, implementation, and staff education. The DON or designee could audit oxygen use for residents affected and take that information to QAPI to ensure compliance and determine the need for further education/monitoring/compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days		21100	Continued from page 6 Education was provided to Cook-C by CDM on the Food Safety Requirement policy on 4/30/2026 What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur; and: Education was initiated by CDM on 3/26/2024 on the Food Safety Requirements policy with all staff being educated by 4/24/2026 any staff not receiving education by 4/24/2026will not be allowed to work until they receive education Food storage will be audited by CDM weekly x 8 weeks Describe the Quality Assurance and Process Improvement Program that will be put into place. QAPI was held on 4/28/2026 to review results of survey and approve the plan of correction. Results of audits will be reviewed at QAPI meeting monthly x 3 months or until substantial compliance is maintained Facility alleges substantial compliance on 5/18/2026			
21390	Infection Control CFR(s): MN Rule 4658.0800 Subp. 4 A-I Subp. 4. Policies and procedures. The infection control program must include policies and procedures which provide for the following: A. surveillance based on systematic data collection to identify nosocomial infections in residents; B. a system for detection, investigation, and control of outbreaks of infectious diseases;		21390	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Education was provided to CNA-G on the Enhanced Barrier Precautions policy on 4/30/2026 by DON/Designee Education was provided to CNA-F on the Enhanced Barrier Precautions policy on 4/30/2026 by DON/Designee Education was provided to CNA-K on the Enhanced Barrier Precautions policy on 4/30/2026 by DON/Designee		05/18/2026	

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21390	Continued from page 7 C. isolation and precautions systems to reduce risk of transmission of infectious agents; D. in-service education in infection prevention and control; E. a resident health program including an immunization program, a tuberculosis program as defined in part 4658.0810, and policies and procedures of resident care practices to assist in the prevention and treatment of infections; F. the development and implementation of employee health policies and infection control practices, including a tuberculosis program as defined in part 4658.0815; G. a system for reviewing antibiotic use; H. a system for review and evaluation of products which affect infection control, such as disinfectants, antiseptics, gloves, and incontinence products; and I. methods for maintaining awareness of current standards of practice in infection control. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and record review, the facility failed to ensure proper personal protective equipment (PPE) usage for 3 of 3 residents (R6, R4, R14) reviewed for enhanced barrier precautions (EBP) who receive tube feeding (R6, R14) and dialysis care (R4). Findings include: R6: R6's Minimum Data Set (MDS) quarterly assessment dated 1/21/26, identified severely impaired cognition and required maximal assistance for mobility. R6's diagnoses included Parkinson's, dementia, major depressive disorder and lack of coordination. R6's physician orders dated 4/24/25, Enhanced Barrier Precautions (EBP) for tube feeding. R6 had a percutaneous endoscopic gastrostomy (PEG) tube for enteral nutrition and medication. Cleanse surrounding skin with warm water using soft cloth, then pat dry. Apply barrier cream to skin under PEG tube disk to prevent moisture related skin redness.	21390	Continued from page 7 Education was provided to CNA-L on the Enhanced Barrier Precautions policy on 4/30/2026 by DON/Designee Education was provided to LPN-A on the Enhanced Barrier Precautions policy on 4/30/2026 by DON/Designee How will you identify other residents having potential to be affected by the same deficient practice and what corrective action will be taken: All residents requiring Enhanced Barrier Precautions have the potential to be affected Education was provided by the Regional Clinical Consultant on 4/24/2026 to the IDT on the Enhanced Barrier Precautions Policy What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur; and: Education was initiated by the DON/Designee on 3/26/2026 with clinical staff on the Enhanced Barrier Precautions policy with all clinical staff being educated by 4/24/2026. Any clinical staff member not being educated by 4/24/2026 will not be allowed to work until education is received. A random audit will be conducted on 5 staff members weekly x 8 weeks to ensure compliance with the Enhanced Barrier Precautions policy. Describe the Quality Assurance and Process Improvement Program that will be put into place. QAPI was held on 4/28/2026 to review results of survey and approve the plan of correction. Results of audits will be reviewed at QAPI meeting monthly x 3 months or until substantial compliance is maintained Facility alleges substantial compliance on 5/18/2026	

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21390	Continued from page 8 R6's care plan (CP) created on 1/27/25, identified R6 was at risk for infection related to indwelling medical device (PEG) tube. EBP when cares are provided to R6. Furthermore, alternation in cognition forgetfulness and confusion related to dementia. Additionally, had impaired swallowing related to Parkinson's, administer tube feedings, medication and flushes per order. R14: R14's MDS comprehensive assessment dated 12/29/25, identified severely impaired cognition and independent with ambulation. R6's diagnoses included non-traumatic brain dysfunction, renal insufficiency, and Alzheimer's disease. R14's physician orders dated 7/19/24, Enhance Barrier Precautions (EBP) for supra-pubic catheter for long term urinary retention. Supra-pubic foley catheter cares clean daily and as needed, empty bag every shift and record results. Educate on importance of risk of infection. R14's CP created on 4/1/24, identified R14 was at risk for infection related to indwelling medical device, supra-pubic catheter, EBP when providing cares. Additionally, R14 had alteration in urinary elimination related to obstructive uropathy, treated with a supra-pubic catheter. During observation on 3/10/26 at 11:13 a.m., certified nursing assistants (CNA)-G and CNA-F performed peri cares and toileting in shower room. There was a large amount of urine on floor, both staff members were not wearing proper EBP while cleaning floor, EZ stand and R6. During observation on 3/11/26 at 8:34a.m., CNA-K attempted to reattach leg bag on R14, bag was hanging out of pants, dragging on the floor while walking to dining room. They walked back to his room, he sat down, CNA-K put on gloves emptied out urine and reattached bag to leg, CNA-K was not wearing proper EBP when cares were performed. During interview on 3/9/26 at 3:30p.m., CNA-L stated EBP was used for the safety of the residents decrease the risk of infection. During interview on 3/10/26 at 11:46 a.m., CNA-G stated standard for infection control was hand washing, before and after cares of residents. EBP, gloves and gown to be worn when cares were done on residents with wounds, catheters, and feeding tubes.		21390				

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21390	Continued from page 9 During interview on 3/10/26 at 12:00 p.m., RN-D stated EBP protected staff and residents from infections. EBP was to wear gloves and gown, hand washing before and after cares. During interview on 3/11/26 at 9:07a.m., CNA-F stated the importance of EBP was to prevent infection, the only time to wear EBP was when manipulating catheters, feeding tubes or wounds. The only time CNA-F wore EBP was when a resident had COVID. She was not an RN, they did the specific treatments, not the nursing assistants, so EBP wasn't required.R4: R4's quarterly MDS assessment, dated 2/23/26, indicated R4 was cognitively intact, had no upper body impairment, was independent with personal hygiene, and required set-up/supervision for upper and lower body dressing. It also indicated R4 received dialysis care (mechanical filtering of blood), had a surgical wound, and received surgical wound care. R4's diagnoses list included diabetes, end-stage kidney disease, heart failure, left leg amputation, and dependence on renal dialysis. R4's care plan dated 1/29/26 indicated R4 receives dialysis 3 times/week, has a dialysis catheter (a tube inserted in the chest or neck used for mechanical filtering of blood), and is at risk for infection related to a dialysis catheter requiring EBP when performing high-contact care activities. R4's provider orders dated 11/17/25 included: dialysis Monday, Wednesday, Friday, post dialysis assessment, monitor dialysis catheter daily for signs of infection, dressing changes to surgical wound, and EBP due to dialysis catheter. R4's nursing assistant care sheet dated 3/12/26 indicated "enhanced barrier precautions when performing high-contact care activities" During an observation and interview on 3/9/26 at 12:52 p.m., R4 stated staff do not wear gowns because she does not have an infection. An orange sign indicating "enhanced barrier precautions" was noted outside R4's room. During observation and interview on 3/11/26 at 11:05 a.m., licensed practical nurse (LPN)-A entered R4's room to perform a scheduled dressing change to R4's surgical site. LPN-A stated she washed her hands prior to entering the room and applied gloves. Without			21390			

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21390	Continued from page 10 donning a gown, LPN-A performed the dressing change to R4's left lower extremity. LPN-A then washed and dried under R4's abdomen, applied powder to R4's abdominal folds. After disposing garbage, removing gloves, and washing hands, LPN-A reviewed the EBP sign on R4's door. LPN-A stated it indicated "barrier precautions and to gown up and glove." When asked what tasks would require gowning and gloving, LPN-A stated she was "drawing a blank." When asked why R4 was on EBP, LPN-A stated it "might be for her PICC line [referring to the central line dialysis catheter], but I don't do anything with that." LPN-A stated staff are only required to wear PPE if they are providing care "for the reason they are on the precautions." LPN-A stated staff receive infection control training upon hire and have online education. During interview on 3/11/26 at 11:53 a.m., LPN-A confirmed R4 is on EBP due to having a dialysis catheter. During interview on 3/12/25 at 9:31 a.m., the director of nursing stated residents are placed on EBP if they have indwelling medical devices, chronic rounds, and MDROs (bacteria resistant to multiple treatments). An order is placed on the medication administration record, care plan is updated, and signage is placed on the door. The director of nursing stated staff are expected to read the signage on the door for instruction regarding precautions. He stated gown and gloves are required for all high-contact cares. A policy titled "Enhanced Barrier Precautions" dated 3/24/25 indicated "It is the policy of this facility to implement enhanced barrier precautions for the prevention of transmission of multidrug-resistant organisms." The policy also indicated, in part, an order for enhanced barrier precautions will be obtained for residents with chronic wounds and/or indwelling medical devices (e.g., central lines, urinary catheters, feeding tubes, etc.). Implementation of enhanced barrier precautions included "PPE for enhanced barrier precautions is only necessary when performing high-contact care activities". High-contact resident care activities included: device care or use: central lines (tubes in the neck or chest providing access to large vessels), PICC lines (tubes placed in the upper arm allowing access to veins) , hemodialysis catheters, and wound care involving any skin opening requiring a dressing. SUGGESTED METHOD OF CORRECTION: The administrator or designee could review policies and procedures to ensure, proper infection control regarding EBP practices were followed. Facility staff could be reeducated and an auditing system developed to		21390				

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21390	Continued from page 11 ensure compliance.	21390			
21540	Unnecessary Drug Usage; Monitoring CFR(s): MN Rule 4658.1315 Subp. 2 Subp. 2. Monitoring. A nursing home must monitor each resident's drug regimen for unnecessary drug usage, based on the nursing home's policies and procedures, and the pharmacist must report any irregularity to the resident's attending physician. If the attending physician does not concur with the nursing home's recommendation, or does not provide adequate justification, and the pharmacist believes the resident's quality of life is being adversely affected, the pharmacist must refer the matter to the medical director for review if the medical director is not the attending physician. If the medical director determines that the attending physician does not have adequate justification for the order and if the attending physician does not change the order, the matter must be referred for review to the Quality Assurance and Assessment (QAA) committee required by part 4658.0070. If the attending physician is the medical director, the consulting pharmacist shall refer the matter directly to the QAA. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on interview and record review, the facility failed to monitor effectiveness of a medication prescribed for sleep by not completing sleep monitoring for 1 of 1 resident (R33) reviewed for unnecessary medications. Findings include: R33's Minimum Data Set (MDS) assessment, dated 12/3/25, /indicated intact cognition, /R33 /was independent with transfers, w/c mobility and required limited assist with bed mobility. R33 diagnoses included chronic systolic and diastolic (congestive) heart failure (a serious condition of the heart's ability to pump blood efficiently), Chronic obstructive pulmonary diseases (an ongoing lung condition caused by damage to the lungs), generalized osteoarthritis. R33's medication orders included: Melatonin 5 milligrams (mg), oral at bedtime: start date:12/01/25 for insomnia.	21540	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: R33 had a sleep study assessment completed on 4/30/2026 How will you identify other residents having potential to be affected by the same deficient practice and what corrective action will be taken: All residents on Melatonin have the potential to be affected An audit of was completed on residents taking Melatonin was conducted and any requiring a sleep study assessment had one scheduled What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur; and: Education was initiated by the DON/Designee on 3/26/2026 with the licensed clinical staff on the Sleep Study assessment and the need to ensure this is completed with the initiation of Melatonin, quarterly and with any significant change on any resident taking Melatonin with all licensed clinical staff receiving education by 4/24/2026. Any staff not receiving education by 4/24/2026 will not be allowed to work until education is received. An audit will be completed quarterly on any resident taking Melatonin as part of their care plan process to ensure a sleep study is completed with any resident not having the sleep study completed having the sleep study scheduled Describe the Quality Assurance and Process Improvement Program that will be put into place. QAPI was held on 4/28/2026 to review results of survey and approve the plan of correction. Results of audits will be reviewed at QAPI meeting monthly x 3 months or	05/18/2026	

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21540	Continued from page 12 R33's Medication Administration Record (MAR) record review from 02/1/26 to 3/11/26 reviewed lacked sleep tracking or monitoring. R33' s progress note reviewed from 02/1/25 to 3/11/26 had no reference to R33 sleep monitoring. During an interview on 3/11/2026 at 4:05 p.m., registered nurse (RN)-C, RN-C stated, "yes, resident is taking a sleep aid, melatonin 5 mg, we usually do a sleep monitoring, but there is no sleep monitoring in place in the assessment for that resident and I do not know why". During an interview on 3/11/2026 4:55 p.m., the director of nursing (DON) stated, "I will not track sleep with Melatonin use due to Melatonin being an over-the-counter medication". The facility policy titled: Gradual Dose Reduction of Psychotropic Drugs reviewed 3/5/2025 indicates, "Psychotropic drug" or "psychotropic medication" is defined as any drug that affects brain activities associated with mental processes and behavior. Psychotropic drugs include, but are not limited to the following categories: antipsychotics, antidepressants, antianxiety, and hypnotics (a class of drugs used preliminary to induce sleep and treat insomnia)SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON) and consulting pharmacist could review and revise policies and procedures for proper monitoring of medication usage effectiveness. The DON or designee, along with the pharmacist, could audit medication reviews on a regular basis to ensure compliance. TIMEFRAME FOR CORRECTION: Twenty-one (21) days.		21540	Continued from page 12 until substantial compliance is maintained Facility alleges substantial compliance on 5/18/2026			
21565	Administration of Medications Self Admin CFR(s): MN Rule 4658.1325 Subp. 4 Subp. 4. Self-administration. A resident may self-administer medications if the comprehensive resident assessment and comprehensive plan of care as required in parts 4658.0400 and 4658.0405 indicate this practice is safe and there is a written order from the attending physician. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and record review, the facility failed to ensure residents were assessed to self-administer medications for 1 of 1 resident (R4)		21565	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: R4 had self-administration of medication assessment completed on 4/30/2026. IDT reviewed results of assessment and resident was deemed safe to self-administer medication (Nystatin) MD was notified of assessment results and order was obtained for resident to self-administer Nystatin on 4/30/2026		05/18/2026	

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NAME OF PROVIDER OR SUPPLIER Rochester Restorative Care Center			STREET ADDRESS, CITY, STATE, ZIP CODE 501 EIGHTH AVENUE SOUTHEAST , ROCHESTER, Minnesota, 55904	
(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
21565	Continued from page 13 reviewed for self-administration of medication (SAM). Findings include: R4's quarterly Minimum Data Set (MDS) assessment, dated 2/23/26 indicated R4 was cognitively intact, had no upper body impairment, was independent with personal hygiene, and required set-up to supervision for upper and lower body dressing. R4's diagnoses list included diabetes, end-stage kidney disease, heart failure, and morbid obesity. R4's self-administration care plan dated 11/20/25 lacked self-administration of nystatin powder (medication used to treat fungal infections). R4's provider orders included: Nystatin powder 1 application to affected areas under right breast and skin folds topically twice a day and as needed. R4's medical record lacked a self-administration assessment for applying Nystatin powder. During observation and interview on 3/10/26 at 3:45 p.m., R4 stated she keeps her nystatin powder locked up in the canvas bag located on her bed. During interview on 3/11/26 at 9:43 a.m., licensed practical nurse (LPN)-A stated R4 administers own injections and completes blood sugar check with nursing supervision and performs her own vitals. LPN-A stated R4 refuses the nystatin powder however it is kept in the medication cart. LPN-A looked in the medication and treatment cart however could not find R4's nystatin powder. During observation and interview on 3/11/25 at 10:12 a.m., R4 indicated she puts the nystatin powder on herself twice a day. R4 stated she feels the area under her abdomen has improved however confirmed she is unable to see what the area looks like. R4 opened the locked canvas bag on her bed that contained a bottle of nystatin powder dated November of 2025. R4 stated she likes that particular bottle because it is easier to use. When she runs out, she has the nursing staff order a new bottle and dump the contents of the new bottle into the bottle she likes. R4 stated the nurses do not offer to put the nystatin powder on. During observation and interview on 3/11/26 at 11:05 a.m., LPN-A arrived to perform R4's dressing change. After the dressing change, LPN-A asked permission to wash under R4's abdominal folds and apply the nystatin	21565	Continued from page 13 How will you identify other residents having potential to be affected by the same deficient practice and what corrective action will be taken: All residents have the potential to be affected Ad-Hoc resident council was held on 4/30/2026 with self-administration of medication policy reviewed with residents An audit was completed of resident rooms to determine if residents had medications at bedside – any found to have medications stored at bedside had self – administration of medication assessment completed and reviewed with IDT. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur; and: Education was initiated by DON/Designee with licensed clinical staff on self-administration of medication policy and medication administration policy was initiated on 3/26/2026 by DON with all staff being licensed clinical staff being educated by 4/24/2026 anyone not being educated by (DATE) will not be allowed to work until they receive education Random audits will be conducted on 5 rooms weekly x 8 weeks or until substantial compliance is met to ensure medications aren't stored at bedside. Describe the Quality Assurance and Process Improvement Program that will be put into place. QAPI was held on 4/28/2026 to review results of survey and approve the plan of correction. Results of audits will be reviewed at QAPI meeting monthly x 3 months or until substantial compliance is maintained Facility alleges substantial compliance on 5/18/2026	

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21565	Continued from page 14 powder. R4 stated "then I'll have to unlock my bag" and proceeded to unlock her canvas bag and hand the nystatin powder to LPN-A. LPN-A then washed and dried under R4's abdomen, applied the nystatin powder, and handed the powder back to R4 to lock in her bag. After leaving the room, LPN-A stated R4 has never allowed her to wash the area or apply the nystatin powder. When asked if R4 keeps the nystatin powder in her room, LPN-A stated "I'm going to say yes since I couldn't find it in the cart." LPN-A stated residents who want to self-administer a medication are "assessed for it" and "have to have something in the orders or care plan." LPN-A stated she has never done a self-administration assessment for R4. During an interview on 3/11/26 at 3:18 p.m., registered nurse (RN)-A stated a self-administration assessment is performed to determine a resident is able to safely administer medications. The assessment involves resident's ability to identify what the medication is, what it is for, and the correct dosage. Residents also must be able to demonstrate safe storage of the medication and have the manual dexterity to administer the medication safely. When the assessment is completed the nursing staff, director of nursing, and nurse practitioner meet to discuss if self-administration is appropriate. If the resident is deemed appropriate, the medical provider or nurse practitioner will sign off allow the resident to administer the medication. RN-A stated there was a time R4 was able to administer a lot of the prescribed medications however the facility has "dialed back" what R4 is allowed to do as they were finding oral medications on the floor. Currently R4 is able to check blood sugar and administer some injectable medications with staff set up and supervision as well as independently administer inhaled medications. RN-A verified R4 did not have a self-administration assessment completed for the nystatin powder. During an interview on 3/12/26 at 9:31 a.m., the director of nursing stated self-administration assessments are required to determine if a resident is able to determine the purpose of safely administering, and store medications. A policy titled Resident Self-Administration of Medication revised January 2026 indicated "A resident may only self-administer medications after the facility's interdisciplinary team has determined which medications may be self-administered safely." SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON) or designee could review and		21565				

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21565	Continued from page 15 revise policies for self administration of medication according to evidence based practices/procedures. Nursing staff could be educated as necessary to the importance of ensuring the resident is capable of administering their own medications initially, quarterly, annually, or with a change to a resident's physical or mental ability to do so. Nursing staff could also ensure there is a physician's order in place, prior to a nurse/medication aide administering medication. The DON or designee, could audit any/all resident's medical records, to ensure compliance with appropriate medication administration. The DON or designee could take that information to QAPI to ensure compliance and determine the need for further education/monitoring/compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	21565			
21640	Disposition of Medications;Returned to Pharm CFR(s): MN Rule 4658.1350 Subp. 4 Subp. 4. Returned to pharmacy. Drugs and prescribed medications used in nursing homes may be returned to the dispensing pharmacy according to part 6800.2700, subpart 2. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation and interview, the facility failed to dispose of discontinued, expired, and discharged residents' medications. This had the potential to affect any resident who received medication from all facility medication rooms. Findings include:On 03/11/2026 10:00 a.m., 1st floor medication storage had 23-40 medication cards from discharged residents awaiting destruction and several bottles of over-the-counter expired bottles awaiting disposal. Registered nurse (RN)-B confirmed the medications on the counter were awaiting destruction and was unsure of the process of medication destruction. RN-B stated, "the nurse manager took care of it, and we do not have one right now". The 1st floor med room storage had the following current resident medications awaiting destruction. R 81 -Flomax capsule 0.4mg (Tamsulosin HCL) Take 0.4 milligrams (mg) by mouth daily -Inderal LA oral capsule Extended Release 24 hours	21640	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: R81 medications were destroyed on 4/30/2026 R15 medications were destroyed on 4/30/2026 R42 medications were destroyed on 4/30/2026 R52 medications were destroyed on 4/30/2026 R48 medications were destroyed on 4/30/2026 R78 medications were destroyed on 4/30/2026 R30 medications were destroyed on 4/30/2026 R2 medications were destroyed on 4/30/2026 R13 medications were destroyed on 4/30/2026 R6 medications were destroyed on 4/30/2026 R51 medications were destroyed on 4/30/2026 R34 medications were destroyed on 4/30/2026 R13 medications were destroyed on 4/30/2026 R22 medications were destroyed on 4/30/2026 R6 medications were destroyed on 4/30/2026 R78 medications were destroyed on 4/30/2026	05/18/2026	

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21640	Continued from page 16 (Propranolol HCL), Take 1 cap my mouth in the evening. - Lipitor oral tablet (Atorvastatin Calcium), take 10 mg by mouth at bedtime -Synthroid Oral tablet (levothyroxine Sodium), take 112 micrograms (mcg) by mouth in the morning. -Venlafaxine HCL ER oral capsule extended release 24 hours (venlafaxine HCL), take 37.5 mg by mouth one time a day every other day -Zyloprim oral tablet (Allopurinol), take 300 mg by mouth one time a day. -Methocarbamol oral tablet, Take 1000 mg by mouth 4 times a day. -Allegra Allergy oral tablet (Fexofenadine HCL), take 180 mg by mouth every 24 hours as needed. R15 - Allegra Allergy oral tablet (Fexofenadine HCL), take 180 mg by mouth on time a day -Crestor oral tablet (Rosuvastatin Calcium), take 10 mg by mouth at bedtime. -Lasix oral tablet (Furosemide) take 40 mg by mouth one time a day. -Rozerem oral tablet (Ramelteon), take 8 mg by mouth at bedtime. - Synthroid Oral tablet (levothyroxine Sodium), take 125 mcg by mouth in the morning. -Lopressor oral tablet (Metoprolol Tartate) Take 12.5 mg by mouth 2 times a day -Omeprazole oral tablet, take 20 mg by mouth 2 times a day. - Zyloprim oral tablet (Allopurinol), take 100 mg by mouth 2 times a day. - Neurontin oral capsule (Gabapentin), take 300 mg by mouth 3 times a day. Tegretol oral tablet (carbamazepine), take 200 mg by mouth 4 times a day. -Benzonatate oral capsule, take 100 mg by mouth every 4			21640	Continued from page 16 R31 medications were destroyed on 4/30/2026 R62 medications were destroyed on 4/30/2026 R80 medications were destroyed on 4/30/2026 How will you identify other residents having potential to be affected by the same deficient practice and what corrective action will be taken: All residents have the potential to be affected An audit of all med rooms was completed by DON/Designee on 4/30/2026 to ensure there were no medications that needed to be destroyed or returned A contract was obtained to have a Med Safe provided for the facility for all medications requiring destruction What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur; and: Education was initiated on 3/26/2026 by DON/Designee with licensed clinical staff on medication destruction and returns with all staff being educated by 4/24/2026. Any staff not receiving education by 4/24/2026 will not be allowed to work until education is received. Med rooms will be reviewed and cleaned weekly by the 11/7 shift on Sunday to ensure medications are destroyed or returned as required An audit of med rooms will be completed weekly by the UM to ensure medication room is clean and free of medications requiring destruction Describe the Quality Assurance and Process Improvement Program that will be put into place. QAPI was held on 4/28/2026 to review results of survey and approve the plan of correction. Results of audits will be reviewed at QAPI meeting monthly x 3 months or until substantial compliance is maintained Facility alleges substantial compliance on 5/18/2026		

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21640	Continued from page 17 hours as needed for cough -Carafate oral tablet 1 gram, take 1 gram by mouth as needed 2 times a day as needed. - Melatonin Oral tablet, give 6 mg by mouth at bedtime as needed. -Ondansetron HCL oral tablet, take 1 mg by mouth every 8 hours as needed. On 03/11/2026 10:42 a.m., the 2nd floor medication storage room had 6 medications on the counter. Licensed practical nurse (LPN)-A acknowledged the 6 medication cards were from discontinued medications orders and discharged residents. LPN-A stated was unsure of the medication destruction process and stated that the night shift was responsible for medications destruction. The 2nd floor medication storage room had 6 medication cards belonging to R42 and R52 awaiting destruction. During observation on 03/11/2026 at 11:51 a.m., registered nurse, (RN)-F, RN-F confirmed, medication cards kept on the counter were from discontinued orders, and discharged patients awaiting destruction. RN-F was unsure of facility medication destruction process and who was responsible for medication destruction. The 3rd floor medication room storage had following current resident medications awaiting destruction. R48 -Atorvastatin 10 mg 1 tab started, 2/26 R78 -Escitalopram 20 mg, started 3/31/25 -Metoprolol 25 mg, 3 cards -Bupropion hcl 159 mg, tab started 10/29/25 R30 -Clindamycin 150 mg caps started 1/23/26- -Torsemide 20 mg 2 tabs daily for 3 days then continue 1 tab daily R2		21640				

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21640	Continued from page 18 -Hyoscyamine 0.125 mg tab, started 4/22/25 R13 - Ondansetron hcl 4 mg tab, started 11/26/2 R6 -Famotidine 20mg, give 1 tablet R51 - Eliquis 5 mg, give 1 tablet by mouth twice a daily R34 -Trazodone 50-gram tablet, give 1.2 tablet by mouth at bedtime as needed sleep R13 - Sertraline 25 mg, give 1 tablet by mouth daily take with 50 mg for total dose of 75 mg R22 -Ondansetron 4 mg tablet, give one tablet by mouth every 8 hrs. as needed for up to 7 days R6 Benzonatate 100 mg capsule, give one capsule by mouth three times daily as needed R78 -Quetiapine 25 mg, give 1.2 tablet by bedtime R31 -Iprat-albut 0.5 (2.5) mg/3ml inhale 3mL vial ben three times daily for SOB. R62 -Paxlovid 300-100mg dose R80 - Cyanocobalamin 1000mcg/ml inject 1 milliliter (ml) intramuscular (IM) weekly It also contained 1 bottle of OTC acetaminophen 325 mg		21640				

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21640	Continued from page 19 open 11/6/2024 exp on bottle 2/2026, 1 bottle of aspirin over the counter 81 mg, expired 2/26/2026, and 1 canister of inhaler -Formoterol Fumarate 20mcg/2ml. During an interview on 3/11/2026 at 1:34p.m., the director of nursing (DON) stated, medication destruction was to be completed by 2 nurses, 1 nurse logged the medications, and the 2nd nurse completed the destruction by disposing of the tablets in a Stericycle water activated solution. DON expected medications destruction to be completed as soon as possible. During an interview with the facility pharmacist on 03/11/2026 at 2:34 p.m., pharmacist reported being unfamiliar with the current medication destruction process for the facility and advised to refer to the facility policy. A policy for medication storage was requested but not received prior to the end of the survey. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could develop new policies and procedures, train staff, and implement measures to assure residents medications are properly destroyed or returned to the pharmacy to prevent diversion. The director of nursing or designee, could conduct random audits; to ensure appropriate measure for medication destruction/return is being implemented. The results of those audits should be taken to the Quality Assurance Performance Improvement (QAPI) to determine compliance or the need to re-evaluate. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.		21640				
21665	Physical Environment CFR(s): MN Rule 4658.1400 A nursing home must provide a safe, clean, functional, comfortable, and homelike physical environment, allowing the resident to use personal belongings to the extent possible. This LICENSURE REQUIREMENT is NOT MET as evidenced by: 584 Based on observation, interviews, and document review, the facility failed to provide a home like dining experience in 2 dining rooms when meals were left served to residents on a plastic food tray.		21665	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Staff working 3/9/2026 7/3 on 3rd floor were provided education on the Serving a Meal policy on 4/30/2026 by DON/Designee Staff working 3/9/2026 3/11 on 2nd floor were provided education on the Servings a Meal Policy on 4/30/2026 by DON/Designee Staff working 3/10/2026 7/3 shift on 3rd floor were provided education on the Serving a Meal Policy on 4/30/2026 by DON/Designee		05/18/2026	

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21665	Continued from page 20 Findings include: During an observation on 3/9/26 at 12:44p.m., of the 3rd floor dining room, lunch trays were brought up in a cart, the staff passed out the trays and left food items on plastic trays in front of residents. During an observation on 3/9/26 at 6:03p.m., of the 2nd floor dining room, dinner trays were brought up in a cart, the staff passed out the trays and left food items on plastic trays in front of the residents. During observation on 3/10/26 at 12:33 p.m., of the 3rd floor dining room, lunch trays were brought up in a cart, the staff passed out the trays to the residents and left food items on the plastic trays. During observation on 3/11/26 at 8:48 a.m., of the 3rd floor dining room, breakfast trays were brought up in a cart, staff passed out the trays and left food items on the plastic trays in front of the residents. During an interview on 3/10/26 at 1:15p.m. licensed practical nurse (LPN)-A stated the residents had always been served their food on the trays and placed in front of them. During interview on 3/11/26 at 9:00a.m., certified nursing assistant (can)-F stated the residents had always had their food served on trays and placed in front of them. During interview on 3/11/26 at 10:00 a.m., R40 stated he would like the meals served on time, and not on trays and added it was not home. During interview on 3/11/26 at 11:00a.m., R45 stated feeling like the dining experience was being in school in a juvenile setting when the food is set in from of us on trays during mealtime. In addition, the staff place the hot foods next to the cold foods on the tray. R45 indicated asking staff to separate the food. A policy entitled, Serving a Meal dated 3/23, included to serve nutritional meals that met the needs of the residents. Additionally, arrange the dishes and silverware so the residents can reach them easily. It was often helpful to take dishes off tray. SUGGESTED METHOD OF CORRECTION: The DON or designee could educate staff and conduct periodic audits of areas residents frequent to ensure a	21665	Continued from page 20 Staff working 3/11/2026 7/3 shift on 3/11/2026 on 3rd floor were provided education on the Serving a Meal policy on 4/30/2026 by DON/Designee How will you identify other residents having potential to be affected by the same deficient practice and what corrective action will be taken: All residents have the potential to be affected Education was provided to the IDT on 4/22/2026 by Regional Clinical Consultant on the Serving a Meal Policy What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur; and: Education was initiated on 3/26/2026 by DON/Designee on the Serving a Meal policy with clinical staff with all clinical staff receiving education by 4/24/2024 not being allowed to work until receiving education Random audits will be conducted on meal service to ensure meals are not being served on a tray to residents 3/week for 8 weeks or until substantial compliance is obtained Describe the Quality Assurance and Process Improvement Program that will be put into place. QAPI was held on 4/28/2026 to review results of survey and approve the plan of correction. Results of audits will be reviewed at QAPI meeting monthly x 3 months or until substantial compliance is maintained Facility alleges substantial compliance on 5/18/2026		

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21665	Continued from page 21 home like environment is obtained to the extent possible.	21665		
23270	Nurse Call System; Existing Construction CFR(s): MN Rule 4658.5515 A communication system must be provided in a nursing home. It must register a call from the resident at the nursing station and activate a signal light by the bedroom door. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review the facility failed to ensure a bathroom call light was functioning for the shower room on the 3rd floor having the potential to affect all residents that use the toilet in the shower room, 7 of 7 (R6, R36, R2, R8, R51, R60, R62) residents were brought to and used an EZ stand for toileting. Findings include: R6's Minimum Data Set (MDS) quarterly assessment dated 1/21/26, identified severely impaired cognition and required maximal assistance for mobility. R6's diagnoses included Parkinson's, dementia, major depressive disorder and lack of coordination. R6's care plan (CP) created on 9/14/24, identified mobility was an area of concern, indicated was not ambulatory and needed transfer assistance of 2 and mechanical lift (EZ stand). Furthermore, the CP identified an area of concern, indicated was at risk for falls due to dementia, impaired coordination and mobility, medications, impulsiveness and safety awareness. R36's MDS comprehensive assessment dated 3/14/25, identified moderate cognitive impairment and left sided weakness in upper and lower extremities. R36's diagnoses included dementia, hemiplegia (left side affected), and congestive heart failure. R36's care plan created on 3/14/24, identified mobility was an area of concern, indicated transfers with assist of 2 and (sit to stand lift) EZ stand. Furthermore, the care plan identified was at risk of falls due to impaired mobility, left side weakness and dementia. R2's MDS quarterly assessment dated 2/10/26, identified	23270	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Call light was repaired in shower room on 3rd floor by Maintenance Director on 4/30/2026 How will you identify other residents having potential to be affected by the same deficient practice and what corrective action will be taken: All residents have the potential to be affected An audit was conducted on all other call lights in the facility on 4/30/2026 by the maintenance director – all were found to be functional What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur; and: Education was initiated with the DON/Designee on reporting items in need of repairs via TELS with clinical staff on 3/26/2026 any clinical staff not receiving education by 4/24/2026 will not be allowed to work until education is received. An audit will be completed by the maintenance director of 5 resident care areas weekly x 8 weeks to ensure call lights are functioning properly Describe the Quality Assurance and Process Improvement Program that will be put into place. QAPI was held on 4/28/2026 to review results of survey and approve the plan of correction. Results of audits will be reviewed at QAPI meeting monthly x 3 months or until substantial compliance is maintained Facility alleges substantial compliance on 5/18/2026	05/18/2026

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NAME OF PROVIDER OR SUPPLIER Rochester Restorative Care Center				STREET ADDRESS, CITY, STATE, ZIP CODE 501 EIGHTH AVENUE SOUTHEAST , ROCHESTER, Minnesota, 55904			
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23270	Continued from page 22 severely impaired cognition and dependent mobility. R2's diagnoses included anxiety, dementia and cardiorespiratory issues. R2's care plan revised on 10/27/25, identified activities of daily living was an area of concern related to mobility status and dementia. The care plan indicated transfers with the assistance of two and EZ stand lift for all transfers. Furthermore, the care plan identified was at risk for falls due to impaired mobility, dementia and medications. R8's MDS quarterly assessment dated 2/6/26, identified severely impaired cognition and substantial/maximal assistance with transfers. R8's diagnoses included non-traumatic brain dysfunction, dementia and seizure disorder. R8's care plan was created on 6/4/23, identified activities of daily living were an area of concern, due to dementia, leg pain, decrease mobility and resistance to assistance. Perform cares in pairs, transfer with assist of 2 and an EZ stand. R51's MDS quarterly assessment dated 2/24/26, identified severely impaired cognition and dependent on all areas of mobility. R51's diagnoses included atrial fibrillation, type II diabetes, depression and dementia. R51's care plan created on 3/8/23, identified activities of daily living were an area of concern, due to weakness, stroke and cognitive impairment. Assist of two and EZ stand with transfers. Furthermore, identified falls were an area of concern, due to weakness, dementia and cognitive deficits. R60's MDS quarterly assessment dated 3/3/26, identified severely impaired cognition and dependent on all areas of mobility. R60's diagnoses included dementia, psychotic and mood disturbances and anxiety. R60's care plan revision on 10/7/24, identified activities of daily living was an area of concern, due to the disease process of Alzheimer's. Transfer with assistance of two and EZ stand. Furthermore, an area of concern was at risk for falls due to being unaware of safety needs and history of falls. R62's MDS comprehensive assessment on 2/20/26, identified severely impaired cognition and dependent on mobility. R62's diagnoses included osteoporosis, hemiplegia and dementia.		23270				

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23270	Continued from page 23 R62's care plan revision on 6/9/25, identified activities of daily living was an area of concern, due to disease process, physical limitations, cognitive losses with spastic hemiplegia. Transfer assist of two and sit to stand lift. Furthermore, an area of concern was at risk for falls related to cognition, unaware of safety needs, incontinence, history of traumatic brain injury and cerebral vascular accident with spastic hemiplegia (type of cerebral palsy that affected one side of body, muscle weakness and stiffness). During observation on 3/10/26 at 11:13 a.m., the shower room had a call light which was a small switch on back wall by the toilet, no cord seen. During observation and interview on 3/10/26 at 12:00, registered nurse (RN)-D went and found a cord, tied it around the call light switch in the shower room by the toilet for residents to use, at that time, the light did turn on outside of door when cord was pulled. RN-D stated things were falling through the cracks on the 3rd floor, they didn't have an RN manager, to educate and facilitate any concerns or issues. During interview on 3/12/26 at 11:28 a.m., CNA-J stated if the call light in the shower room wasn't working, they would hear a resident yelling or banging for assistance. During observation and interview on 3/12/26 at 12:17p.m., the call light was not lit up in hallway nor ringing at the nurse's station for the shower room. CNA-F and director of nursing (DON) were at the nurse's desk filling out the a maintenance report. The DON stated it was the 1st time he was told there was a problem with the call light. During interview on 3/12/2026 at 4:47 p.m., RN-E and RN-F verified that call light was not working. RN-E asked to pull call light, red light came on, there was no sound to alert staff, the light on the board in nurses' station also came on with no sound, Both nurses present, confirmed call light not working. Maintenance called, he came and verified that the call light was not working, and he had a call out to have call light fixed. Record review a document entitled, Building Tasks dated 9/25-3/26, Conduct a Test of the Nurse Call System was marked at completed on 2/20/26.		23270				

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23270	Continued from page 24 The steps were: 1. For each department, notify the appropriate person in charge that the call system is being tested 2. Check all devices transmitting to, and received from nurse call system, to include pullcords, pendants and pagers. Repair as necessary 3. Check call cords in bathrooms and shower rooms. Ensure call cord length is no more than 6" from the floor. Repair as necessary 4. Notify the appropriate person in charge that the test has been completed and has been returned to operational status 5. Check call light clips 6. If system is capable, run report to identify equipment alerts, such as low battery The Call Lights: Accessibility and Timely response Policy, revised 1/26, indicated The purpose of this policy is to assure the facility is adequately equipped with a call light at each residents' bedside, toilet, and bathing facility to allow residents to call for assistance. Call lights will directly relay to a staff member or centralized location to ensure appropriate response. Staff will ensure the call light is within reach of resident and secure, as needed. The call system must be accessible to the resident at each toilet and bath or shower facility. The call system should be accessible to a resident lying on the floor. Staff will report problems with a call light or the call system immediately to the supervisor and/or maintenance director and will provide immediate or alternative solutions until the problem can be remedied. (Examples include replace "call light", provide a bell or whistle, increase frequency of rounding, etc.) SUGGESTED METHOD OF CORRECTION: The maintenance director or designee could review the system and make needed repairs to ensure residents are able to call for staff help at all times. The director or designee could then audit to ensure consistent, safe system functioning. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	23270			

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E0000	Initial Comments On 3/9/26-3/12/26, 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			04/17/2026	
F0000	INITIAL COMMENTS On 3/9/26-3/12/26, 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:H51847801C (2793857), H51847942C (2612067), H51847874C (MN00111412/1073210), H51847875C (MN00111170/1073209), H51847973C (MN00112661/1073214), H51848020C (2796479). NO deficiencies were cited. 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			04/17/2026	
F0554 SS = D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by		F0554	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: R4 had self-administration of medication assessment		05/18/2026	

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
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F0554 SS = D	Continued from page 1 §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and record review, the facility failed to ensure residents were assessed to self-administer medications for 1 of 1 resident (R4) reviewed for self-administration of medication (SAM). Findings include: R4's quarterly Minimum Data Set (MDS) assessment, dated 2/23/26 indicated R4 was cognitively intact, had no upper body impairment, was independent with personal hygiene, and required set-up to supervision for upper and lower body dressing. R4's diagnoses list included diabetes, end-stage kidney disease, heart failure, and morbid obesity. R4's self-administration care plan dated 11/20/25 lacked self-administration of nystatin powder (medication used to treat fungal infections). R4's provider orders included: Nystatin powder 1 application to affected areas under right breast and skin folds topically twice a day and as needed. R4's medical record lacked a self-administration assessment for applying Nystatin powder. During observation and interview on 3/10/26 at 3:45 p.m., R4 stated she keeps her nystatin powder locked up in the canvas bag located on her bed. During interview on 3/11/26 at 9:43 a.m., licensed practical nurse (LPN)-A stated R4 administers own injections and completes blood sugar check with nursing supervision and performs her own vitals. LPN-A stated R4 refuses the nystatin powder however it is kept in the medication cart. LPN-A looked in the medication and treatment cart however could not find R4's nystatin powder. During observation and interview on 3/11/25 at 10:12 a.m., R4 indicated she puts the nystatin powder on herself twice a day. R4 stated she feels the area under her abdomen has improved however confirmed she is unable to see what the area looks like. R4 opened the locked canvas bag on her bed that contained a bottle of nystatin powder dated November of 2025. R4 stated she likes that particular bottle because it is easier to use. When she runs out, she has the nursing staff order	F0554	Continued from page 1 completed on 4/30/2026. IDT reviewed results of assessment and resident was deemed safe to self-administer medication (Nystatin) MD was notified of assessment results and order was obtained for resident to self-administer Nystatin on 4/30/2026 How will you identify other residents having potential to be affected by the same deficient practice and what corrective action will be taken: All residents have the potential to be affected Ad-Hoc resident council was held on 4/30/2026 with self-administration of medication policy reviewed with residents An audit was completed of resident rooms to determine if residents had medications at bedside – any found to have medications stored at bedside had self – administration of medication assessment completed and reviewed with IDT. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur; and: Education was initiated by DON/Designee with licensed clinical staff on self-administration of medication policy and medication administration policy was initiated on 3/26/2026 by DON with all staff being licensed clinical staff being educated by 4/24/2026 anyone not being educated by (DATE) will not be allowed to work until they receive education Random audits will be conducted on 5 rooms weekly x 8 weeks or until substantial compliance is met to ensure medications aren't stored at bedside. Describe the Quality Assurance and Process Improvement Program that will be put into place. QAPI was held on 4/28/2026 to review results of survey and approve the plan of correction. Results of audits will be reviewed at QAPI meeting monthly x 3 months or until substantial compliance is maintained	

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F0554 SS = D	Continued from page 2 a new bottle and dump the contents of the new bottle into the bottle she likes. R4 stated the nurses do not offer to put the nystatin powder on. During observation and interview on 3/11/26 at 11:05 a.m., LPN-A arrived to perform R4's dressing change. After the dressing change, LPN-A asked permission to wash under R4's abdominal folds and apply the nystatin powder. R4 stated "then I'll have to unlock my bag" and proceeded to unlock her canvas bag and hand the nystatin powder to LPN-A. LPN-A then washed and dried under R4's abdomen, applied the nystatin powder, and handed the powder back to R4 to lock in her bag. After leaving the room, LPN-A stated R4 has never allowed her to wash the area or apply the nystatin powder. When asked if R4 keeps the nystatin powder in her room, LPN-A stated "I'm going to say yes since I couldn't find it in the cart." LPN-A stated residents who want to self-administer a medication are "assessed for it" and "have to have something in the orders or care plan." LPN-A stated she has never done a self-administration assessment for R4. During an interview on 3/11/26 at 3:18 p.m., registered nurse (RN)-A stated a self-administration assessment is performed to determine a resident is able to safely administer medications. The assessment involves resident's ability to identify what the medication is, what it is for, and the correct dosage. Residents also must be able to demonstrate safe storage of the medication and have the manual dexterity to administer the medication safely. When the assessment is completed the nursing staff, director of nursing, and nurse practitioner meet to discuss if self-administration is appropriate. If the resident is deemed appropriate, the medical provider or nurse practitioner will sign off allow the resident to administer the medication. RN-A stated there was a time R4 was able to administer a lot of the prescribed medications however the facility has "dialed back" what R4 is allowed to do as they were finding oral medications on the floor. Currently R4 is able to check blood sugar and administer some injectable medications with staff set up and supervision as well as independently administer inhaled medications. RN-A verified R4 did not have a self-administration assessment completed for the nystatin powder. During an interview on 3/12/26 at 9:31 a.m., the director of nursing stated self-administration assessments are required to determine if a resident is able to determine the purpose of safely administering, and store medications.		F0554	Continued from page 2 Facility alleges substantial compliance on 5/18/2026			

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F0554 SS = D	Continued from page 3 A policy titled Resident Self-Administration of Medication revised January 2026 indicated "A resident may only self-administer medications after the facility's interdisciplinary team has determined which medications may be self-administered safely."	F0554		
F0580 SS = D	Notify of Changes (Injury/Delirium/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the	F0580	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Skin check was completed on R4 by (PERSON) on (DATE) with no adverse finding noted. R4 MD notified of findings from skin check and R4 documented refusals with order obtained to DC Nystatin on 4/30/2026 How will you identify other residents having potential to be affected by the same deficient practice and what corrective action will be taken: All residents have the potential to be affected An audit was completed on 4/30/2026 by DON/Designee for refused medications in last 30 days with MD notified of refusals Education was provided by the Regional Clinical Consultant on 4/22/2026 with the IDT on the Medication Administration policy with instruction on expectations when resident refuses medication. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur; and: Education with licensed clinical staff on the Medication Administration policy with instruction on expectations when resident refuses medication was initiated on 3/26/2026 by the DON/Designee with all licensed clinical staff being educated by end of business on 4/24/2026 with any staff not receiving education by 4/24/2026 not being allowed to work until they receive education. The medication not administered report will be reviewed Monday – Friday as part of the daily clinical standup to ensure refusals have appropriate follow up with anything occurring on the weekend being reviewed on the	05/18/2026

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F0580 SS = D	Continued from page 4 resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and record review, the facility failed to update the provider timely of ordered medication refusals for 2 of 2 residents (R4, R44) reviewed for medication administration. Findings include: R4: R4's face sheet indicates R4 was readmitted to the facility on 11/17/25 after a 12-day hospital stay for a below the knee amputation. R4's quarterly Minimum Data Set (MDS) assessment, dated 2/23/26, indicated R4 was cognitively intact, had no upper body impairment, was independent with personal hygiene, and required set-up to supervision for upper and lower body dressing. R4's diagnoses list included diabetes, end-stage kidney disease, heart failure, and morbid obesity. R4's care plan indicated R4 is resistive/noncompliant with treatments/cares related to manipulative behaviors, loss of independence and control with a goal of understanding the consequences of refusal/noncompliance. R4's provider orders dated 11/18/25 indicated: Nystatin powder (medication used to treat fungal infections) 1 application to affected areas under right breast and skin folds topically twice a day and as needed. R4's medication administration record (MAR) indicated the following refusals of the Nystatin powder: Nov. 2025: 21 of 26 possible administrations			F0580	Continued from page 4 Monday following the weekend. Describe the Quality Assurance and Process Improvement Program that will be put into place. QAPI was held on 4/28/2026 to review results of survey and approve the plan of correction. Results of audits will be reviewed at QAPI meeting monthly x 3 months or until substantial compliance is maintained Facility alleges substantial compliance on 5/18/2026		

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F0580 SS = D	Continued from page 5 Dec. 2025: 54 of 62 possible administrations Jan. 2026: 49 of 62 possible administrations Feb. 2026: 43 of 56 possible administrations During an interview on 3/11/26 at 9:43 a.m., licensed practical nurse (LPN)-A stated R4 "has yet to allow me to put it [nystatin powder] on her". During an observation and interview on 3/11/26 at 11:05 a.m., LPN-A entered R4's room to perform a dressing change. After performing the dressing change, R4 allowed LPN-A to wash under her abdominal folds and apply the nystatin powder R4 kept in a locked bag on her bed. Upon leaving R4's room, LPN-A stated R4 has never allowed her to wash under the abdominal folds and apply the powder. LPN-A stated R4's abdominal folds looked "a little red" and "did not look like it had any powder on it.". During an interview on 3/11/26 at 2:52 p.m., the facility nurse practitioner stated R4 has a history of refusing medications and treatments however was not notified R4 has consistently refused the nystatin powder since November 2025. The nurse practitioner stated she would expect to be notified so she can speak to the resident about the refusal and have an interdisciplinary team meeting regarding the refusal. During an interview on 3/11/26 at 3:01 p.m., registered nurse (RN)-G stated if a resident consistently refuses a medication or treatment, the clinical manager is notified. RN-G would also notify the provider if they were in the facility to speak to the resident about either discontinuing the order or changing it to "as needed". During an interview on 3/11/26 at 3:18 p.m., RN-A stated residents who consistently refuse a medication/treatment are educated why the medication is important and what may happen they continue to refuse it. If the resident still refuses, the provider is notified and asked to discontinue the order. RN-A stated she was not aware R4 was consistently refusing the nystatin powder therefore she was "guessing they didn't notify" the provider either. During an interview on 3/12/26 at 8:39 a.m., licensed practical nurse (LPN)-B stated if a resident consistently refuses a medication or treatment, she would let the clinical manager know and send a message to the provider. LPN-A stated R4 is known to refuse		F0580				

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F0580 SS = D	Continued from page 6 treatments, medications, and cares when offered, preferring to do things on "her time". LPN-A stated R4 refuses to allow nursing staff to put on nystatin powder. During an interview on 3/12/26 at 9:31 a.m., the director of nursing stated if a resident consistently refuses a medication/treatment, the provider is updated so order can be discontinued so the staff are not consistently documenting refusals. The director of nursing stated the provider was notified of the refusals February 2026. Documentation provided by the director of nursing indicated notification sent to the provider on 2/20/26 of R4 refusing all medications and treatments specifically on 2/20/26. The documentation provided also indicated on 2/28/26 communication was sent to the provider regarding R4 refusing the treatment to her surgical wound. Neither notification mentioned R4 had consistently refused the nystatin powder since November 2025. R44: R44's Admission MDS assessment, dated 2/20/26, indicated intact cognition, R44 required partial/moderate assistance with toileting hygiene. R44's diagnoses included chronic respiratory failure with hypoxia, dependence on supplemental oxygen, acute kidney failure, hypertensive heart and chronic kidney disease with heart failure, Type2 diabetes mellitus, Chronic Pulmonary edema, moderate persistent asthma, dependence of renal dialysis. R44's was admitted On 02/5/26 and orders dated 2/05/25 included: oxygen 2 liters via nasal cannula continuously. During observation on 03/10/26 11:11 a.m., R44 came down the unit hallway on her motorized scooter with no oxygen in use. R44 stated, the portable oxygen tank was empty and was in search of staff to have the tank filled. The director of nursing (DON) filled in the portable oxygen tank for R44 at 11:115 a.m. R44 took the oxygen tank from the DON and passed RN-B in the hallway and went back to her room with no oxygen in use. During observation on 03/10/26 11:23 a.m., and 11:28 a.m., oxygen tank was filled but not in used by R44.		F0580				

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F0580 SS = D	Continued from page 7 During an interview on 03/10/26 1:38 p.m., RN-B stated they had seen R44 at times with no oxygen in use, was not sure if R44 oxygen order was continuous or as needed and had told R44 at times to put the oxygen back on. During an interview on 03/10/26 2:28 p.m., the DON stated they had seen R44 with no oxygen in use. DON stated R44 declined oxygen use and stated, "I don't need it", when DON had offered to turn on the portable oxygen tank after the tank was filled. DON also stated, "I have never seen her with her oxygen in use". R44's oxygen order of 2 liters via nasal cannula continuous was communicated to DON and DON stated, "I will call the provider to get an order to wean her off oxygen". Based on communication with R44's primary care provider, medical doctor (MD) on 03/12/26 at 2:00 p.m., MD expected the facility to have sent an SBAR (situation, background, assessment, recommendation) and an updated vital sign for ongoing need for supplemental oxygen. Review of an undated facility policy titled, Notification of changes, indicates, circumstances requiring notification include Circumstances that require a need to alter treatment.		F0580				
F0584 SS = E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft.		F0584	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Staff working 3/9/2026 7/3 on 3rd floor were provided education on the Serving a Meal policy on 4/30/2026 by DON/Designee Staff working 3/9/2026 3/11 on 2nd floor were provided education on the Servings a Meal Policy on 4/30/2026 by DON/Designee Staff working 3/10/2026 7/3 shift on 3rd floor were provided education on the Serving a Meal Policy on 4/30/2026 by DON/Designee Staff working 3/11/2026 7/3 shift on 3/11/2026 on 3rd floor were provided education on the Serving a Meal policy on 4/30/2026 by DON/Designee How will you identify other residents having potential to be affected by the same deficient practice and what corrective action will be taken:		05/18/2026	

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F0584 SS = E	Continued from page 8 §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interviews, and document review, the facility failed to provide a home like dining experience in 2 dining rooms when meals were left served to residents on a plastic food tray. Findings include: During an observation on 3/9/26 at 12:44p.m., of the 3rd floor dining room, lunch trays were brought up in a cart, the staff passed out the trays and left food items on plastic trays in front of residents. During an observation on 3/9/26 at 6:03p.m., of the 2nd floor dining room, dinner trays were brought up in a cart, the staff passed out the trays and left food items on plastic trays in front of the residents. During observation on 3/10/26 at 12:33 p.m., of the 3rd floor dining room, lunch trays were brought up in a cart, the staff passed out the trays to the residents and left food items on the plastic trays. During observation on 3/11/26 at 8:48 a.m., of the 3rd floor dining room, breakfast trays were brought up in a cart, staff passed out the trays and left food items on	F0584	Continued from page 8 All residents have the potential to be affected Education was provided to the IDT on 4/22/2026 by Regional Clinical Consultant on the Serving a Meal Policy What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur; and: Education was initiated on 3/26/2026 by DON/Designee on the Serving a Meal policy with clinical staff with all clinical staff receiving education by 4/24/2024 not being allowed to work until receiving education Random audits will be conducted on meal service to ensure meals are not being served on a tray to residents 3/week for 8 weeks or until substantial compliance is obtained Describe the Quality Assurance and Process Improvement Program that will be put into place. QAPI was held on 4/28/2026 to review results of survey and approve the plan of correction. Results of audits will be reviewed at QAPI meeting monthly x 3 months or until substantial compliance is maintained Facility alleges substantial compliance on 5/18/2026	

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F0584 SS = E	Continued from page 9 the plastic trays in front of the residents. During an interview on 3/10/26 at 1:15p.m. licensed practical nurse (LPN)-A stated the residents had always been served their food on the trays and placed in front of them. During interview on 3/11/26 at 9:00a.m., certified nursing assistant (can)-F stated the residents had always had their food served on trays and placed in front of them. During interview on 3/11/26 at 10:00 a.m., R40 stated he would like the meals served on time, and not on trays and added it was not home. During interview on 3/11/26 at 11:00a.m., R45 stated feeling like the dining experience was being in school in a juvenile setting when the food is set in from of us on trays during mealtime. In addition, the staff place the hot foods next to the cold foods on the tray. R45 indicated asking staff to separate the food. A policy entitled, Serving a Meal dated 3/23, included to serve nutritional meals that met the needs of the residents. Additionally, arrange the dishes and silverware so the residents can reach them easily. It was often helpful to take dishes off tray.	F0584		
F0655 SS = D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders.	F0655	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: R77 had a baseline care plan provided to him on 4/30/2026 by MDS director How will you identify other residents having potential to be affected by the same deficient practice and what corrective action will be taken: All new admissions have the potential to be affected Education was provided to the IDT on the Baseline Care Plan policy by the Regional Clinical Consultant on 4/22/2026 An audit was conducted by DON/Designee on admissions for the past 30 days to ensure a baseline care plan was developed and provided to the resident per the regulations	05/18/2026

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F0655 SS = D	Continued from page 10 (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to complete baseline care plan within 48 hours of admission for 1 of 1 resident (R77) reviewed for care plans. Findings include: R77's admission Minimum Data Set (MDS) assessment was not available at time of survey. A facility document title Nursing-Admissions/Readmission Observation dated 3/5/26, noted R77 was alert and oriented to person, place, time, and situation. R77's cognition was intact. R77 requires transfer assistance, assistance with activities of daily living (ADL), and assistance		F0655	Continued from page 10 What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur; and: Education was initiated on 3/26/2026 with licensed clinical staff by DON/Designee on the Baseline Care Plan policy with all licensed clinical staff receiving education by 4/24/2026 with any licensed clinical staff not receiving education by 4/24/2026 not being allowed to work until education is received. New admission charts will be reviewed Monday – Friday as part of the daily clinical standup process with any weekend admissions being reviewed on the following Monday to ensure the baseline care plan policy has been followed. Describe the Quality Assurance and Process Improvement Program that will be put into place. QAPI was held on 4/28/2026 to review results of survey and approve the plan of correction. Results of audits will be reviewed at QAPI meeting monthly x 3 months or until substantial compliance is maintained Facility alleges substantial compliance on 5/18/2026			

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F0655 SS = D	Continued from page 11 managing new colostomy, (a surgical opening in the colon that allows stool to e xit the body through a stoma into an external pouch). R77's diagnoses included intestinal obstruction requiring a new colostomy, Parkinson's, urinary retention, and generalized muscle weakness. R77's electronic health record (EHR) indicated R77 was admitted to the facility on 3/5/26 at approximately 2 p.m. EHR lacked evidence a baseline care plan had been initiated within 48 hours of admission. During an interview on 3/10/26 at 1:49 p.m., physician assistant (PA)-A stated it is his expectation that the baseline care plan be created in the first 48 hours after admission. PA-A stated the baseline care plan is important, so staff know how to provide basic cares such as hygiene, ambulation, skin concerns, fall interventions, and any resident-specific concerns. PA-A stated the baseline care plan for R77 was especially important due to the complexity of his hospital stay prior to admission to facility. During an interview on 3/10/26 at 2:00 p.m., director of nursing (DON) stated the process for admitting a resident included: the health unit coordinator (HUC) transcribed admission orders based on the hospital dismissal summary or after visit summary the facility received, a nurse reviewing those orders, and loading the orders into the medication admission record (MAR) and treatment admission record (TAR) in the EMR. Additionally, the nurse would enter a baseline care plan based on those orders. The comprehensive care plan would be completed after the facility could evaluate all areas of resident care in the coming weeks. The DON stated the HUC had transcribed the orders, however, the nurse had not reviewed the orders and uploaded the orders to the MAR and TAR and no baseline care plan was completed. The DON stated the baseline care plan is important so staff can care for the residents' basic needs, establish likes and dislikes, and make sure the residents are safe. An undated facility policy titled Baseline Care Plan, the baseline care plan will be developed within 48 hours of a resident's admission.			F0655			
F0657 SS = D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans			F0657	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: R33 smoking care plan was updated by the MDS		05/18/2026

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F0657 SS = D	Continued from page 12 §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 document review, the facility failed to revise and update a care plan for 1of 1 resident (R33) reviewed for care plan timing and revision. Findings include: R33's Minimum Data Set (MDS) assessment, dated 12/3/25, /indicated intact cognition, /R33 /was independent with transfers, w/c mobility and required limited assist with bed mobility. R33 's diagnoses included chronic systolic and diastolic (congestive) heart failure (a serious condition of the heart's ability to pump blood efficiently), Chronic obstructive pulmonary diseases (an ongoing lung condition caused by damage to the lungs), generalized osteoarthritis. R33's care plan dated 11/19/25 indicated R33 was allowed to smoke independently in designated smoking		F0657	Continued from page 12 coordinator on 4/30/2026 to reflect the recommendations of the smoking assessment with those recommendations flowing to the resident Kardex R33 TAR was updated on 4/30/2026 for nursing staff to retrieve smoking paraphernalia and keep secured at nurses station. R33 was educated on the Smoking Policy and requirement to follow the recommendations from her Safe Smoking Assessment to continue smoking. How will you identify other residents having potential to be affected by the same deficient practice and what corrective action will be taken: All residents who smoke are at risk A Safe Smoking Assessment was completed on all residents who smoke with care plan, Kardex, and TARs updated appropriately Education was provided to all residents who smoke on the facility policy and the requirement to follow the policy and recommendations from the safe smoking assessments to continue to be allowed to smoke. An Ad Hoc resident council meeting was held on 4/30/2026 to review the smoking policy What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur; and: Education was initiated with the clinical staff on the Smoking Policy and the need to complete Safe Smoking Assessments on all individuals who smoke and maintain possession of all smoking paraphernalia except when resident is smoking by the DON on 3/26/2026 with all staff receiving education by 4/24/2026 any staff not receiving education by 4/24/2026 will not be allowed to work until education is received. Residents who smoke will be reviewed weekly as part of the weekly At Risk meeting to ensure that care plan is accurate and residents are compliant with the recommendations and facility policy. A care conference will be scheduled for any resident found not to be compliant with the recommendations and policy.			

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F0657 SS = D	Continued from page 13 areas, needed reminders and assistance to use smoking apron, and smoking materials needed to be secured at the nurses' station or other designated areas for storage. R33's Smoking Assessment completed on 2/20/26, indicated R33 was safe to smoke without supervision, demonstrated safe smoking practices, no indication of smoking apron use, and facility stored lighter and cigarettes. R33's care plan was not updated to reflect the changes noted in the 2/20/26 smoking assessment. R33's MAR/TAR (medications administration/ treatments administration record) dated 3/10/26 lacked smoking assessment recommendations/interventions. R33's Task Description list (task assigned to nursing assistants) dated 3/1/26 lacked smoking tasks. During an observation on 3/9/26 at 6:46 p.m., R33 took her smoking materials from her room and continued to go out to the designated smoking area. R33 did not use a smoking apron. R33 demonstrated safe smoking practices. During an interview on 3/09/26 3:03 p.m., R33 stated, she kept her smoking materials locked in her room, smoked 1-2 cigarettes a day, and reported no smoking apron use while smoking. During an interview 3/10/26 10:49 a.m., registered nurse (RN-B) stated was not sure if R33 went out to smoke or was getting some fresh air. RN-B stated, "that information will be on the MAR/TAR, and a staff member would have been assigned to R33, if R33 was a smoker". During an interview on 3/10/26 11:20 a.m., nursing assistant (NA-E)stated, R33 used to smoke, and had not seen R33 smoke today. NA-E stated, "I will ask the nurse, the DON or look at Task Description list". During an interview on 3/10/26 at 2:27 p.m., the director of nursing (DON), explained the process of assessment to care planning and updates. DON stated, "after the Smoking Assessment was completed, nursing was responsible for updating the care plan, staff was notified, and information was available on the Task List and in the care plan. DON stated, "no point of care notification is sent out to notify staff of updates, staff are expected to review care plan for updates". During an interview on 3/12/26 at 8:45 a.m., DON			F0657	Continued from page 13 Describe the Quality Assurance and Process Improvement Program that will be put into place. QAPI was held on 4/28/20526 to review results of survey and approve the plan of correction. Results of audits will be reviewed at QAPI meeting monthly x 3 months or until substantial compliance is maintained Facility alleges substantial compliance on 5/18/2026		

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F0657 SS = D		Continued from page 14 stated, R33 stored smoking materials in her room, R33 was safe to smoke independently and R33 needed no smoking apron. Facility policy on care plan revision and update requested and not provided.		F0657			
F0658 SS = D		Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review the facility failed to provide professional standards of practice when staff completed treatments without a provider order, failed to request orders for treatment, and failed to document treatment completion for 1 of 1 resident (R77) reviewed for ostomy cares. Findings Include: R77's admission Minimum Data Set (MDS) assessment was not available at time of survey. A facility document title Nursing-Admissions/Readmission Observation dated 3/5/26, noted R77 was alert and oriented to person, place, time, and situation. R77's cognition was intact. R77 requires transfer assistance, assistance with activities of daily living (ADL), and assistance managing new colostomy (a surgical procedure that creates an opening (stoma) in the abdomen, allowing stool to exit the body when the colon cannot function normally),. R77's diagnoses included intestinal obstruction requiring a new colostomy, Parkinson's, urinary retention, and generalized muscle weakness R77's care plan dated 3/6/26, lacked direction or interventions of how to care for the colostomy. R77's admission orders included empty bag every shift and record amount; the admission orders and baseline care plan lacked specific appliance change instructions (i.e., bag type, bag size, skin protectants, skin barriers, and bag removal).		F0658		What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: MD of R77 was contacted orders were received on 4/30/2026 to reflect instructions on colostomy changes LPN-A was provided education by DON/Designee on the standards of practice that we do not provide medical services without an order How will you identify other residents having potential to be affected by the same deficient practice and what corrective action will be taken: All residents with colostomy have the potential to be affected Education was provided to the IDT on 4/22/2026 by the Regional Clinical Consultant on the expectations that we ensure that residents have appropriate orders and that services aren't provided without a physician order An audit was conducted on 4/30/2026 to ensure that all residents with colostomy have appropriate orders and care plans by DON/Designee What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur; and: Education was initiated on 3/26/2026 by DON/Designee with licensed clinical staff on the need to obtain physician orders prior to providing a medical treatment with all licensed clinical staff being educated by 4/24/2026 any resident not receiving education by 4/24/2026 not being allowed to work until education is received All admission and readmission charts will be reviewed Monday – Friday as part of the daily clinical standup with any admissions/readmissions being reviewed on the	

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F0658 SS = D	Continued from page 15 During observation on 3/9/26 at 2:11 p.m., R77 was waiting in his room for facility staff to assist him to the bathroom; while waiting R77 pulled off the colostomy bag and tossed it into the garbage can in his room. Facility staff arrived, closed room door, and assisted resident with changing his clothing and applying a new colostomy bag. According to the American Nurses Association (ANA) an RN's scope of practice is to implement orders, not to create them. The authority to create orders rests with authorized prescribers like physicians and nurse practitioners. Further, RN's need a provider's order to provide medical treatment, such as colostomy site care. During an interview on 3/10/26 at 10:37 a.m., licensed practical nurse (LPN)-A stated R77's colostomy care information should be in his admission orders or his baseline care plan. LPN-A confirmed R77 did not have colostomy care orders and did not have a colostomy care plan. LPN-A stated since the colostomy care information was not in the orders or care plan, she would look at R77's hospital dismissal instructions to verify what colostomy supplies R77 required. LPN-A stated she was unsure what colostomy supplies were used for R77's current colostomy bag. LPN-A stated the last colostomy bag change was not documented appropriately because the colostomy orders had not been entered so staff would not have a place to chart the colostomy bag change. LPN-A stated staff could have also done a progress note to document the last colostomy bag change; LPN-A verified this was also not completed. LPN-A stated staff should have requested a provider order after changing the colostomy bag; LPN-A verified this was also not completed. During an interview on 3/10/26 at 10:41 a.m., director of nursing (DON) stated R77 should have had colostomy care admission orders and a baseline colostomy care plan. DON stated the baseline care plan for R77 was incomplete; with no colostomy care information entered. DON further stated the current colostomy orders lacked specific care information such as bag type and size, skin protectants, and frequency of changes. The DON stated treatments such as colostomy care would require a provider order. The DON stated any treatment provided to residents should be documented in the residents' chart. The DON stated if a treatment is needed and completed urgently, the staff providing the treatment should immediately request an order from the provider for the treatment. Further, the DON stated it is an expectation any time a treatment is provided, with or without an order, be documented in the resident chart.	F0658	Continued from page 15 following Monday to ensure that orders have been obtained for colostomy care Describe the Quality Assurance and Process Improvement Program that will be put into place. QAPI was held on 4/28/2026 to review results of survey and approve the plan of correction. Results of audits will be reviewed at QAPI meeting monthly x 3 months or until substantial compliance is maintained Facility alleges substantial compliance on 5/18/2026	

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F0658 SS = D	Continued from page 16 The DON confirmed a treatment was performed without an order, an order was not subsequently requested, and the treatment was not documented. During an interview on 3/10/26 at 1:49 p.m., physician assistant (PA)-A stated it was his expectation admission orders, and baseline care plan be entered immediately so staff know how to care for and provide treatment to the resident with a colostomy. Additionally, if staff did not have an order for treatment, they should reach out to the provider immediately to obtain an order. Further, PA-A stated he expected all treatments to be documented so facility staff knew about the treatments the resident was receiving. A document titled Registered Nurse Job Description dated 8/2/23, registered nurses provide professional nursing care to residents in accordance with physician orders and facility policies.	F0658		
F0689 SS = E	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 observation, interview, and document review, the facility failed to comprehensively assess transfers with a mechanical lift or develop and implement policies to ensure safety and supervision for 7 of 7 residents (R6, R36, R2, R8, R51, R60, R62) reviewed for accidents. Additionally, the facility failed to identify fall risk resulting in two falls for 1 of 1 resident (R77) reviewed for repeated falls. Findings include: R6's quarterly Minimum Data Set (MDS) assessment dated 1/21/26, identified severely impaired cognition and required maximal assistance for mobility. R6's diagnoses included Parkinson's, dementia, major	F0689	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: R6 was evaluated by therapy for safety with bathroom transfers and use of EZ stand mechanical lift with careplan and kardex updated R36 was evaluated by therapy for safety with bathroom transfers and use of EZ stand mechanical lift with careplan and kardex updated R2 was evaluated by therapy for safety with bathroom transfers and use of EZ stand mechanical lift with careplan and kardex updated R8 was evaluated by therapy for safety with bathroom transfers and use of EZ stand mechanical lift with careplan and kardex updated R51 was evaluated by therapy for safety with bathroom transfers and use of EZ stand mechanical lift with careplan and kardex updated R60 was evaluated by therapy for safety with bathroom transfers and use of EZ stand mechanical lift with careplan and kardex updated R62 was evaluated by therapy for safety with bathroom transfers and use of EZ stand mechanical lift with careplan and kardex updated	05/18/2026

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F0689 SS = E	Continued from page 17 depressive disorder and lack of coordination. R6's care plan (CP) created on 9/14/24, identified mobility was an area of concern, indicated was not ambulatory and needed transfer assistance of 2 and mechanical lift (EZ stand). Furthermore, the CP identified an area of concern, indicated was at risk for falls due to dementia, impaired coordination and mobility, medications, impulsiveness and safety awareness. R36's MDS comprehensive assessment dated 3/14/25, identified moderate cognitive impairment and left sided weakness in upper and lower extremities. R36's diagnoses included dementia, hemiplegia (left side affected), and congestive heart failure. R36's care plan created on 3/14/24, identified mobility was an area of concern, indicated transfers with assist of 2 and (sit to stand lift) EZ stand. Furthermore, the care plan identified was at risk of falls due to impaired mobility, left side weakness and dementia. R2's MDS quarterly assessment dated 2/10/26, identified severely impaired cognition and dependent mobility. R2's diagnoses included anxiety, dementia and cardiorespiratory issues. R2's care plan revised on 10/27/25, identified activities of daily living was an area of concern related to mobility status and dementia. The care plan indicated transfers with the assistance of two and EZ stand lift for all transfers. Furthermore, the care plan identified was at risk for falls due to impaired mobility, dementia and medications. R8's MDS quarterly assessment dated 2/6/26, identified severely impaired cognition and substantial/maximal assistance with transfers. R8's diagnoses included non-traumatic brain dysfunction, dementia and seizure disorder. R8's care plan was created on 6/4/23, identified activities of daily living were an area of concern, due to dementia, leg pain, decrease mobility and resistance to assistance. Perform cares in pairs, transfer with assist of 2 and an EZ stand. R51's MDS quarterly assessment dated 2/24/26, identified severely impaired cognition and dependent on all areas of mobility. R51's diagnoses included atrial fibrillation, type II diabetes, depression and dementia.	F0689	Continued from page 17 R77 kardex was updated to include transfer, ambulation status, and fall risk interventions NA-I, NA-H, NA-J, and RN-D were educated by DON/Designee on 4/30/2026 on maintaining resident safety and supervision while toileting and using the EZ Stand How will you identify other residents having potential to be affected by the same deficient practice and what corrective action will be taken: All residents have the potential to be affected All residents using the EZ stand were evaluated for safety and supervision requirements during toileting by therapy All admissions for the past 30 days were reviewed to ensure there was a Kardex in place and it accurately reflected the transfer, ambulation status, and fall risk interventions Education was provided to the IDT on ensuring the Comprehensive Care Plan policy to include ensuring the Kardex contains the resident transfer status, ambulation status, and fall risk interventions by the Regional Clinical Consultant on 4/22/2026 What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur; and: Education was initiated on 3/26/2026 by the DON/Designee with clinical staff on safe transfer procedure using the EZ Stand lift with understanding validated by a competency. Any clinical staff not receiving education by 4/24/2026 will not be allowed to work until education received. Education was initiated on 3/26/2026 by the DON/Designee with clinical staff on accessing and referencing the Kardex for cares and to notify the UM/DON if there are questions or changes in the resident status that would necessitate the Care Plan/Kardex being updated 5 random observations will be completed weekly x 8 weeks will be completed to ensure that safe transfer procedures are followed when using the EZ stand lift	

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F0689 SS = E	Continued from page 18 R51's care plan created on 3/8/23, identified activities of daily living were an area of concern, due to weakness, stroke and cognitive impairment. Assist of two and EZ stand with transfers. Furthermore, identified falls were an area of concern, due to weakness, dementia and cognitive deficits. R60's MDS quarterly assessment dated 3/3/26, identified severely impaired cognition and dependent on all areas of mobility. R60's diagnoses included dementia, psychotic and mood disturbances and anxiety. R60's care plan revision on 10/7/24, identified activities of daily living was an area of concern, due to the disease process of Alzheimer's. Transfer with assistance of two and EZ stand. Furthermore, an area of concern was at risk for falls due to being unaware of safety needs and history of falls. R62's MDS comprehensive assessment on 2/20/26, identified severely impaired cognition and dependent on mobility. R62's diagnoses included osteoporosis, hemiplegia and dementia. R62's care plan revision on 6/9/25, identified activities of daily living was an area of concern, due to disease process, physical limitations, cognitive losses with spastic hemiplegia. Transfer assist of two and sit to stand lift. Furthermore, an area of concern was at risk for falls related to cognition, unaware of safety needs, incontinence, history of traumatic brain injury and cerebral vascular accident with spastic hemiplegia (type of cerebral palsy that affected one side of body, muscle weakness and stiffness). During observation on 3/10/26 at 11:02 a.m., R6 was in room, sitting in wheelchair repeating the word, "help". Registered nurse (RN)-D-went into room and asked if R6 needed anything. RN-D wheeled R6 to shower room. Nursing assistant (NA)-F and NA-G hooked up the sling to EZ stand, elevated R6, moved the stand over the toilet lowered her down at 11:13 a.m. Staff left R6 attached to the stand and staff left room. At 11:17a.m., the staff returned to the shower room. There was a large amount of urine on the floor, the EZ stand and R6. RN-D left and returned with clean bottoms and socks, while NA-G and NA-F cleaned the floor, EZ stand, and R6. During observation on 3/12/26 at 2:30 p.m., R2 was wheeled into shower room, hooked up to the EZ stand by NA-I and NA-H elevated and brought to toilet and lowered her down, remained hooked up to EZ stand on the toilet. NA-I stayed with resident except when she left	F0689	Continued from page 18 Kardexes will be reviewed and updated as indicated by changes in status Monday – Friday as part of the daily clinical stand up process Describe the Quality Assurance and Process Improvement Program that will be put into place. QAPI was held on 4/28/2026 to review results of survey and approve the plan of correction. Results of audits will be reviewed at QAPI meeting monthly x 3 months or until substantial compliance is maintained Facility alleges substantial compliance on 5/18/2026	

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F0689 SS = E	Continued from page 19 to go find assistance, for approximately 2 minutes. The staff provided cares and transferred her back into wheelchair. During interview on 3/12/26 at 11:28 a.m., NA-J stated residents that use the EZ stand for transfers to the toilet were brought into the shower room, since the bathrooms in their rooms were too small to use. She stated the process for EZ stand was to explain to resident what was happening, as cares were being provided. The EZ stand remained connected to the resident on the toilet because it was safer, kept the resident from falling forward. It was common practice for staff not to stay in shower room with resident. During interview on 3/12/26 at 12:35 p.m., RN-D stated the process for using the EZ stand was to have two staff members when doing transfers. The residents remained hooked in sling connected to EZ stand while on the toilet. The residents were left alone in the shower room. During interview on 3/12/26 at 1:54 p.m., physical therapist assistant (PTA)-A stated it was not acceptable for residents to be hooked up to the EZ stand and left alone. There was an assessment for safety of being left alone on the toilet and the resident had to be independent. However, the residents that used the EZ stand on that floor needed continuous supervision. The EZ stand should be removed while resident is on the toilet. During interview on 3/12/26 at 4:38p.m., director of nursing (DON) stated the expectations for use of shower room to toilet residents with the use of the EZ stand was to follow the transfer status lift, it required two staff members, hook up the resident, position properly and safely, bring them as close to the toilet as possible and lower. The EZ stand remained attached to the resident while using the toilet. A staff member needed to be in the line of sight of resident. DON stated he was not aware that staff were leaving residents unattended and hooked up to the EZ stand while in the shower room. The manual for the Drive EZ Sit to Stand lift indicated: How to transfer the Patient to the desired surface 1. Have the wheelchair, bed or commode ready: If transfer the patient to a commode, position the patient over the commode.	F0689		

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F0689 SS = E	Continued from page 20 2. Press the (M1) DOWN button and lower the patient onto the desired surface. 3. Lock the rear swivel casters of lift. 4. Unhook the sling from all attachment points on the lift. 5. Instruct the patient to lift their feet off the footplate. 6. Remove the sling from around the patient. 7. Pull the lift away from the wheelchair, bed or commode. The policy Safe Resident Handling/Transfers dated 2023 stated: It is the policy of this facility to ensure that residents are handled and transferred safely to prevent or minimize risks of injury and provide and promote a safe, secure and comfortable experience for the resident while keeping the employees safe in accordance with current standards and guidelines. Staff will perform mechanical lifts/transfers according to the manufacturer's instructions for use of the device. Staff members are expected to maintain compliance with safe handling/transfer practices. R77: R77's admission Minimum Data Set (MDS) was not available at time of survey. A facility document title Nursing-Admissions/Readmission Observation dated 3/5/26, noted R77 was alert and oriented to person, place, time, and situation. R77's cognition was intact. R77 requires transfer assistance, assistance with activities of daily living (ADL), and assistance managing new colostomy. R77's diagnoses included intestinal obstruction requiring a new colostomy (a surgical procedure that creates an opening (stoma) in the abdomen, allowing stool to exit the body when the colon cannot function normally), Parkinson's, urinary retention, and generalized muscle weakness. R77 was admitted to the facility on 3/5/26 at approximately 2:00 p.m. R77's baseline care plan dated 3/6/26 contained only information about resident socialization and activities. The baseline care plan lacked information about fall risk, how to minimize falls, how to minimize injuries related to falls, and resident-specific fall interventions.	F0689					

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED

OMB NO. 0938-0391

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F0689 SS = E	Continued from page 21 R77's electronic medical record (EMR) lacked a fall assessment. Review of R77's progress notes revealed: -Fall 3/8/26 at 11:09 p.m. R77 was found sitting up on the floor with his back against the bed, legs extended, with grippy socks. R77 sustained a bruise on his left buttock. Resident stated he was reaching for his urinal. -Fall 3/8/26 at 8:32 a.m. R77 was found on the floor between his bed and the bathroom door. No injuries were noted. Resident stated he was trying to get to bathroom. During an observation on 3/9/26 at 2:09 p.m., R77 was in his wheelchair in his room, stated he wanted to get up and needed help with his ostomy. R77's roommate encouraged him to wait for staff assistance. R77 kept stating he needed to get up and use the restroom and get this thing in his abdomen taken care of. During an observation on 3/9/26 at 2:11 p.m., nursing assistant (NA)-A entered R77's room to assist resident to the bathroom and change his clothing. R77 stood up with assistance from NA-A and appeared unsteady on his feet. During an interview on 3/9/26 at 3:07 p.m., NA-A stated each resident should have a Kardex (documentation system that enables nurses to write, organize, and freely reference key resident data). However, NA-A stated R77 did not have a completed Kardex. NA-A stated if a resident didn't have a Kardex, they would get information about a resident during shift change report. NA-A was unable to verbalize the information that was given about R77 during shift change report. Additionally, NA-A could only state R77 required assistance with ambulation but could not state how R77 ambulated. NA-A couldn't state whether R77 was a fall risk or if he had any fall interventions. During an interview on 3/9/26 at 3:10 p.m., NA-B stated R77 did not have a Kardex yet. NA-B stated she would look at R77's care plan since he didn't have a Kardex. NA-B stated she was unsure if R77 was a fall risk since he didn't have a care plan. NA-B couldn't state any resident-specific fall interventions for R77. During an interview on 3/10/26 at 10:37 a.m., licensed practical nurse (LPN)-A stated each resident should have a Kardex and a care plan indicating if they are a	F0689		

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F0689 SS = E	Continued from page 22 fall risk and what interventions work to prevent falls. LPN-A confirmed R77 did not have a Kardex or a resident-specific fall care plan. LPN-A confirmed R77 had fallen twice in less than 12 hours. LPN-A stated it is important to have both a Kardex and fall care plan because staff need to know how to care for each resident and prevent injuries if the resident falls. During an interview on 3/10/26 at 10:41 a.m., director of nursing (DON) stated the resident was admitted to the facility in the afternoon on 3/5/26. The DON stated the resident should have a completed baseline care plan completed in the first 48 hours after admission. The DON stated the baseline care plan should contain information about fall risk, how to prevent falls, and resident-specific interventions to prevent falls. The DON confirmed that the R77 did not have a Kardex, and the baseline care plan had not been completed within 48 hours after admission. The DON confirmed R77's falls were due to him reaching for something. The DON stated R77 should have a care plan entry for fall risk with resident specific interventions to include bed in lowest position, appropriate footwear, and commonly used items within reach. The DON stated it is important to have a completed Kardex and fall care plan to ensure residents are safe. A facility policy titled Fall Prevention Program dated 11/2025, each resident will be assessed for fall risk and will receive care and services in accordance with their individualized level of risk to minimize the likelihood of falls.		F0689				
F0691 SS = D	Colostomy, Urostomy, or Ileostomy Care CFR(s): 483.25(f) §483.25(f) Colostomy, urostomy,, or ileostomy care. The facility must ensure that residents who require colostomy, urostomy, or ileostomy services, receive such care consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to ensure physician orders were in place to provide treatment and monitoring for a colostomy (opening to allow waste to exit the body and be collected in a pouch) for 1 of 1 resident (R77) reviewed for ostomy care.		F0691	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: MD of R77 was contacted orders were received on 4/30/2026 to reflect instructions on colostomy changes LPN-A was provided education by DON/Designee on the standards of practice that we do not provide medical services without an order on 4/30/2026 How will you identify other residents having potential to be affected by the same deficient practice and what corrective action will be taken: All residents with colostomy have the potential to be affected		05/18/2026	

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F0691 SS = D	Continued from page 23 Findings Include: R77 was admitted to the facility on 3/5/26 R77's admission Minimum Data Set (MDS) assessment was not available at time of survey. A facility document titled Nursing-Admissions/Readmission Observation dated 3/5/26, noted R77 was alert and oriented to person, place, time, and situation. R77's cognition was intact. R77 requires transfer assistance, assistance with activities of daily living (ADL), and assistance managing new colostomy (a surgical procedure that creates an opening (stoma) in the abdomen, allowing stool to exit the body when the colon cannot function normally). R77's diagnoses included intestinal obstruction requiring a new colostomy, Parkinson's, urinary retention, and generalized muscle weakness R77's care plan dated 3/6/26, lacked direction or interventions of how to care for the colostomy. R77's admission orders included empty bag every shift and record amount; the admission orders lacked specific appliance change instructions (i.e., bag type, bag size, skin protectants, skin barriers, and bag removal). During observation and interview on 3/9/26 at 2:09 p.m., R77 was wheeling himself down the hall, his colostomy bag on the outside of his body, was visible since his shirt was not covering it. R77 stated he does not like it when his colostomy bag is visible and pulled his shirt down over the colostomy bag and pulled his flannel shirt together to cover the shirt. During observation on 3/9/26 at 2:11 p.m., R77 was waiting in his room for facility staff to assist him to the bathroom; while waiting R77 pulled off the colostomy bag and tossed it into the garbage can in his room. Facility staff arrived, closed room door, and assisted resident with changing his clothing and applying a new colostomy bag. During an interview on 3/10/26 at 10:37 a.m., licensed practical nurse (LPN)-A stated R77's colostomy care information should be in his admission orders and/or his baseline care plan. LPN-A confirmed R77 did not have colostomy care orders and did not have a colostomy care plan. During an interview on 3/10/26 at 10:41 a.m., director of nursing (DON) stated R77 should have colostomy care	F0691	Continued from page 23 Education was provided to the IDT on 4/22/2026 by the Regional Clinical Consultant on the expectations that we ensure that residents have appropriate orders and that services aren't provided without a physician order An audit was conducted on 4/30/2026 to ensure that all residents with colostomy have appropriate orders and care plans What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur; and: Education was initiated on 3/26/2026 by DON/Designee with licensed clinical staff on the need to obtain physician orders prior to providing a medical treatment with all licensed clinical staff being educated by 4/24/2026 any resident not receiving education by 4/24/2026 not being allowed to work until education is received All admission and readmission charts will be reviewed Monday – Friday as part of the daily clinical standup with any admissions/readmissions being reviewed on the following Monday to ensure that orders have been obtained for colostomy care Describe the Quality Assurance and Process Improvement Program that will be put into place. QAPI was held on 4/28/2026 to review results of survey and approve the plan of correction. Results of audits will be reviewed at QAPI meeting monthly x 3 months or until substantial compliance is maintained Facility alleges substantial compliance on 5/18/2026	

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F0691 SS = D	Continued from page 24 admission orders and a baseline colostomy care plan. DON stated the baseline care plan for R77 was incomplete; with no colostomy care information entered. DON further stated the current colostomy orders lacked specific care information such as bag type and size, skin protectants, and frequency of changes. DON stated it is important for colostomy care orders and colostomy care plan to be entered upon admission so staff can provide appropriate colostomy care. An undated facility policy titled Ostomy Care – Colostomy, Urostomy, and Ileostomy was received, ostomy care will be provided by licensed nurses and under the orders of the attending physician. Further, the frequency of pouch changes and the products required for changing ostomy devices will be noted on the resident's person-centered care plan.			F0691			
F0695 SS = D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and record review, the facility failed to provide oxygen therapy as ordered for 1 of 1 resident (R44) reviewed for respiratory care. Findings include: R44's Admission Minimum Data Set (MDS) assessment, dated 2/20/26, indicated intact cognition, R44 required partial to moderate assistance with toileting hygiene. R44's diagnoses included chronic respiratory failure with hypoxia, dependence on supplemental oxygen, chronic pulmonary edema, moderate persistent asthma, and dependence of renal dialysis. R44's was admitted on 2/5/26 with including, oxygen 2 liters via nasal cannula continuously. During an observation on 3/09/26 at 7:24 p.m., R44 was			F0695	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: R44 MD was contacted with orders received to make oxygen PRN to maintain oxygen saturation >90% on 3/11/2026 How will you identify other residents having potential to be affected by the same deficient practice and what corrective action will be taken: All residents on Oxygen have the potential to be affected Education was provided by the Regional Clinical Consultant on 4/22/2026 to the IDT on the Oxygen Administration policy An audit was conducted on 4/30/2026 by the DON/Designee to ensure that residents are receiving on-going assessment of the resident's condition warranting oxygen and the resident response to Oxygen What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur; and: Education was initiated on 3/26/2026 by DON/Designee on the Oxygen Administration policy and the need for residents receiving oxygen to receive on-going		05/18/2026

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F0695 SS = D	Continued from page 25 on the oxygen concentrator with a flow rate of 3 liters. During observation on 3/10/26 11:11 a.m., R44 came down the unit hallway on her motorized scooter with no oxygen in use. R44 stated, the portable oxygen tank was empty and was in search of staff to have the tank filled. R44 searched for staff for 4 minutes. The director of nursing (DON) filled the portable oxygen tank for R44 at 11:15 a.m. R44 took the oxygen tank and went back to her room with no oxygen in use. During observation on 3/10/26 11:23 a.m., and 11:28 am oxygen tank was not in use. During observation on 3/10/26 at 11:49 a.m., R44 was in her room, and was using the oxygen concentrator, on 3 liters via nasal cannula. At 11:50 a.m., registered nurse, (RN)-B entered R44's room, had a conversation with R44 and exited at 11:52 a.m. During observation on 3/10/26 12:03 p.m., R44 came out of the room, the portable oxygen tank in use via nasal cannula on 2 liters and stated was going to the dining room for lunch. During an interview with RN-B on 3/10/26 1:38 p.m., RN-B stated, had seen R44 at times with no oxygen in use, and was not sure if R44 oxygen order was continuous or as needed. During an interview with nursing assistant (NA)-E on 3/10/26 at 1:39 p.m., NA-E stated had seen R44 without oxygen in use. NA-E stated had seen R44 down the hallway and needed the portable oxygen tank filled. During an interview on 3/10/26 2:28 p.m., the DON verified filling the tank for R44. DON stated, "I have never seen her with her oxygen in use". During an interview on 3/12/26 at 2:00 p.m., medical doctor, (MD) expected the facility to have sent an SBAR (situation, background, assessment, recommendation) and updated vitals for ongoing need for supplemental oxygen. An undated facility provided policy indicated staff shall document ongoing assessment of the resident's condition warranting oxygen and the response to oxygen therapy.	F0695	Continued from page 25 assessment of the resident's condition warranting oxygen and the resident response to Oxygen with all staff receiving education by 4/24/2026. Any staff not receiving education by 4/24/2026 will not be allowed to work until education is received An audit will be completed weekly x 8 weeks on residents receiving oxygen to ensure on-going assessment of the resident's condition and the resident's response to Oxygen is being documented appropriately and an SBAR is completed with MD notification with changes in resident condition changes. Describe the Quality Assurance and Process Improvement Program that will be put into place. QAPI was held on 4/28/2026 to review results of survey and approve the plan of correction. Results of audits will be reviewed at QAPI meeting monthly x 3 months or until substantial compliance is maintained Facility alleges substantial compliance on 5/18/2026		
F0698 SS = D	Dialysis	F0698	What corrective action(s) will be accomplished for those residents found to have been affected by the	05/18/2026	

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F0698 SS = D	Continued from page 26 CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and record review, the facility failed to complete ongoing assessment of the resident's condition and monitoring complications before and after dialysis treatments received at a certified dialysis facility for 1 of 1 resident (R44) reviewed for dialysis. Findings include: R44's Admission Minimum Data Set (MDS) assessment, dated 2/20/26, indicated intact cognition, R44 required partial/moderate assistance with toileting hygiene. R44's diagnoses included acute kidney failure, dependence of renal dialysis hypertensive heart and chronic kidney disease with heart failure, type2 diabetes mellitus, Pulmonary edema, moderate persistent asthma, dependence on supplemental oxygen, Chronic respiratory failure with hypoxia. R44's was admitted On 02/5/26 and orders dated 2/19/25 included: dialysis pre and post assessment every Tuesday, Thursday and Saturday. Print and send assessment with resident to dialysis, place returned paperwork in manager box. Review of R44's MAR/TAR (medications administration/ treatments administration record) dated 2/5/26 to 2/28/26 and 3/1/26 to 3/10/26, indicated pre and post dialysis assessments were completed 2/24/2026, 2/27/26, 3/3/26. R44's record lacked other days completed. During an interview on 3/9/26 at 7:20 p.m., the director of nursing (DON) verified R44's dialysis pre-assessment form had not been sent consistently. DON was unable to provide completed dialysis pre or post assessment when requested. During an interview on 3/10/26 at 10:44 a.m., registered nurse RN-(B) stated R44 was leaving at 12:15 p.m., and the dialysis pre- assessment will be completed and sent with R44 to the dialysis center.	F0698	Continued from page 26 deficient practice: Education was provided to RN-B on the Hemodialysis policy and the requirement to complete pre/post dialysis assessment on the resident by DON/Designee on 4/30/2026. How will you identify other residents having potential to be affected by the same deficient practice and what corrective action will be taken: All residents receiving hemodialysis have the potential to be affected. Education was provided on 4/22/2026 by the Regional Nurse Consultant to the IDT on the Hemodialysis policy and need to ensure that pre/post dialysis assessments are completed and collaborative care is maintained with the dialysis center An audit was completed on residents receiving hemodialysis to ensure that pre/post dialysis assessments have been completed and collaborative care is maintained with the dialysis center Care plans of residents receiving hemodialysis updated to include need for post treatment monitoring on 4/30/2026 by MDS coordinator What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur; and: Education was initiated on 3/26/2026 by the DON/Designee on the Hemodialysis policy and the need for completing pre/post dialysis assessment and maintaining collaborative care with the dialysis center with all licensed clinical staff receiving education by 4/24/2026. Any licensed clinical staff not receiving education by 4/24/2026 will not be allowed to work until education is received Residents receiving dialysis will be reviewed as part of the clinical morning stand up process to ensure pre/post dialysis assessments are completed and collaborative care with the dialysis center is maintained.	

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F0698 SS = D	Continued from page 27 During an interview on 03/10/26 2:09 p.m., RN-B was unable to provide a copy of the dialysis pre-assessment form sent with R44. During an interview 03/12/26 at 2:00 p.m., medical doctor (MD) expected the facility to have completed the pre and post dialysis assessments and notified them and the dialysis center of any changes in R44's weight and status. An undated facility provided policy indicated, an ongoing assessment of the resident's condition and monitoring for complications before and after dialysis treatments received at a certified dialysis facility.	F0698	Continued from page 27 Describe the Quality Assurance and Process Improvement Program that will be put into place. QAPI was held on 4/28/2026 to review results of survey and approve the plan of correction. Results of audits will be reviewed at QAPI meeting monthly x 3 months or until substantial compliance is maintained Facility alleges substantial compliance on 5/18/2026	05/18/2026
F0732 SS = C	Posted Nurse Staffing Information CFR(s): §483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements.	F0732	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Education provided to facility clinical leadership on requirements of staffing information being posted at all nursing stations at eye level of residents by Regional Clinical Consultant on 4/22/2026 How will you identify other residents having potential to be affected by the same deficient practice and what corrective action will be taken: All residents have the potential to be affected. Staffing information is posted daily at each nurse station at eye level of residents What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur; and: Education was initiated by the DON/Designee with licensed clinical staff on the requirement for nurse staffing information to be posted in a prominent place readily accessible to residents and visitors on 3/26/2026 with all licensed clinical staff receiving education by 4/24/20206. Any staff not receiving education by 4/24/2026 will not be allowed to work until education is received. DON/Designee will audit postings 5/week x 4 weeks, then 3/week x 4 weeks, then weekly x 4 weeks or until substantial compliance is obtained	

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F0732 SS = C	Continued from page 28 (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents, staff, and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interviews, and documents review, the facility failed to include the daily census and actual hours worked by nursing staff groups on the daily staffing data document. This deficient practice had the potential to affect all residents who resided in the facility and/or any visitors who may have wanted to view the information. Findings include: During observation on 3/9/26 at 11:30 a.m., upon entry of the survey, the staff posting for 03/09/26 did not show the daily census and actual hours worked by nursing staff groups. During documents review on 3/10/26, daily schedule reports (daily staffing data document) provided by facility for 03/9/26 to 3/13/26 all lacked the daily census and actual hours worked by nursing staff groups. During an interview on 03/12/26 at 10:11 a.m., the scheduler stated there was a change in template in September and the daily census and actual hours worked by nursing staff groups has been missing from the daily staffing data document. During an interview on 03/12/26 11:51 am, the facility	F0732	Continued from page 28 Describe the Quality Assurance and Process Improvement Program that will be put into place. QAPI was held on 4/28/2026to review results of survey and approve the plan of correction. Results of audits will be reviewed at QAPI meeting monthly x 3 months or until substantial compliance is maintained Facility alleges substantial compliance on 5/18/2026	

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F0732 SS = C	Continued from page 29 administrator acknowledged the daily census and actual hours worked by nursing staff groups was not shown on the facility daily staffing data document.	F0732		
F0755 SS = E	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(f). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is NOT MET as evidenced by: Based on observation and interview, the facility failed to dispose of discontinued, expired, and discharged residents' medications. This had the potential to affect any resident who received medication from all facility medication rooms. Findings include:	F0755	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: R81 medications were destroyed on 4/30/2026 R15 medications were destroyed on 4/30/2026 R42 medications were destroyed on 4/30/2026 R52 medications were destroyed on 4/30/2026 R48 medications were destroyed on 4/30/2026 R78 medications were destroyed on 4/30/2026 R30 medications were destroyed on 4/30/2026 R2 medications were destroyed on 4/30/2026 R13 medications were destroyed on 4/30/2026 R6 medications were destroyed on 4/30/2026 R51 medications were destroyed on 4/30/2026 R34 medications were destroyed on 4/30/2026 R13 medications were destroyed on 4/30/2026 R22 medications were destroyed on 4/30/2026 R6 medications were destroyed on 4/30/2026 R78 medications were destroyed on 4/30/2026 R31 medications were destroyed on 4/30/2026 R62 medications were destroyed on 4/30/2026 R80 medications were destroyed on 4/30/2026 How will you identify other residents having potential to be affected by the same deficient practice and what corrective action will be taken: All residents have the potential to be affected	05/18/2026

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F0755 SS = E	Continued from page 30 On 03/11/2026 10:00 a.m., 1st floor medication storage had 23-40 medication cards from discharged residents awaiting destruction and several bottles of over-the-counter expired bottles awaiting disposal. Registered nurse (RN)-B confirmed the medications on the counter were awaiting destruction and was unsure of the process of medication destruction. RN-B stated, “the nurse manager took care of it, and we do not have one right now”. The 1st floor med room storage had the following current resident medications awaiting destruction. R 81 -Flomax capsule 0.4mg (Tamsulosin HCL) Take 0.4 milligrams (mg) by mouth daily -Inderal LA oral capsule Extended Release 24 hours (Propranolol HCL), Take 1 cap my mouth in the evening. - Lipitor oral tablet (Atorvastatin Calcium), take 10 mg by mouth at bedtime -Synthroid Oral tablet (levothyroxine Sodium), take 112 micrograms (mcg) by mouth in the morning. -Venlafaxine HCL ER oral capsule extended release 24 hours (venlafaxine HCL), take 37.5 mg by mouth one time a day every other day -Zyloprim oral tablet (Allopurinol), take 300 mg by mouth one time a day. -Methocarbamol oral tablet, Take 1000 mg by mouth 4 times a day. -Allegra Allergy oral tablet (Fexofenadine HCL), take 180 mg by mouth every 24 hours as needed. R15 - Allegra Allergy oral tablet (Fexofenadine HCL), take 180 mg by mouth on time a day -Crestor oral tablet (Rosuvastatin Calcium), take 10 mg by mouth at bedtime. -Lasix oral tablet (Furosemide) take 40 mg by mouth one time a day. -Rozerem oral tablet (Ramelteon), take 8 mg by mouth at bedtime.	F0755	Continued from page 30 An audit of all med rooms was completed by DON/Designee on 4/30/2026 to ensure there were no medications that needed to be destroyed or returned A contract was obtained to have a Med Safe provided for the facility for all medications requiring destruction What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur; and: Education was initiated on 3/26/2026 by DON/Designee with licensed clinical staff on medication destruction and returns with all staff being educated by 4/24/2026. Any staff not receiving education by 4/24/2026 will not be allowed to work until education is received. Med rooms will be reviewed and cleaned weekly by the 11/7 shift on Sunday to ensure medications are destroyed or returned as required An audit of med rooms will be completed weekly by the UM to ensure medication room is clean and free of medications requiring destruction Describe the Quality Assurance and Process Improvement Program that will be put into place. QAPI was held on 4/28/2026 to review results of survey and approve the plan of correction. Results of audits will be reviewed at QAPI meeting monthly x 3 months or until substantial compliance is maintained Facility alleges substantial compliance on 5/18/2026	

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F0755 SS = E	Continued from page 31 - Synthroid Oral tablet (levothyroxine Sodium), take 125 mcg by mouth in the morning. - Lopressor oral tablet (Metoprolol Tartate) Take 12.5 mg by mouth 2 times a day - Omeprazole oral tablet, take 20 mg by mouth 2 times a day. - Zylprim oral tablet (Allopurinol), take 100 mg by mouth 2 times a day. - Neurontin oral capsule (Gabapentin), take 300 mg by mouth 3 times a day. Tegretol oral tablet (carbamazepine), take 200 mg by mouth 4 times a day. - Benzonatate oral capsule, take 100 mg by mouth every 4 hours as needed for cough - Carafate oral tablet 1 gram, take 1 gram by mouth as needed 2 times a day as needed. - Melatonin Oral tablet, give 6 mg by mouth at bedtime as needed. - Ondansetron HCL oral tablet, take 1 mg by mouth every 8 hours as needed. On 03/11/2026 10:42 a.m., the 2nd floor medication storage room had 6 medications on the counter. Licensed practical nurse (LPN)-A acknowledged the 6 medication cards were from discontinued medications orders and discharged residents. LPN-A stated was unsure of the medication destruction process and stated that the night shift was responsible for medications destruction. The 2nd floor medication storage room had 6 medication cards belonging to R42 and R52 awaiting destruction. During observation on 03/11/2026 at 11:51 a.m., registered nurse, (RN)-F, RN-F confirmed, medication cards kept on the counter were from discontinued orders, and discharged patients awaiting destruction. RN-F was unsure of facility medication destruction process and who was responsible for medication destruction. The 3rd floor medication room storage had following current resident medications awaiting destruction. R48			F0755			

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F0755 SS = E	Continued from page 32 -Atorvastatin 10 mg 1 tab started, 2/26 R78 -Escitalopram 20 mg, started 3/31/25 -Metoprolol 25 mg, 3 cards -Bupropion hcl 159 mg, tab started 10/29/25 R30 -Clindamycin 150 mg caps started 1/23/26- -Torsemide 20 mg 2 tabs daily for 3 days then continue 1 tab daily R2 -Hyoscyamine 0.125 mg tab, started 4/22/25 R13 - Ondansetron hcl 4 mg tab, started 11/26/2 R6 -Famotidine 20mg, give 1 tablet R51 - Eliquis 5 mg, give 1 tablet by mouth twice a daily R34 -Trazodone 50-gram tablet, give 1.2 tablet by mouth at bedtime as needed sleep R13 - Sertraline 25 mg, give 1 tablet by mouth daily take with 50 mg for total dose of 75 mg R22 -Ondansetron 4 mg tablet, give one tablet by mouth every 8 hrs. as needed for up to 7 days R6 Benzonatate 100 mg capsule, give one capsule by mouth three times daily as needed			F0755			

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F0755 SS = E	Continued from page 33 R78 -Quetiapine 25 mg, give 1.2 tablet by bedtime R31 -Iprat-albut 0.5 (2.5) mg/3ml inhale 3mL vial ben three times daily for SOB. R62 -Paxlovid 300-100mg dose R80 - Cyanocobalamin 1000mcg/ml inject 1 milliliter (ml) intramuscular (IM) weekly It also contained 1 bottle of OTC acetaminophen 325 mg open 11/6/2024 exp on bottle 2/2026, 1 bottle of aspirin over the counter 81 mg, expired 2/26/2026, and 1 canister of inhaler -Formoterol Fumarate 20mcg/2ml. During an interview on 3/11/2026 at 1:34p.m., the director of nursing (DON) stated, medication destruction was to be completed by 2 nurses, 1 nurse logged the medications, and the 2nd nurse completed the destruction by disposing of the tablets in a Stericycle water activated solution. DON expected medications destruction to be completed as soon as possible. During an interview with the facility pharmacist on 03/11/2026 at 2:34 p.m., pharmacist reported being unfamiliar with the current medication destruction process for the facility and advised to refer to the facility policy. A policy for medication storage was requested but not received prior to the end of the survey.			F0755			
F0757 SS = D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or			F0757	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: R33 had a sleep study assessment completed on 4/30/2026 How will you identify other residents having potential to be affected by the same deficient practice and what corrective action will be taken:		05/18/2026

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F0757 SS = D	Continued from page 34 §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is NOT MET as evidenced by: Based on interview and record review, the facility failed to monitor effectiveness of a medication prescribed for sleep by not completing sleep monitoring for 1 of 1 resident (R33) reviewed for unnecessary medications. Findings include: R33's Minimum Data Set (MDS) assessment, dated 12/3/25, /indicated intact cognition, /R33 /was independent with transfers, w/c mobility and required limited assist with bed mobility. R33 diagnoses included chronic systolic and diastolic (congestive) heart failure (a serious condition of the heart's ability to pump blood efficiently), Chronic obstructive pulmonary diseases (an ongoing lung condition caused by damage to the lungs), generalized osteoarthritis. R33's medication orders included: Melatonin 5 milligrams (mg), oral at bedtime: start date:12/01/25 for insomnia. R33's Medication Administration Record (MAR) record review from 02/1/26 to 3/11/26 reviewed lacked sleep tracking or monitoring. R33' s progress note reviewed from 02/1/25 to 3/11/26 had no reference to R33 sleep monitoring. During an interview on 3/11/2026 at 4:05 p.m., registered nurse (RN)-C, RN-C stated, "yes, resident is		F0757	Continued from page 34 All residents on Melatonin have the potential to be affected An audit of was completed on residents taking Melatonin was conducted and any requiring a sleep study assessment had one scheduled What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur; and: Education was initiated by the DON/Designee on 3/26/2026 with the licensed clinical staff on the Sleep Study assessment and the need to ensure this is completed with the initiation of Melatonin, quarterly and with any significant change on any resident taking Melatonin with all licensed clinical staff receiving education by 4/24/2026. Any staff not receiving education by 4/24/2026 will not be allowed to work until education is received. An audit will be completed quarterly on any resident taking Melatonin as part of their care plan process to ensure a sleep study is completed with any resident not having the sleep study completed having the sleep study scheduled Describe the Quality Assurance and Process Improvement Program that will be put into place. QAPI was held on 4/28/2026 to review results of survey and approve the plan of correction. Results of audits will be reviewed at QAPI meeting monthly x 3 months or until substantial compliance is maintained Facility alleges substantial compliance on 5/18/2026			

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F0757 SS = D	Continued from page 35 taking a sleep aid, melatonin 5 mg, we usually do a sleep monitoring, but there is no sleep monitoring in place in the assessment for that resident and I do not know why". During an interview on 3/11/2026 4:55 p.m., the director of nursing (DON) stated, "I will not track sleep with Melatonin use due to Melatonin being an over-the-counter medication". The facility policy titled: Gradual Dose Reduction of Psychotropic Drugs reviewed 3/5/2025 indicates, "Psychotropic drug" or "psychotropic medication" is defined as any drug that affects brain activities associated with mental processes and behavior. Psychotropic drugs include, but are not limited to the following categories: antipsychotics, antidepressants, anxiety, and hypnotics (a class of drugs used preliminary to induce sleep and treat insomnia)		F0757				
F0812 SS = F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and record review, the facility failed to ensure food stored in the		F0812	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Expired sliced ham was disposed of by the CDM on 3/12/2026 Lettuce was disposed of by the CDM on 3/12/2026 Box of food on the floor was placed on shelf on 3/12/2026 Box of food touching the freezer fan blade was moved away from the fan on 3/12/2026 How will you identify other residents having potential to be affected by the same deficient practice and what corrective action will be taken: All residents have the potential to be affected Education was provided to Cook-C by CDM on the Food Safety Requirement policy on 4/30/2026 What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur; and: Education was initiated by CDM on 3/26/2024 on the Food		05/18/2026	

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F0812 SS = F	Continued from page 36 refrigerator were labeled, dated and free of expired foods. This deficient practice had the potential to affect all residents, staff and visitors who received food from facility kitchen. Findings include: During the initial kitchen tour on 3/9/26 at 10:34 a.m., cook (C)-A greeted surveyor inside the kitchen. The following items were observed in the fridge expired and undated food: -Sliced Ham, expired on 3/2/26 -no date on lettuce, browning and wilting Additionally, the following items were observed in the freezer: -box of food sitting directly on the freezer floor -box on top shelf of freezer touching freezer fan blade During the follow up kitchen tour on 3/12/26 at 12:25 p.m., district manager (DM) stated the expired sliced ham, and undated lettuce had been thrown out. DM confirmed the box on the floor of the freezer had been placed on a shelf. DM confirmed the box touching the freezer fan blade had been pushed back away from the fan blade. DM stated undated items should be thrown out immediately and foods in the fridge longer than 3 days should be thrown out. DM stated it is important to use expiration dates to ensure palatability and to prevent food borne illnesses. DM stated it is important to keep food boxes correctly place to ensure freezer equipment continues to work as intended. A facility policy was requested and not received.		F0812	Continued from page 36 Safety Requirements policy with all staff being educated by 4/24/2026 any staff not receiving education by 4/24/2026will not be allowed to work until they receive education Food storage will be audited by CDM weekly x 8 weeks Describe the Quality Assurance and Process Improvement Program that will be put into place. QAPI was held on 4/28/2026 to review results of survey and approve the plan of correction. Results of audits will be reviewed at QAPI meeting monthly x 3 months or until substantial compliance is maintained Facility alleges substantial compliance on 5/18/2026			
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.		F0880	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Education was provided to CNA-G on the Enhanced Barrier Precautions policy on 4/30/2026 by DON/Designee Education was provided to CNA-F on the Enhanced Barrier Precautions policy on 4/30/2026 by DON/Designee		05/18/2026	

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F0880 SS = D	Continued from page 37 §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; (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.	F0880	Continued from page 37 Education was provided to CNA-K on the Enhanced Barrier Precautions policy on 4/30/2026 by DON/Designee Education was provided to CNA-L on the Enhanced Barrier Precautions policy on 4/30/2026 by DON/Designee Education was provided to LPN-A on the Enhanced Barrier Precautions policy on 4/30/2026 by DON/Designee How will you identify other residents having potential to be affected by the same deficient practice and what corrective action will be taken: All residents requiring Enhanced Barrier Precautions have the potential to be affected Education was provided by the Regional Clinical Consultant on 4/24/2026 to the IDT on the Enhanced Barrier Precautions Policy What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur; and: Education was initiated by the DON/Designee on 3/26/2026 with clinical staff on the Enhanced Barrier Precautions policy with all clinical staff being educated by 4/24/2026. Any clinical staff member not being educated by 4/24/2026 will not be allowed to work until education is received. A random audit will be conducted on 5 staff members weekly x 8 weeks to ensure compliance with the Enhanced Barrier Precautions policy. Describe the Quality Assurance and Process Improvement Program that will be put into place. QAPI was held on 4/28/2026 to review results of survey and approve the plan of correction. Results of audits will be reviewed at QAPI meeting monthly x 3 months or until substantial compliance is maintained Facility alleges substantial compliance on 5/18/2026	

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F0880 SS = D	Continued from page 38 §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, interview, and record review, the facility failed to ensure proper personal protective equipment (PPE) usage for 3 of 3 residents (R6, R4, R14) reviewed for enhanced barrier precautions (EBP) who receive tube feeding (R6, R14) and dialysis care (R4). Findings include: R6: R6's Minimum Data Set (MDS) quarterly assessment dated 1/21/26, identified severely impaired cognition and required maximal assistance for mobility. R6's diagnoses included Parkinson's, dementia, major depressive disorder and lack of coordination. R6's physician orders dated 4/24/25, Enhanced Barrier Precautions (EBP) for tube feeding. R6 had a percutaneous endoscopic gastrostomy (PEG) tube for enteral nutrition and medication. Cleanse surrounding skin with warm water using soft cloth, then pat dry. Apply barrier cream to skin under PEG tube disk to prevent moisture related skin redness. R6's care plan (CP) created on 1/27/25, identified R6 was at risk for infection related to indwelling medical device (PEG) tube. EBP when cares are provided to R6. Furthermore, alternation in cognition forgetfulness and confusion related to dementia. Additionally, had impaired swallowing related to Parkinson's, administer tube feedings, medication and flushes per order. R14: R14's MDS comprehensive assessment dated 12/29/25,		F0880				

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F0880 SS = D	Continued from page 39 identified severely impaired cognition and independent with ambulation. R6's diagnoses included non-traumatic brain dysfunction, renal insufficiency, and Alzheimer's disease. R14's physician orders dated 7/19/24, Enhance Barrier Precautions (EBP) for supra-pubic catheter for long term urinary retention. Supra-pubic foley catheter cares clean daily and as needed, empty bag every shift and record results. Educate on importance of risk of infection. R14's CP created on 4/1/24, identified R14 was at risk for infection related to indwelling medical device, supra-pubic catheter, EBP when providing cares. Additionally, R14 had alteration in urinary elimination related to obstructive uropathy, treated with a supra-pubic catheter. During observation on 3/10/26 at 11:13 a.m., certified nursing assistants (CNA)-G and CNA-F performed peri cares and toileting in shower room. There was a large amount of urine on floor, both staff members were not wearing proper EBP while cleaning floor, EZ stand and R6. During observation on 3/11/26 at 8:34a.m., CNA-K attempted to reattach leg bag on R14, bag was hanging out of pants, dragging on the floor while walking to dining room. They walked back to his room, he sat down, CNA-K put on gloves emptied out urine and reattached bag to leg, CNA-K was not wearing proper EBP when cares were performed. During interview on 3/9/26 at 3:30p.m., CNA-L stated EBP was used for the safety of the residents decrease the risk of infection. During interview on 3/10/26 at 11:46 a.m., CNA-G stated standard for infection control was hand washing, before and after cares of residents. EBP, gloves and gown to be worn when cares were done on residents with wounds, catheters, and feeding tubes. During interview on 3/10/26 at 12:00 p.m., RN-D stated EBP protected staff and residents from infections. EBP was to wear gloves and gown, hand washing before and after cares. During interview on 3/11/26 at 9:07a.m., CNA-F stated the importance of EBP was to prevent infection, the only time to wear EBP was when manipulating catheters, feeding tubes or wounds. The only time CNA-F wore EBP was when a resident had COVID. She was not an RN, they			F0880			

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F0880 SS = D	Continued from page 40 did the specific treatments, not the nursing assistants, so EBP wasn't required. R4: R4's quarterly MDS assessment, dated 2/23/26, indicated R4 was cognitively intact, had no upper body impairment, was independent with personal hygiene, and required set-up/supervision for upper and lower body dressing. It also indicated R4 received dialysis care (mechanical filtering of blood), had a surgical wound, and received surgical wound care. R4's diagnoses list included diabetes, end-stage kidney disease, heart failure, left leg amputation, and dependence on renal dialysis. R4's care plan dated 1/29/26 indicated R4 receives dialysis 3 times/week, has a dialysis catheter (a tube inserted in the chest or neck used for mechanical filtering of blood), and is at risk for infection related to a dialysis catheter requiring EBP when performing high-contact care activities. R4's provider orders dated 11/17/25 included: dialysis Monday, Wednesday, Friday, post dialysis assessment, monitor dialysis catheter daily for signs of infection, dressing changes to surgical wound, and EBP due to dialysis catheter. R4's nursing assistant care sheet dated 3/12/26 indicated "enhanced barrier precautions when performing high-contact care activities" During an observation and interview on 3/9/26 at 12:52 p.m., R4 stated staff do not wear gowns because she does not have an infection. An orange sign indicating "enhanced barrier precautions" was noted outside R4's room. During observation and interview on 3/11/26 at 11:05 a.m., licensed practical nurse (LPN)-A entered R4's room to perform a scheduled dressing change to R4's surgical site. LPN-A stated she washed her hands prior to entering the room and applied gloves. Without donning a gown, LPN-A performed the dressing change to R4's left lower extremity. LPN-A then washed and dried under R4's abdomen, applied powder to R4's abdominal folds. After disposing garbage, removing gloves, and washing hands, LPN-A reviewed the EBP sign on R4's door. LPN-A stated it indicated "barrier precautions and to gown up and glove." When asked what tasks would requiring gowning and gloving, LPN-A stated she was		F0880				

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F0880 SS = D	Continued from page 41 “drawing a blank.” When asked why R4 was on EBP, LPN-A stated it “might be for her PICC line [referring to the central line dialysis catheter], but I don’t do anything with that.” LPN-A stated staff are only required to wear PPE if they are providing care “for the reason they are on the precautions.” LPN-A stated staff receive infection control training upon hire and have online education. During interview on 3/11/26 at 11:53 a.m., LPN-A confirmed R4 is on EBP due to having a dialysis catheter. During interview on 3/12/25 at 9:31 a.m., the director of nursing stated residents are placed on EBP if they have indwelling medical devices, chronic rounds, and MDROs (bacteria resistant to multiple treatments). An order is placed on the medication administration record, care plan is updated, and signage is placed on the door. The director of nursing stated staff are expected to read the signage on the door for instruction regarding precautions. He stated gown and gloves are required for all high-contact cares. A policy titled “Enhanced Barrier Precautions” dated 3/24/25 indicated “It is the policy of this facility to implement enhanced barrier precautions for the prevention of transmission of multidrug-resistant organisms.” The policy also indicated, in part, an order for enhanced barrier precautions will be obtained for residents with chronic wounds and/or indwelling medical devices (e.g., central lines, urinary catheters, feeding tubes, etc.). Implementation of enhanced barrier precautions included “PPE for enhanced barrier precautions is only necessary when performing high-contact care activities”. High-contact resident care activities included: device care or use: central lines (tubes in the neck or chest providing access to large vessels), PICC lines (tubes placed in the upper arm allowing access to veins) , hemodialysis catheters, and wound care involving any skin opening requiring a dressing.	F0880		
F0919 SS = D	Resident Call System CFR(s): 483.90(g)(1)(2) §483.90(g) Resident Call System The facility must be adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area from-	F0919	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Call light was repaired in shower room on 3rd floor by Maintenance Director on 4/30/2026 How will you identify other residents having potential to be affected by the same deficient practice and what	05/18/2026

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F0919 SS = D	Continued from page 42 §483.90(g)(1) Each resident's bedside; and §483.90(g)(2) Toilet and bathing facilities. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review the facility failed to ensure a bathroom call light was functioning for the shower room on the 3rd floor having the potential to affect all residents that use the toilet in the shower room, 7 of 7 (R6, R36, R2, R8, R51, R60, R62) residents were brought to and used an EZ stand for toileting. Findings include: R6's Minimum Data Set (MDS) quarterly assessment dated 1/21/26, identified severely impaired cognition and required maximal assistance for mobility. R6's diagnoses included Parkinson's, dementia, major depressive disorder and lack of coordination. R6's care plan (CP) created on 9/14/24, identified mobility was an area of concern, indicated was not ambulatory and needed transfer assistance of 2 and mechanical lift (EZ stand). Furthermore, the CP identified an area of concern, indicated was at risk for falls due to dementia, impaired coordination and mobility, medications, impulsiveness and safety awareness. R36's MDS comprehensive assessment dated 3/14/25, identified moderate cognitive impairment and left sided weakness in upper and lower extremities. R36's diagnoses included dementia, hemiplegia (left side affected), and congestive heart failure. R36's care plan created on 3/14/24, identified mobility was an area of concern, indicated transfers with assist of 2 and (sit to stand lift) EZ stand. Furthermore, the care plan identified was at risk of falls due to impaired mobility, left side weakness and dementia. R2's MDS quarterly assessment dated 2/10/26, identified severely impaired cognition and dependent mobility. R2's diagnoses included anxiety, dementia and cardiorespiratory issues. R2's care plan revised on 10/27/25, identified activities of daily living was an area of concern related to mobility status and dementia. The care plan indicated transfers with the assistance of two and EZ	F0919	Continued from page 42 corrective action will be taken: All residents have the potential to be affected An audit was conducted on all other call lights in the facility on 4/30/2026 by the maintenance director – all were found to be functional What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur; and: Education was initiated with the DON/Designee on reporting items in need of repairs via TELS with clinical staff on 3/26/2026 any clinical staff not receiving education by 4/24/2026 will not be allowed to work until education is received. An audit will be completed by the maintenance director of 5 resident care areas weekly x 8 weeks to ensure call lights are functioning properly Describe the Quality Assurance and Process Improvement Program that will be put into place. QAPI was held on 4/28/2026 to review results of survey and approve the plan of correction. Results of audits will be reviewed at QAPI meeting monthly x 3 months or until substantial compliance is maintained Facility alleges substantial compliance on 5/18/2026	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245184	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/12/2026
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F0919 SS = D	Continued from page 43 stand lift for all transfers. Furthermore, the care plan identified was at risk for falls due to impaired mobility, dementia and medications. R8's MDS quarterly assessment dated 2/6/26, identified severely impaired cognition and substantial/maximal assistance with transfers. R8's diagnoses included non-traumatic brain dysfunction, dementia and seizure disorder. R8's care plan was created on 6/4/23, identified activities of daily living were an area of concern, due to dementia, leg pain, decrease mobility and resistance to assistance. Perform cares in pairs, transfer with assist of 2 and an EZ stand. R51's MDS quarterly assessment dated 2/24/26, identified severely impaired cognition and dependent on all areas of mobility. R51's diagnoses included atrial fibrillation, type II diabetes, depression and dementia. R51's care plan created on 3/8/23, identified activities of daily living were an area of concern, due to weakness, stroke and cognitive impairment. Assist of two and EZ stand with transfers. Furthermore, identified falls were an area of concern, due to weakness, dementia and cognitive deficits. R60's MDS quarterly assessment dated 3/3/26, identified severely impaired cognition and dependent on all areas of mobility. R60's diagnoses included dementia, psychotic and mood disturbances and anxiety. R60's care plan revision on 10/7/24, identified activities of daily living was an area of concern, due to the disease process of Alzheimer's. Transfer with assistance of two and EZ stand. Furthermore, an area of concern was at risk for falls due to being unaware of safety needs and history of falls. R62's MDS comprehensive assessment on 2/20/26, identified severely impaired cognition and dependent on mobility. R62's diagnoses included osteoporosis, hemiplegia and dementia. R62's care plan revision on 6/9/25, identified activities of daily living was an area of concern, due to disease process, physical limitations, cognitive losses with spastic hemiplegia. Transfer assist of two and sit to stand lift. Furthermore, an area of concern was at risk for falls related to cognition, unaware of safety needs, incontinence, history of traumatic brain injury and cerebral vascular accident with spastic	F0919		

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F0919 SS = D	Continued from page 44 hemiplegia (type of cerebral palsy that affected one side of body, muscle weakness and stiffness). During observation on 3/10/26 at 11:13 a.m., the shower room had a call light which was a small switch on back wall by the toilet, no cord seen. During observation and interview on 3/10/26 at 12:00, registered nurse (RN)-D went and found a cord, tied it around the call light switch in the shower room by the toilet for residents to use, at that time, the light did turn on outside of door when cord was pulled. RN-D stated things were falling through the cracks on the 3rd floor, they didn't have an RN manager, to educate and facilitate any concerns or issues. During interview on 3/12/26 at 11:28 a.m., CNA-J stated if the call light in the shower room wasn't working, they would hear a resident yelling or banging for assistance. During observation and interview on 3/12/26 at 12:17p.m., the call light was not lit up in hallway nor ringing at the nurse's station for the shower room. CNA-F and director of nursing (DON) were at the nurse's desk filling out the a maintenance report. The DON stated it was the 1st time he was told there was a problem with the call light. During interview on 3/12/2026 at 4:47 p.m., RN-E and RN-F verified that call light was not working. RN-E asked to pull call light, red light came on, there was no sound to alert staff, the light on the board in nurses' station also came on with no sound, Both nurses present, confirmed call light not working. Maintenance called, he came and verified that the call light was not working, and he had a call out to have call light fixed. Record review a document entitled, Building Tasks dated 9/25-3/26, Conduct a Test of the Nurse Call System was marked at completed on 2/20/26. The steps were: 1. For each department, notify the appropriate person in charge that the call system is being tested 2. Check all devices transmitting to, and received from nurse call system, to include pullcords, pendants and pagers. Repair as necessary 3. Check call cords in bathrooms and shower rooms. Ensure call cord length is no more than 6" from the		F0919				

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F0919 SS = D	Continued from page 45 floor. Repair as necessary 4. Notify the appropriate person in charge that the test has been completed and has been returned to operational status 5. Check call light clips 6. If system is capable, run report to identify equipment alerts, such as low battery The Call Lights: Accessibility and Timely response Policy, revised 1/26, indicated The purpose of this policy is to assure the facility is adequately equipped with a call light at each residents' bedside, toilet, and bathing facility to allow residents to call for assistance. Call lights will directly relay to a staff member or centralized location to ensure appropriate response. Staff will ensure the call light is within reach of resident and secure, as needed. The call system must be accessible to the resident at each toilet and bath or shower facility. The call system should be accessible to a resident lying on the floor. Staff will report problems with a call light or the call system immediately to the supervisor and/or maintenance director and will provide immediate or alternative solutions until the problem can be remedied. (Examples include replace “call light”, provide a bell or whistle, increase frequency of rounding, etc.)			F0919			

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20000	Initial Comments *****ATTENTION***** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 3/9/26-3/12/26, a standard licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Nursing Home Licensure and the following correction orders are issued. Please indicate in your electronic plan of correction you have reviewed these orders, and identify the date when they will be completed.		20000			04/17/2026	

Office of Primary Care and Health Systems Management

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE		TITLE	(X6) DATE
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20000	Continued from page 1 The following complaints were reviewed: H51847801C (2793857), H51847942C (2612067), H51847874C (MN00111412/1073210), H51847875C (MN00111170/1073209), H51847973C (MN00112661/1073214), H51848020C (2796479). NO licensing orders were issued. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor's findings are the Suggested Method of Correction and Time period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin https://www.health.state.mn.us/facilities/regulation/infbulletins/ib14_1.html. The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.		20000				
20270	Use of Oxygen CFR(s): MN Rule 4658.0090 A nursing home must develop and implement policies and procedures for the safe storage and use of oxygen. This LICENSURE REQUIREMENT is NOT MET as evidenced by:		20270	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: R44 MD was contacted with orders received to make oxygen PRN to maintain oxygen saturation >90% on 3/11/2026		05/18/2026	

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20270	Continued from page 2 Based on observation, interview, and record review, the facility failed to provide oxygen therapy as ordered for 1 of 1 resident (R44) reviewed for respiratory care. Findings include: R44's Admission Minimum Data Set (MDS) assessment, dated 2/20/26, indicated intact cognition, R44 required partial to moderate assistance with toileting hygiene. R44's diagnoses included chronic respiratory failure with hypoxia, dependence on supplemental oxygen, chronic pulmonary edema, moderate persistent asthma, and dependence of renal dialysis. R44's was admitted on 2/5/26 with including, oxygen 2 liters via nasal cannula continuously. During an observation on 3/09/26 at 7:24 p.m., R44 was on the oxygen concentrator with a flow rate of 3 liters. During observation on 3/10/26 11:11 a.m., R44 came down the unit hallway on her motorized scooter with no oxygen in use. R44 stated, the portable oxygen tank was empty and was in search of staff to have the tank filled. R44 searched for staff for 4 minutes. The director of nursing (DON) filled the portable oxygen tank for R44 at 11:15 a.m. R44 took the oxygen tank and went back to her room with no oxygen in use. During observation on 3/10/26 11:23 a.m., and 11:28 am oxygen tank was not in use. During observation on 3/10/26 at 11:49 a.m., R44 was in her room, and was using the oxygen concentrator, on 3 liters via nasal cannula. At 11:50 a.m., registered nurse, (RN)-B entered R44's room, had a conversation with R44 and exited at 11:52 a.m. During observation on 3/10/26 12:03 p.m., R44 came out of the room, the portable oxygen tank in use via nasal cannula on 2 liters and stated was going to the dining room for lunch. During an interview with RN-B on 3/10/26 1:38 p.m., RN-B stated, had seen R44 at times with no oxygen in use, and was not sure if R44 oxygen order was continuous or as needed. During an interview with nursing assistant (NA)-E on 3/10/26 at 1:39 p.m., NA-E stated had seen R44 without		20270	Continued from page 2 How will you identify other residents having potential to be affected by the same deficient practice and what corrective action will be taken: All residents on Oxygen have the potential to be affected Education was provided by the Regional Clinical Consultant on 4/22/2026 to the IDT on the Oxygen Administration policy An audit was conducted on 4/30/2026 by the DON/Designee to ensure that residents are receiving on-going assessment of the resident's condition warranting oxygen and the resident response to Oxygen What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur; and: Education was initiated on 3/26/2026 by DON/Designee on the Oxygen Administration policy and the need for residents receiving oxygen to receive on-going assessment of the resident's condition warranting oxygen and the resident response to Oxygen with all staff receiving education by 4/24/2026. Any staff not receiving education by 4/24/2026 will not be allowed to work until education is received An audit will be completed weekly x 8 weeks on residents receiving oxygen to ensure on-going assessment of the resident's condition and the resident's response to Oxygen is being documented appropriately and an SBAR is completed with MD notification with changes in resident condition changes. Describe the Quality Assurance and Process Improvement Program that will be put into place. QAPI was held on 4/28/2026 to review results of survey and approve the plan of correction. Results of audits will be reviewed at QAPI meeting monthly x 3 months or until substantial compliance is maintained Facility alleges substantial compliance on 5/18/2026			

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20270	Continued from page 3 oxygen in use. NA-E stated had seen R44 down the hallway and needed the portable oxygen tank filled. During an interview on 3/10/26 2:28 p.m., the DON verified filling the tank for R44. DON stated, "I have never seen her with her oxygen in use". During an interview on 3/12/26 at 2:00 p.m., medical doctor, (MD) expected the facility to have sent an SBAR (situation, background, assessment, recommendation) and updated vitals for ongoing need for supplemental oxygen. An undated facility provided policy indicated staff shall document ongoing assessment of the resident's condition warranting oxygen and the response to oxygen therapy. SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON) or designee could review and revise policies for oxygen use including assessment, implementation, and staff education. The DON or designee could audit oxygen use for residents affected and take that information to QAPI to ensure compliance and determine the need for further education/monitoring/compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.		20270				
20570	Comprehensive Plan of Care; Revision CFR(s): MN Rule 4658.0405 Subp. 4 Subp. 4. Revision. A comprehensive plan of care must be reviewed and revised by an interdisciplinary team that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, with the participation of the resident, the resident's legal guardian or chosen representative at least quarterly and within seven days of the revision of the comprehensive resident assessment required by part 4658.0400, subpart 3, item B. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review, the facility failed to revise and update a care plan for 1of 1 resident (R33) reviewed for care plan timing and revision. Findings include:		20570	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: R33 smoking care plan was updated by the MDS coordinator on 4/30/2026 to reflect the recommendations of the smoking assessment with those recommendations flowing to the resident Kardex R33 TAR was updated on 4/30/2026 for nursing staff to retrieve smoking paraphernalia and keep secured at nurses station. R33 was educated on the Smoking Policy and requirement to follow the recommendations from her Safe Smoking Assessment to continue smoking. How will you identify other residents having potential to be affected by the same deficient practice and what corrective action will be taken: All residents who smoke are at risk		05/18/2026	

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20570	Continued from page 4 R33's Minimum Data Set (MDS) assessment, dated 12/3/25, /indicated intact cognition, /R33 /was independent with transfers, w/c mobility and required limited assist with bed mobility. R33 's diagnoses included chronic systolic and diastolic (congestive) heart failure (a serious condition of the heart's ability to pump blood efficiently), Chronic obstructive pulmonary diseases (an ongoing lung condition caused by damage to the lungs), generalized osteoarthritis. R33's care plan dated 11/19/25 indicated R33 was allowed to smoke independently in designated smoking areas, needed reminders and assistance to use smoking apron, and smoking materials needed to be secured at the nurses' station or other designated areas for storage. R33's Smoking Assessment completed on 2/20/26, indicated R33 was safe to smoke without supervision, demonstrated safe smoking practices, no indication of smoking apron use, and facility stored lighter and cigarettes. R33's care plan was not updated to reflect the changes noted in the 2/20/26 smoking assessment. R33's MAR/TAR (medications administration/ treatments administration record) dated 3/10/26 lacked smoking assessment recommendations/interventions. R33's Task Description list (task assigned to nursing assistants) dated 3/1/26 lacked smoking tasks. During an observation on 3/9/26 at 6:46 p.m., R33 took her smoking materials from her room and continued to go out to the designated smoking area. R33 did not use a smoking apron. R33 demonstrated safe smoking practices. During an interview on 3/09/26 3:03 p.m., R33 stated, she kept her smoking materials locked in her room, smoked 1-2 cigarettes a day, and reported no smoking apron use while smoking. During an interview 3/10/26 10:49 a.m., registered nurse (RN-B) stated was not sure if R33 went out to smoke or was getting some fresh air. RN-B stated, "that information will be on the MAR/TAR, and a staff member would have been assigned to R33, if R33 was a smoker". During an interview on 3/10/26 11:20 a.m., nursing assistant (NA-E)stated, R33 used to smoke, and had not seen R33 smoke today. NA-E stated, "I will ask the nurse, the DON or look at Task Description list".		20570	Continued from page 4 A Safe Smoking Assessment was completed on all residents who smoke with care plan, Kardex, and TARs updated appropriately Education was provided to all residents who smoke on the facility policy and the requirement to follow the policy and recommendations from the safe smoking assessments to continue to be allowed to smoke. An Ad Hoc resident council meeting was held on 4/30/2026 to review the smoking policy What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur; and: Education was initiated with the clinical staff on the Smoking Policy and the need to complete Safe Smoking Assessments on all individuals who smoke and maintain possession of all smoking paraphernalia except when resident is smoking by the DON on 3/26/2026 with all staff receiving education by 4/24/2026 any staff not receiving education by 4/24/2026 will not be allowed to work until education is received. Residents who smoke will be reviewed weekly as part of the weekly At Risk meeting to ensure that care plan is accurate and residents are compliant with the recommendations and facility policy. A care conference will be scheduled for any resident found not to be compliant with the recommendations and policy. Describe the Quality Assurance and Process Improvement Program that will be put into place. QAPI was held on 4/28/20526 to review results of survey and approve the plan of correction. Results of audits will be reviewed at QAPI meeting monthly x 3 months or until substantial compliance is maintained Facility alleges substantial compliance on 5/18/2026			

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20570	Continued from page 5 During an interview on 3/10/26 at 2:27 p.m., the director of nursing (DON), explained the process of assessment to care planning and updates. DON stated, “after the Smoking Assessment was completed, nursing was responsible for updating the care plan, staff was notified, and information was available on the Task List and in the care plan. DON stated, “no point of care notification is sent out to notify staff of updates, staff are expected to review care plan for updates”. During an interview on 3/12/26 at 8:45 a.m., DON stated, R33 stored smoking materials in her room, R33 was safe to smoke independently and R33 needed no smoking apron. Facility policy on care plan revision and update requested and not provided. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and revise policies and procedures related to revision of the care plan as needed to meet the needs of each individual resident. The director of nursing or designee could develop a system to educate staff and develop a monitoring system to ensure individual care plans are revised as necessary. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.		20570				
21100	Food Supplies; Storage of Perishable food CFR(s): MN Rule 4658.0650 Subp. 5 Subp. 5. Storage of perishable food. All perishable food must be stored off the floor on washable, corrosion-resistant shelving under sanitary conditions, and at temperatures which will protect against spoilage. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and record review, the facility failed to ensure food stored in the refrigerator were labeled, dated and free of expired foods. This deficient practice had the potential to affect all residents, staff and visitors who received food from facility kitchen. Findings include: During the initial kitchen tour on 3/9/26 at 10:34 a.m., cook (C)-A greeted surveyor inside the kitchen.		21100	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Expired sliced ham was disposed of by the CDM on 3/12/2026 Lettuce was disposed of by the CDM on 3/12/2026 Box of food on the floor was placed on shelf on 3/12/2026 Box of food touching the freezer fan blade was moved away from the fan on 3/12/2026 How will you identify other residents having potential to be affected by the same deficient practice and what corrective action will be taken: All residents have the potential to be affected		05/18/2026	

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21100	Continued from page 6 The following items were observed in the fridge expired and undated food: -Sliced Ham, expired on 3/2/26 -no date on lettuce, browning and wilting Additionally, the following items were observed in the freezer: -box of food sitting directly on the freezer floor -box on top shelf of freezer touching freezer fan blade During the follow up kitchen tour on 3/12/26 at 12:25 p.m., district manager (DM) stated the expired sliced ham, and undated lettuce had been thrown out. DM confirmed the box on the floor of the freezer had been placed on a shelf. DM confirmed the box touching the freezer fan blade had been pushed back away from the fan blade. DM stated undated items should be thrown out immediately and foods in the fridge longer than 3 days should be thrown out. DM stated it is important to use expiration dates to ensure palatability and to prevent food borne illnesses. DM stated it is important to keep food boxes correctly place to ensure freezer equipment continues to work as intended. A facility policy was requested and not received. SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON) or designee could review and revise policies for oxygen use including assessment, implementation, and staff education. The DON or designee could audit oxygen use for residents affected and take that information to QAPI to ensure compliance and determine the need for further education/monitoring/compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days		21100	Continued from page 6 Education was provided to Cook-C by CDM on the Food Safety Requirement policy on 4/30/2026 What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur; and: Education was initiated by CDM on 3/26/2024 on the Food Safety Requirements policy with all staff being educated by 4/24/2026 any staff not receiving education by 4/24/2026will not be allowed to work until they receive education Food storage will be audited by CDM weekly x 8 weeks Describe the Quality Assurance and Process Improvement Program that will be put into place. QAPI was held on 4/28/2026 to review results of survey and approve the plan of correction. Results of audits will be reviewed at QAPI meeting monthly x 3 months or until substantial compliance is maintained Facility alleges substantial compliance on 5/18/2026			
21390	Infection Control CFR(s): MN Rule 4658.0800 Subp. 4 A-I Subp. 4. Policies and procedures. The infection control program must include policies and procedures which provide for the following: A. surveillance based on systematic data collection to identify nosocomial infections in residents; B. a system for detection, investigation, and control of outbreaks of infectious diseases;		21390	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Education was provided to CNA-G on the Enhanced Barrier Precautions policy on 4/30/2026 by DON/Designee Education was provided to CNA-F on the Enhanced Barrier Precautions policy on 4/30/2026 by DON/Designee Education was provided to CNA-K on the Enhanced Barrier Precautions policy on 4/30/2026 by DON/Designee		05/18/2026	

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21390	Continued from page 7 C. isolation and precautions systems to reduce risk of transmission of infectious agents; D. in-service education in infection prevention and control; E. a resident health program including an immunization program, a tuberculosis program as defined in part 4658.0810, and policies and procedures of resident care practices to assist in the prevention and treatment of infections; F. the development and implementation of employee health policies and infection control practices, including a tuberculosis program as defined in part 4658.0815; G. a system for reviewing antibiotic use; H. a system for review and evaluation of products which affect infection control, such as disinfectants, antiseptics, gloves, and incontinence products; and I. methods for maintaining awareness of current standards of practice in infection control. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and record review, the facility failed to ensure proper personal protective equipment (PPE) usage for 3 of 3 residents (R6, R4, R14) reviewed for enhanced barrier precautions (EBP) who receive tube feeding (R6, R14) and dialysis care (R4). Findings include: R6: R6's Minimum Data Set (MDS) quarterly assessment dated 1/21/26, identified severely impaired cognition and required maximal assistance for mobility. R6's diagnoses included Parkinson's, dementia, major depressive disorder and lack of coordination. R6's physician orders dated 4/24/25, Enhanced Barrier Precautions (EBP) for tube feeding. R6 had a percutaneous endoscopic gastrostomy (PEG) tube for enteral nutrition and medication. Cleanse surrounding skin with warm water using soft cloth, then pat dry. Apply barrier cream to skin under PEG tube disk to prevent moisture related skin redness.	21390	Continued from page 7 Education was provided to CNA-L on the Enhanced Barrier Precautions policy on 4/30/2026 by DON/Designee Education was provided to LPN-A on the Enhanced Barrier Precautions policy on 4/30/2026 by DON/Designee How will you identify other residents having potential to be affected by the same deficient practice and what corrective action will be taken: All residents requiring Enhanced Barrier Precautions have the potential to be affected Education was provided by the Regional Clinical Consultant on 4/24/2026 to the IDT on the Enhanced Barrier Precautions Policy What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur; and: Education was initiated by the DON/Designee on 3/26/2026 with clinical staff on the Enhanced Barrier Precautions policy with all clinical staff being educated by 4/24/2026. Any clinical staff member not being educated by 4/24/2026 will not be allowed to work until education is received. A random audit will be conducted on 5 staff members weekly x 8 weeks to ensure compliance with the Enhanced Barrier Precautions policy. Describe the Quality Assurance and Process Improvement Program that will be put into place. QAPI was held on 4/28/2026 to review results of survey and approve the plan of correction. Results of audits will be reviewed at QAPI meeting monthly x 3 months or until substantial compliance is maintained Facility alleges substantial compliance on 5/18/2026	

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21390	Continued from page 8 R6's care plan (CP) created on 1/27/25, identified R6 was at risk for infection related to indwelling medical device (PEG) tube. EBP when cares are provided to R6. Furthermore, alternation in cognition forgetfulness and confusion related to dementia. Additionally, had impaired swallowing related to Parkinson's, administer tube feedings, medication and flushes per order. R14: R14's MDS comprehensive assessment dated 12/29/25, identified severely impaired cognition and independent with ambulation. R6's diagnoses included non-traumatic brain dysfunction, renal insufficiency, and Alzheimer's disease. R14's physician orders dated 7/19/24, Enhance Barrier Precautions (EBP) for supra-pubic catheter for long term urinary retention. Supra-pubic foley catheter cares clean daily and as needed, empty bag every shift and record results. Educate on importance of risk of infection. R14's CP created on 4/1/24, identified R14 was at risk for infection related to indwelling medical device, supra-pubic catheter, EBP when providing cares. Additionally, R14 had alteration in urinary elimination related to obstructive uropathy, treated with a supra-pubic catheter. During observation on 3/10/26 at 11:13 a.m., certified nursing assistants (CNA)-G and CNA-F performed peri cares and toileting in shower room. There was a large amount of urine on floor, both staff members were not wearing proper EBP while cleaning floor, EZ stand and R6. During observation on 3/11/26 at 8:34a.m., CNA-K attempted to reattach leg bag on R14, bag was hanging out of pants, dragging on the floor while walking to dining room. They walked back to his room, he sat down, CNA-K put on gloves emptied out urine and reattached bag to leg, CNA-K was not wearing proper EBP when cares were performed. During interview on 3/9/26 at 3:30p.m., CNA-L stated EBP was used for the safety of the residents decrease the risk of infection. During interview on 3/10/26 at 11:46 a.m., CNA-G stated standard for infection control was hand washing, before and after cares of residents. EBP, gloves and gown to be worn when cares were done on residents with wounds, catheters, and feeding tubes.		21390				

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21390	Continued from page 9 During interview on 3/10/26 at 12:00 p.m., RN-D stated EBP protected staff and residents from infections. EBP was to wear gloves and gown, hand washing before and after cares. During interview on 3/11/26 at 9:07a.m., CNA-F stated the importance of EBP was to prevent infection, the only time to wear EBP was when manipulating catheters, feeding tubes or wounds. The only time CNA-F wore EBP was when a resident had COVID. She was not an RN, they did the specific treatments, not the nursing assistants, so EBP wasn't required.R4: R4's quarterly MDS assessment, dated 2/23/26, indicated R4 was cognitively intact, had no upper body impairment, was independent with personal hygiene, and required set-up/supervision for upper and lower body dressing. It also indicated R4 received dialysis care (mechanical filtering of blood), had a surgical wound, and received surgical wound care. R4's diagnoses list included diabetes, end-stage kidney disease, heart failure, left leg amputation, and dependence on renal dialysis. R4's care plan dated 1/29/26 indicated R4 receives dialysis 3 times/week, has a dialysis catheter (a tube inserted in the chest or neck used for mechanical filtering of blood), and is at risk for infection related to a dialysis catheter requiring EBP when performing high-contact care activities. R4's provider orders dated 11/17/25 included: dialysis Monday, Wednesday, Friday, post dialysis assessment, monitor dialysis catheter daily for signs of infection, dressing changes to surgical wound, and EBP due to dialysis catheter. R4's nursing assistant care sheet dated 3/12/26 indicated "enhanced barrier precautions when performing high-contact care activities" During an observation and interview on 3/9/26 at 12:52 p.m., R4 stated staff do not wear gowns because she does not have an infection. An orange sign indicating "enhanced barrier precautions" was noted outside R4's room. During observation and interview on 3/11/26 at 11:05 a.m., licensed practical nurse (LPN)-A entered R4's room to perform a scheduled dressing change to R4's surgical site. LPN-A stated she washed her hands prior to entering the room and applied gloves. Without			21390			

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21390	Continued from page 10 donning a gown, LPN-A performed the dressing change to R4's left lower extremity. LPN-A then washed and dried under R4's abdomen, applied powder to R4's abdominal folds. After disposing garbage, removing gloves, and washing hands, LPN-A reviewed the EBP sign on R4's door. LPN-A stated it indicated "barrier precautions and to gown up and glove." When asked what tasks would require gowning and gloving, LPN-A stated she was "drawing a blank." When asked why R4 was on EBP, LPN-A stated it "might be for her PICC line [referring to the central line dialysis catheter], but I don't do anything with that." LPN-A stated staff are only required to wear PPE if they are providing care "for the reason they are on the precautions." LPN-A stated staff receive infection control training upon hire and have online education. During interview on 3/11/26 at 11:53 a.m., LPN-A confirmed R4 is on EBP due to having a dialysis catheter. During interview on 3/12/25 at 9:31 a.m., the director of nursing stated residents are placed on EBP if they have indwelling medical devices, chronic rounds, and MDROs (bacteria resistant to multiple treatments). An order is placed on the medication administration record, care plan is updated, and signage is placed on the door. The director of nursing stated staff are expected to read the signage on the door for instruction regarding precautions. He stated gown and gloves are required for all high-contact cares. A policy titled "Enhanced Barrier Precautions" dated 3/24/25 indicated "It is the policy of this facility to implement enhanced barrier precautions for the prevention of transmission of multidrug-resistant organisms." The policy also indicated, in part, an order for enhanced barrier precautions will be obtained for residents with chronic wounds and/or indwelling medical devices (e.g., central lines, urinary catheters, feeding tubes, etc.). Implementation of enhanced barrier precautions included "PPE for enhanced barrier precautions is only necessary when performing high-contact care activities". High-contact resident care activities included: device care or use: central lines (tubes in the neck or chest providing access to large vessels), PICC lines (tubes placed in the upper arm allowing access to veins) , hemodialysis catheters, and wound care involving any skin opening requiring a dressing. SUGGESTED METHOD OF CORRECTION: The administrator or designee could review policies and procedures to ensure, proper infection control regarding EBP practices were followed. Facility staff could be reeducated and an auditing system developed to		21390				

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21390	Continued from page 11 ensure compliance.	21390			
21540	TIME PERIOD FOR CORRECTION: Twenty-one (21) days. Unnecessary Drug Usage; Monitoring CFR(s): MN Rule 4658.1315 Subp. 2 Subp. 2. Monitoring. A nursing home must monitor each resident's drug regimen for unnecessary drug usage, based on the nursing home's policies and procedures, and the pharmacist must report any irregularity to the resident's attending physician. If the attending physician does not concur with the nursing home's recommendation, or does not provide adequate justification, and the pharmacist believes the resident's quality of life is being adversely affected, the pharmacist must refer the matter to the medical director for review if the medical director is not the attending physician. If the medical director determines that the attending physician does not have adequate justification for the order and if the attending physician does not change the order, the matter must be referred for review to the Quality Assurance and Assessment (QAA) committee required by part 4658.0070. If the attending physician is the medical director, the consulting pharmacist shall refer the matter directly to the QAA. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on interview and record review, the facility failed to monitor effectiveness of a medication prescribed for sleep by not completing sleep monitoring for 1 of 1 resident (R33) reviewed for unnecessary medications. Findings include: R33's Minimum Data Set (MDS) assessment, dated 12/3/25, /indicated intact cognition, /R33 /was independent with transfers, w/c mobility and required limited assist with bed mobility. R33 diagnoses included chronic systolic and diastolic (congestive) heart failure (a serious condition of the heart's ability to pump blood efficiently), Chronic obstructive pulmonary diseases (an ongoing lung condition caused by damage to the lungs), generalized osteoarthritis. R33's medication orders included: Melatonin 5 milligrams (mg), oral at bedtime: start date:12/01/25 for insomnia.	21540	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: R33 had a sleep study assessment completed on 4/30/2026 How will you identify other residents having potential to be affected by the same deficient practice and what corrective action will be taken: All residents on Melatonin have the potential to be affected An audit of was completed on residents taking Melatonin was conducted and any requiring a sleep study assessment had one scheduled What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur; and: Education was initiated by the DON/Designee on 3/26/2026 with the licensed clinical staff on the Sleep Study assessment and the need to ensure this is completed with the initiation of Melatonin, quarterly and with any significant change on any resident taking Melatonin with all licensed clinical staff receiving education by 4/24/2026. Any staff not receiving education by 4/24/2026 will not be allowed to work until education is received. An audit will be completed quarterly on any resident taking Melatonin as part of their care plan process to ensure a sleep study is completed with any resident not having the sleep study completed having the sleep study scheduled Describe the Quality Assurance and Process Improvement Program that will be put into place. QAPI was held on 4/28/2026 to review results of survey and approve the plan of correction. Results of audits will be reviewed at QAPI meeting monthly x 3 months or	05/18/2026	

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21540	Continued from page 12 R33's Medication Administration Record (MAR) record review from 02/1/26 to 3/11/26 reviewed lacked sleep tracking or monitoring. R33' s progress note reviewed from 02/1/25 to 3/11/26 had no reference to R33 sleep monitoring. During an interview on 3/11/2026 at 4:05 p.m., registered nurse (RN)-C, RN-C stated, "yes, resident is taking a sleep aid, melatonin 5 mg, we usually do a sleep monitoring, but there is no sleep monitoring in place in the assessment for that resident and I do not know why". During an interview on 3/11/2026 4:55 p.m., the director of nursing (DON) stated, "I will not track sleep with Melatonin use due to Melatonin being an over-the-counter medication". The facility policy titled: Gradual Dose Reduction of Psychotropic Drugs reviewed 3/5/2025 indicates, "Psychotropic drug" or "psychotropic medication" is defined as any drug that affects brain activities associated with mental processes and behavior. Psychotropic drugs include, but are not limited to the following categories: antipsychotics, antidepressants, antianxiety, and hypnotics (a class of drugs used preliminary to induce sleep and treat insomnia)SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON) and consulting pharmacist could review and revise policies and procedures for proper monitoring of medication usage effectiveness. The DON or designee, along with the pharmacist, could audit medication reviews on a regular basis to ensure compliance. TIMEFRAME FOR CORRECTION: Twenty-one (21) days.		21540	Continued from page 12 until substantial compliance is maintained Facility alleges substantial compliance on 5/18/2026			
21565	Administration of Medications Self Admin CFR(s): MN Rule 4658.1325 Subp. 4 Subp. 4. Self-administration. A resident may self-administer medications if the comprehensive resident assessment and comprehensive plan of care as required in parts 4658.0400 and 4658.0405 indicate this practice is safe and there is a written order from the attending physician. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and record review, the facility failed to ensure residents were assessed to self-administer medications for 1 of 1 resident (R4)		21565	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: R4 had self-administration of medication assessment completed on 4/30/2026. IDT reviewed results of assessment and resident was deemed safe to self-administer medication (Nystatin) MD was notified of assessment results and order was obtained for resident to self-administer Nystatin on 4/30/2026		05/18/2026	

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21565	Continued from page 13 reviewed for self-administration of medication (SAM). Findings include: R4's quarterly Minimum Data Set (MDS) assessment, dated 2/23/26 indicated R4 was cognitively intact, had no upper body impairment, was independent with personal hygiene, and required set-up to supervision for upper and lower body dressing. R4's diagnoses list included diabetes, end-stage kidney disease, heart failure, and morbid obesity. R4's self-administration care plan dated 11/20/25 lacked self-administration of nystatin powder (medication used to treat fungal infections). R4's provider orders included: Nystatin powder 1 application to affected areas under right breast and skin folds topically twice a day and as needed. R4's medical record lacked a self-administration assessment for applying Nystatin powder. During observation and interview on 3/10/26 at 3:45 p.m., R4 stated she keeps her nystatin powder locked up in the canvas bag located on her bed. During interview on 3/11/26 at 9:43 a.m., licensed practical nurse (LPN)-A stated R4 administers own injections and completes blood sugar check with nursing supervision and performs her own vitals. LPN-A stated R4 refuses the nystatin powder however it is kept in the medication cart. LPN-A looked in the medication and treatment cart however could not find R4's nystatin powder. During observation and interview on 3/11/25 at 10:12 a.m., R4 indicated she puts the nystatin powder on herself twice a day. R4 stated she feels the area under her abdomen has improved however confirmed she is unable to see what the area looks like. R4 opened the locked canvas bag on her bed that contained a bottle of nystatin powder dated November of 2025. R4 stated she likes that particular bottle because it is easier to use. When she runs out, she has the nursing staff order a new bottle and dump the contents of the new bottle into the bottle she likes. R4 stated the nurses do not offer to put the nystatin powder on. During observation and interview on 3/11/26 at 11:05 a.m., LPN-A arrived to perform R4's dressing change. After the dressing change, LPN-A asked permission to wash under R4's abdominal folds and apply the nystatin	21565	Continued from page 13 How will you identify other residents having potential to be affected by the same deficient practice and what corrective action will be taken: All residents have the potential to be affected Ad-Hoc resident council was held on 4/30/2026 with self-administration of medication policy reviewed with residents An audit was completed of resident rooms to determine if residents had medications at bedside – any found to have medications stored at bedside had self – administration of medication assessment completed and reviewed with IDT. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur; and: Education was initiated by DON/Designee with licensed clinical staff on self-administration of medication policy and medication administration policy was initiated on 3/26/2026 by DON with all staff being licensed clinical staff being educated by 4/24/2026 anyone not being educated by (DATE) will not be allowed to work until they receive education Random audits will be conducted on 5 rooms weekly x 8 weeks or until substantial compliance is met to ensure medications aren't stored at bedside. Describe the Quality Assurance and Process Improvement Program that will be put into place. QAPI was held on 4/28/2026 to review results of survey and approve the plan of correction. Results of audits will be reviewed at QAPI meeting monthly x 3 months or until substantial compliance is maintained Facility alleges substantial compliance on 5/18/2026	

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21565	Continued from page 14 powder. R4 stated "then I'll have to unlock my bag" and proceeded to unlock her canvas bag and hand the nystatin powder to LPN-A. LPN-A then washed and dried under R4's abdomen, applied the nystatin powder, and handed the powder back to R4 to lock in her bag. After leaving the room, LPN-A stated R4 has never allowed her to wash the area or apply the nystatin powder. When asked if R4 keeps the nystatin powder in her room, LPN-A stated "I'm going to say yes since I couldn't find it in the cart." LPN-A stated residents who want to self-administer a medication are "assessed for it" and "have to have something in the orders or care plan." LPN-A stated she has never done a self-administration assessment for R4. During an interview on 3/11/26 at 3:18 p.m., registered nurse (RN)-A stated a self-administration assessment is performed to determine a resident is able to safely administer medications. The assessment involves resident's ability to identify what the medication is, what it is for, and the correct dosage. Residents also must be able to demonstrate safe storage of the medication and have the manual dexterity to administer the medication safely. When the assessment is completed the nursing staff, director of nursing, and nurse practitioner meet to discuss if self-administration is appropriate. If the resident is deemed appropriate, the medical provider or nurse practitioner will sign off allow the resident to administer the medication. RN-A stated there was a time R4 was able to administer a lot of the prescribed medications however the facility has "dialed back" what R4 is allowed to do as they were finding oral medications on the floor. Currently R4 is able to check blood sugar and administer some injectable medications with staff set up and supervision as well as independently administer inhaled medications. RN-A verified R4 did not have a self-administration assessment completed for the nystatin powder. During an interview on 3/12/26 at 9:31 a.m., the director of nursing stated self-administration assessments are required to determine if a resident is able to determine the purpose of safely administering, and store medications. A policy titled Resident Self-Administration of Medication revised January 2026 indicated "A resident may only self-administer medications after the facility's interdisciplinary team has determined which medications may be self-administered safely." SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON) or designee could review and		21565				

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21565	Continued from page 15 revise policies for self administration of medication according to evidence based practices/procedures. Nursing staff could be educated as necessary to the importance of ensuring the resident is capable of administering their own medications initially, quarterly, annually, or with a change to a resident's physical or mental ability to do so. Nursing staff could also ensure there is a physician's order in place, prior to a nurse/medication aide administering medication. The DON or designee, could audit any/all resident's medical records, to ensure compliance with appropriate medication administration. The DON or designee could take that information to QAPI to ensure compliance and determine the need for further education/monitoring/compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	21565			
21640	Disposition of Medications;Returned to Pharm CFR(s): MN Rule 4658.1350 Subp. 4 Subp. 4. Returned to pharmacy. Drugs and prescribed medications used in nursing homes may be returned to the dispensing pharmacy according to part 6800.2700, subpart 2. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation and interview, the facility failed to dispose of discontinued, expired, and discharged residents' medications. This had the potential to affect any resident who received medication from all facility medication rooms. Findings include:On 03/11/2026 10:00 a.m., 1st floor medication storage had 23-40 medication cards from discharged residents awaiting destruction and several bottles of over-the-counter expired bottles awaiting disposal. Registered nurse (RN)-B confirmed the medications on the counter were awaiting destruction and was unsure of the process of medication destruction. RN-B stated, "the nurse manager took care of it, and we do not have one right now". The 1st floor med room storage had the following current resident medications awaiting destruction. R 81 -Flomax capsule 0.4mg (Tamsulosin HCL) Take 0.4 milligrams (mg) by mouth daily -Inderal LA oral capsule Extended Release 24 hours	21640	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: R81 medications were destroyed on 4/30/2026 R15 medications were destroyed on 4/30/2026 R42 medications were destroyed on 4/30/2026 R52 medications were destroyed on 4/30/2026 R48 medications were destroyed on 4/30/2026 R78 medications were destroyed on 4/30/2026 R30 medications were destroyed on 4/30/2026 R2 medications were destroyed on 4/30/2026 R13 medications were destroyed on 4/30/2026 R6 medications were destroyed on 4/30/2026 R51 medications were destroyed on 4/30/2026 R34 medications were destroyed on 4/30/2026 R13 medications were destroyed on 4/30/2026 R22 medications were destroyed on 4/30/2026 R6 medications were destroyed on 4/30/2026 R78 medications were destroyed on 4/30/2026	05/18/2026	

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21640	Continued from page 16 (Propranolol HCL), Take 1 cap my mouth in the evening. - Lipitor oral tablet (Atorvastatin Calcium), take 10 mg by mouth at bedtime -Synthroid Oral tablet (levothyroxine Sodium), take 112 micrograms (mcg) by mouth in the morning. -Venlafaxine HCL ER oral capsule extended release 24 hours (venlafaxine HCL), take 37.5 mg by mouth one time a day every other day -Zyloprim oral tablet (Allopurinol), take 300 mg by mouth one time a day. -Methocarbamol oral tablet, Take 1000 mg by mouth 4 times a day. -Allegra Allergy oral tablet (Fexofenadine HCL), take 180 mg by mouth every 24 hours as needed. R15 - Allegra Allergy oral tablet (Fexofenadine HCL), take 180 mg by mouth on time a day -Crestor oral tablet (Rosuvastatin Calcium), take 10 mg by mouth at bedtime. -Lasix oral tablet (Furosemide) take 40 mg by mouth one time a day. -Rozerem oral tablet (Ramelteon), take 8 mg by mouth at bedtime. - Synthroid Oral tablet (levothyroxine Sodium), take 125 mcg by mouth in the morning. -Lopressor oral tablet (Metoprolol Tartate) Take 12.5 mg by mouth 2 times a day -Omeprazole oral tablet, take 20 mg by mouth 2 times a day. - Zyloprim oral tablet (Allopurinol), take 100 mg by mouth 2 times a day. - Neurontin oral capsule (Gabapentin), take 300 mg by mouth 3 times a day. Tegretol oral tablet (carbamazepine), take 200 mg by mouth 4 times a day. -Benzonatate oral capsule, take 100 mg by mouth every 4	21640	Continued from page 16 R31 medications were destroyed on 4/30/2026 R62 medications were destroyed on 4/30/2026 R80 medications were destroyed on 4/30/2026 How will you identify other residents having potential to be affected by the same deficient practice and what corrective action will be taken: All residents have the potential to be affected An audit of all med rooms was completed by DON/Designee on 4/30/2026 to ensure there were no medications that needed to be destroyed or returned A contract was obtained to have a Med Safe provided for the facility for all medications requiring destruction What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur; and: Education was initiated on 3/26/2026 by DON/Designee with licensed clinical staff on medication destruction and returns with all staff being educated by 4/24/2026. Any staff not receiving education by 4/24/2026 will not be allowed to work until education is received. Med rooms will be reviewed and cleaned weekly by the 11/7 shift on Sunday to ensure medications are destroyed or returned as required An audit of med rooms will be completed weekly by the UM to ensure medication room is clean and free of medications requiring destruction Describe the Quality Assurance and Process Improvement Program that will be put into place. QAPI was held on 4/28/2026 to review results of survey and approve the plan of correction. Results of audits will be reviewed at QAPI meeting monthly x 3 months or until substantial compliance is maintained Facility alleges substantial compliance on 5/18/2026	

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21640	Continued from page 17 hours as needed for cough -Carafate oral tablet 1 gram, take 1 gram by mouth as needed 2 times a day as needed. - Melatonin Oral tablet, give 6 mg by mouth at bedtime as needed. -Ondansetron HCL oral tablet, take 1 mg by mouth every 8 hours as needed. On 03/11/2026 10:42 a.m., the 2nd floor medication storage room had 6 medications on the counter. Licensed practical nurse (LPN)-A acknowledged the 6 medication cards were from discontinued medications orders and discharged residents. LPN-A stated was unsure of the medication destruction process and stated that the night shift was responsible for medications destruction. The 2nd floor medication storage room had 6 medication cards belonging to R42 and R52 awaiting destruction. During observation on 03/11/2026 at 11:51 a.m., registered nurse, (RN)-F, RN-F confirmed, medication cards kept on the counter were from discontinued orders, and discharged patients awaiting destruction. RN-F was unsure of facility medication destruction process and who was responsible for medication destruction. The 3rd floor medication room storage had following current resident medications awaiting destruction. R48 -Atorvastatin 10 mg 1 tab started, 2/26 R78 -Escitalopram 20 mg, started 3/31/25 -Metoprolol 25 mg, 3 cards -Bupropion hcl 159 mg, tab started 10/29/25 R30 -Clindamycin 150 mg caps started 1/23/26- -Torsemide 20 mg 2 tabs daily for 3 days then continue 1 tab daily R2		21640				

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21640	Continued from page 18 -Hyoscyamine 0.125 mg tab, started 4/22/25 R13 - Ondansetron hcl 4 mg tab, started 11/26/2 R6 -Famotidine 20mg, give 1 tablet R51 - Eliquis 5 mg, give 1 tablet by mouth twice a daily R34 -Trazodone 50-gram tablet, give 1.2 tablet by mouth at bedtime as needed sleep R13 - Sertraline 25 mg, give 1 tablet by mouth daily take with 50 mg for total dose of 75 mg R22 -Ondansetron 4 mg tablet, give one tablet by mouth every 8 hrs. as needed for up to 7 days R6 Benzonatate 100 mg capsule, give one capsule by mouth three times daily as needed R78 -Quetiapine 25 mg, give 1.2 tablet by bedtime R31 -Iprat-albut 0.5 (2.5) mg/3ml inhale 3mL vial ben three times daily for SOB. R62 -Paxlovid 300-100mg dose R80 - Cyanocobalamin 1000mcg/ml inject 1 milliliter (ml) intramuscular (IM) weekly It also contained 1 bottle of OTC acetaminophen 325 mg		21640				

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21640	Continued from page 19 open 11/6/2024 exp on bottle 2/2026, 1 bottle of aspirin over the counter 81 mg, expired 2/26/2026, and 1 canister of inhaler -Formoterol Fumarate 20mcg/2ml. During an interview on 3/11/2026 at 1:34p.m., the director of nursing (DON) stated, medication destruction was to be completed by 2 nurses, 1 nurse logged the medications, and the 2nd nurse completed the destruction by disposing of the tablets in a Stericycle water activated solution. DON expected medications destruction to be completed as soon as possible. During an interview with the facility pharmacist on 03/11/2026 at 2:34 p.m., pharmacist reported being unfamiliar with the current medication destruction process for the facility and advised to refer to the facility policy. A policy for medication storage was requested but not received prior to the end of the survey. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could develop new policies and procedures, train staff, and implement measures to assure residents medications are properly destroyed or returned to the pharmacy to prevent diversion. The director of nursing or designee, could conduct random audits; to ensure appropriate measure for medication destruction/return is being implemented. The results of those audits should be taken to the Quality Assurance Performance Improvement (QAPI) to determine compliance or the need to re-evaluate. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.		21640				
21665	Physical Environment CFR(s): MN Rule 4658.1400 A nursing home must provide a safe, clean, functional, comfortable, and homelike physical environment, allowing the resident to use personal belongings to the extent possible. This LICENSURE REQUIREMENT is NOT MET as evidenced by: 584 Based on observation, interviews, and document review, the facility failed to provide a home like dining experience in 2 dining rooms when meals were left served to residents on a plastic food tray.		21665	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Staff working 3/9/2026 7/3 on 3rd floor were provided education on the Serving a Meal policy on 4/30/2026 by DON/Designee Staff working 3/9/2026 3/11 on 2nd floor were provided education on the Servings a Meal Policy on 4/30/2026 by DON/Designee Staff working 3/10/2026 7/3 shift on 3rd floor were provided education on the Serving a Meal Policy on 4/30/2026 by DON/Designee		05/18/2026	

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21665	Continued from page 20 Findings include: During an observation on 3/9/26 at 12:44p.m., of the 3rd floor dining room, lunch trays were brought up in a cart, the staff passed out the trays and left food items on plastic trays in front of residents. During an observation on 3/9/26 at 6:03p.m., of the 2nd floor dining room, dinner trays were brought up in a cart, the staff passed out the trays and left food items on plastic trays in front of the residents. During observation on 3/10/26 at 12:33 p.m., of the 3rd floor dining room, lunch trays were brought up in a cart, the staff passed out the trays to the residents and left food items on the plastic trays. During observation on 3/11/26 at 8:48 a.m., of the 3rd floor dining room, breakfast trays were brought up in a cart, staff passed out the trays and left food items on the plastic trays in front of the residents. During an interview on 3/10/26 at 1:15p.m. licensed practical nurse (LPN)-A stated the residents had always been served their food on the trays and placed in front of them. During interview on 3/11/26 at 9:00a.m., certified nursing assistant (can)-F stated the residents had always had their food served on trays and placed in front of them. During interview on 3/11/26 at 10:00 a.m., R40 stated he would like the meals served on time, and not on trays and added it was not home. During interview on 3/11/26 at 11:00a.m., R45 stated feeling like the dining experience was being in school in a juvenile setting when the food is set in from of us on trays during mealtime. In addition, the staff place the hot foods next to the cold foods on the tray. R45 indicated asking staff to separate the food. A policy entitled, Serving a Meal dated 3/23, included to serve nutritional meals that met the needs of the residents. Additionally, arrange the dishes and silverware so the residents can reach them easily. It was often helpful to take dishes off tray. SUGGESTED METHOD OF CORRECTION: The DON or designee could educate staff and conduct periodic audits of areas residents frequent to ensure a		21665	Continued from page 20 Staff working 3/11/2026 7/3 shift on 3/11/2026 on 3rd floor were provided education on the Serving a Meal policy on 4/30/2026 by DON/Designee How will you identify other residents having potential to be affected by the same deficient practice and what corrective action will be taken: All residents have the potential to be affected Education was provided to the IDT on 4/22/2026 by Regional Clinical Consultant on the Serving a Meal Policy What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur; and: Education was initiated on 3/26/2026 by DON/Designee on the Serving a Meal policy with clinical staff with all clinical staff receiving education by 4/24/2024 not being allowed to work until receiving education Random audits will be conducted on meal service to ensure meals are not being served on a tray to residents 3/week for 8 weeks or until substantial compliance is obtained Describe the Quality Assurance and Process Improvement Program that will be put into place. QAPI was held on 4/28/2026 to review results of survey and approve the plan of correction. Results of audits will be reviewed at QAPI meeting monthly x 3 months or until substantial compliance is maintained Facility alleges substantial compliance on 5/18/2026			

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21665	Continued from page 21 home like environment is obtained to the extent possible. TIME PERIOD FOR CORRECTION: Twenty One (21) days.		21665				
23270	Nurse Call System; Existing Construction CFR(s): MN Rule 4658.5515 A communication system must be provided in a nursing home. It must register a call from the resident at the nursing station and activate a signal light by the bedroom door. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review the facility failed to ensure a bathroom call light was functioning for the shower room on the 3rd floor having the potential to affect all residents that use the toilet in the shower room, 7 of 7 (R6, R36, R2, R8, R51, R60, R62) residents were brought to and used an EZ stand for toileting. Findings include: R6's Minimum Data Set (MDS) quarterly assessment dated 1/21/26, identified severely impaired cognition and required maximal assistance for mobility. R6's diagnoses included Parkinson's, dementia, major depressive disorder and lack of coordination. R6's care plan (CP) created on 9/14/24, identified mobility was an area of concern, indicated was not ambulatory and needed transfer assistance of 2 and mechanical lift (EZ stand). Furthermore, the CP identified an area of concern, indicated was at risk for falls due to dementia, impaired coordination and mobility, medications, impulsiveness and safety awareness. R36's MDS comprehensive assessment dated 3/14/25, identified moderate cognitive impairment and left sided weakness in upper and lower extremities. R36's diagnoses included dementia, hemiplegia (left side affected), and congestive heart failure. R36's care plan created on 3/14/24, identified mobility was an area of concern, indicated transfers with assist of 2 and (sit to stand lift) EZ stand. Furthermore, the care plan identified was at risk of falls due to impaired mobility, left side weakness and dementia. R2's MDS quarterly assessment dated 2/10/26, identified		23270	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Call light was repaired in shower room on 3rd floor by Maintenance Director on 4/30/2026 How will you identify other residents having potential to be affected by the same deficient practice and what corrective action will be taken: All residents have the potential to be affected An audit was conducted on all other call lights in the facility on 4/30/2026 by the maintenance director – all were found to be functional What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur; and: Education was initiated with the DON/Designee on reporting items in need of repairs via TELS with clinical staff on 3/26/2026 any clinical staff not receiving education by 4/24/2026 will not be allowed to work until education is received. An audit will be completed by the maintenance director of 5 resident care areas weekly x 8 weeks to ensure call lights are functioning properly Describe the Quality Assurance and Process Improvement Program that will be put into place. QAPI was held on 4/28/2026 to review results of survey and approve the plan of correction. Results of audits will be reviewed at QAPI meeting monthly x 3 months or until substantial compliance is maintained Facility alleges substantial compliance on 5/18/2026		05/18/2026	

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23270	Continued from page 22 severely impaired cognition and dependent mobility. R2's diagnoses included anxiety, dementia and cardiorespiratory issues. R2's care plan revised on 10/27/25, identified activities of daily living was an area of concern related to mobility status and dementia. The care plan indicated transfers with the assistance of two and EZ stand lift for all transfers. Furthermore, the care plan identified was at risk for falls due to impaired mobility, dementia and medications. R8's MDS quarterly assessment dated 2/6/26, identified severely impaired cognition and substantial/maximal assistance with transfers. R8's diagnoses included non-traumatic brain dysfunction, dementia and seizure disorder. R8's care plan was created on 6/4/23, identified activities of daily living were an area of concern, due to dementia, leg pain, decrease mobility and resistance to assistance. Perform cares in pairs, transfer with assist of 2 and an EZ stand. R51's MDS quarterly assessment dated 2/24/26, identified severely impaired cognition and dependent on all areas of mobility. R51's diagnoses included atrial fibrillation, type II diabetes, depression and dementia. R51's care plan created on 3/8/23, identified activities of daily living were an area of concern, due to weakness, stroke and cognitive impairment. Assist of two and EZ stand with transfers. Furthermore, identified falls were an area of concern, due to weakness, dementia and cognitive deficits. R60's MDS quarterly assessment dated 3/3/26, identified severely impaired cognition and dependent on all areas of mobility. R60's diagnoses included dementia, psychotic and mood disturbances and anxiety. R60's care plan revision on 10/7/24, identified activities of daily living was an area of concern, due to the disease process of Alzheimer's. Transfer with assistance of two and EZ stand. Furthermore, an area of concern was at risk for falls due to being unaware of safety needs and history of falls. R62's MDS comprehensive assessment on 2/20/26, identified severely impaired cognition and dependent on mobility. R62's diagnoses included osteoporosis, hemiplegia and dementia.		23270				

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23270	Continued from page 23 R62's care plan revision on 6/9/25, identified activities of daily living was an area of concern, due to disease process, physical limitations, cognitive losses with spastic hemiplegia. Transfer assist of two and sit to stand lift. Furthermore, an area of concern was at risk for falls related to cognition, unaware of safety needs, incontinence, history of traumatic brain injury and cerebral vascular accident with spastic hemiplegia (type of cerebral palsy that affected one side of body, muscle weakness and stiffness). During observation on 3/10/26 at 11:13 a.m., the shower room had a call light which was a small switch on back wall by the toilet, no cord seen. During observation and interview on 3/10/26 at 12:00, registered nurse (RN)-D went and found a cord, tied it around the call light switch in the shower room by the toilet for residents to use, at that time, the light did turn on outside of door when cord was pulled. RN-D stated things were falling through the cracks on the 3rd floor, they didn't have an RN manager, to educate and facilitate any concerns or issues. During interview on 3/12/26 at 11:28 a.m., CNA-J stated if the call light in the shower room wasn't working, they would hear a resident yelling or banging for assistance. During observation and interview on 3/12/26 at 12:17p.m., the call light was not lit up in hallway nor ringing at the nurse's station for the shower room. CNA-F and director of nursing (DON) were at the nurse's desk filling out the a maintenance report. The DON stated it was the 1st time he was told there was a problem with the call light. During interview on 3/12/2026 at 4:47 p.m., RN-E and RN-F verified that call light was not working. RN-E asked to pull call light, red light came on, there was no sound to alert staff, the light on the board in nurses' station also came on with no sound, Both nurses present, confirmed call light not working. Maintenance called, he came and verified that the call light was not working, and he had a call out to have call light fixed. Record review a document entitled, Building Tasks dated 9/25-3/26, Conduct a Test of the Nurse Call System was marked at completed on 2/20/26.		23270				

Minnesota State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 03/12/2026	
NAME OF PROVIDER OR SUPPLIER Rochester Restorative Care Center				STREET ADDRESS, CITY, STATE, ZIP CODE 501 EIGHTH AVENUE SOUTHEAST , ROCHESTER, Minnesota, 55904			
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23270	Continued from page 24 The steps were: 1. For each department, notify the appropriate person in charge that the call system is being tested 2. Check all devices transmitting to, and received from nurse call system, to include pullcords, pendants and pagers. Repair as necessary 3. Check call cords in bathrooms and shower rooms. Ensure call cord length is no more than 6" from the floor. Repair as necessary 4. Notify the appropriate person in charge that the test has been completed and has been returned to operational status 5. Check call light clips 6. If system is capable, run report to identify equipment alerts, such as low battery The Call Lights: Accessibility and Timely response Policy, revised 1/26, indicated The purpose of this policy is to assure the facility is adequately equipped with a call light at each residents' bedside, toilet, and bathing facility to allow residents to call for assistance. Call lights will directly relay to a staff member or centralized location to ensure appropriate response. Staff will ensure the call light is within reach of resident and secure, as needed. The call system must be accessible to the resident at each toilet and bath or shower facility. The call system should be accessible to a resident lying on the floor. Staff will report problems with a call light or the call system immediately to the supervisor and/or maintenance director and will provide immediate or alternative solutions until the problem can be remedied. (Examples include replace "call light", provide a bell or whistle, increase frequency of rounding, etc.) SUGGESTED METHOD OF CORRECTION: The maintenance director or designee could review the system and make needed repairs to ensure residents are able to call for staff help at all times. The director or designee could then audit to ensure consistent, safe system functioning. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.			23270			