



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

July 17, 2026

Administrator

NORTH RIDGE HEALTH AND REHAB

5430 BOONE AVENUE NORTH

NEW HOPE, MN 55428

RE: CCN: 245183

Cycle Start Date: June 18, 2026

Dear Administrator:

On July 8, 2026, we informed you that we may impose enforcement remedies.

On June 25, 2026, the Minnesota Departments of Health and Public Safety completed a survey and it has been determined that your facility is not in substantial compliance.

The most serious deficiencies in your facility were found to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the electronically attached CMS-2567, whereby corrections are required.

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy(ies) listed below to the CMS location for imposition. The CMS location concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Mandatory Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective September 18, 2026.

The CMS location will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective September 18, 2026. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective September 18, 2026.

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

The CMS location may determine to impose other remedies such as a Civil Money Penalty.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than \$13,343, has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by September 18, 2026, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, NORTH RIDGE HEALTH AND REHAB will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from September 18, 2026. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

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. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

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.

DEPARTMENT CONTACT

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

Judy Loecken, Regional Operations Supervisor

St. Cloud B District Office

Health Regulation Division

Minnesota Department of Health

4140 Thielman Lane

Saint Cloud, Minnesota 56301-4557

Email: judy.loecken@state.mn.us

Office: (320) 223-7300 Mobile: (320) 426-0175

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 - Health Regulation Division staff and/or

the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their 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 SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by December 18, 2026 if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 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.

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at <https://dab.efile.hhs.gov> no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

tamika.brown@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
202-795-7490

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Steven Delich, Program Representative at (312) 886-5216. Information may also be emailed to tamika.brown@cms.hhs.gov.

INFORMAL DISPUTE RESOLUTION (IDR)

In accordance with 42 CFR 488.331 and Minnesota Statute 144A.10 subd 15, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

<https://forms.web.health.state.mn.us/form/NHDisputeResolution>

This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at:

https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,



Kamala Fiske-Downing
Compliance Analyst | Federal Enforcement
Health Regulation Division

Minnesota Department of Health

Kamala.Fiske-Downing@state.mn.us

Office: 651-201-4112



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Administrator
NORTH RIDGE HEALTH AND REHAB
5430 BOONE AVENUE NORTH
NEW HOPE, MN 55428

Re: State Nursing Home Licensing Orders
Event ID: 1F34F7-H1

Dear Administrator:

The above facility survey was completed on June 25, 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:

Judy Loecken, Regional Operations Supervisor
St. Cloud B District Office
Health Regulation Division
Minnesota Department of Health
4140 Thielman Lane
Saint Cloud, Minnesota 56301-4557
Email: judy.loecken@state.mn.us
Office: (320) 223-7300 Mobile: (320) 426-0175

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.

Sincerely,



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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245183		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 06/25/2026	
NAME OF PROVIDER OR SUPPLIER NORTH RIDGE HEALTH AND REHAB				STREET ADDRESS, CITY, STATE, ZIP CODE 5430 BOONE AVENUE NORTH , NEW HOPE, Minnesota, 55428			
(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
E0000	Initial Comments On 6/22/26 through 6/25/26, 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			
F0000	INITIAL COMMENTS On 6/22/26 through 6/25/26, a standard recertification survey (S5183042-0) 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 with NO deficiencies cited: H51833022C (3049974) H51831582C (1008831) H51831594C (2693077) H51831593C (2698232) H51831590C (2701147) H51831587C (2715252) H51831589C (2715569) H51831581C (2715590) H51831591C (2718107) H51831586C (2722942)			F0000			

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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F0000	Continued from page 1 H51831585C (2732806) H51831583C (2785303) H51831660C (2995084) H51832859C (3038052) H51833012C (3050588 / 3050195) The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.			F0000			
F0550 SS = E	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights.			F0550			

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F0550 SS = E	Continued from page 2 The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review, the facility failed to provide a dignified dining experience for 7 of 7 residents (R28, R124, R128, R197, R233, R244, R257) when meals were served on hard plastic trays in the dining room. Further, the facility failed to ensure resident's right to privacy and dignity for 1 of 1 residents (R2) when staff failed to knock and wait for permission before entering the resident's room. Findings include: R28's quarterly Minimum Data Set assessment (MDS), dated 5/31/26, indicated R28 had intact cognition, and an admission date of 10/24/25. R124's quarterly MDS, dated 4/13/26, indicated R124 had severely impaired cognition, no hallucinations or delusions, and an admission date of 11/21/18. R128's annual MDS, dated 5/16/26, indicated R128 had short-term and long-term memory issues, severely impaired daily decision making, and an admission date of 11/13/20. R197's quarterly MDS, dated 6/4/26, indicated R128 had intact cognition, and an admission date of 11/25/25. R233's quarterly MDS, dated 4/28/26, indicated R233 had moderately impaired cognition and an			F0550			

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F0550 SS = E	Continued from page 3 admission date of 10/18/24. R244's quarterly MDS, dated 5/1/26, indicated R244 had short term and long-term memory issues, severely impaired daily decision making, and an admission date of 4/5/19. R257's annual MDS, dated 6/14/26, indicated R257 had moderately impaired cognition, no hallucinations or delusions, and an admission date of 8/26/22. During an observation of lunch service on 6/23/26 at 12:59 p.m., five residents (R124, R128, R233, R244, R257) were observed eating in the small dining room on the 2W unit, with two staff observed assisting residents at the tables. Positioned on the table in front of each resident was a meal on a hard plastic serving tray. Each hard plastic tray had a food plate, silverware, and beverage containers on it. The warming lids from the plates were tipped upside down on the table in front of the residents. During an observation of lunch service on 6/24/26 at 11:46 a.m., the lunch meal service was observed on the 2nd floor west main dining room. The dining room had a steam serving table with food items. The staff placed the food items, beverages, and silverware onto a hard plastic serving tray. The meals were then delivered to each resident at their table. However, the hard plastic servicing trays were then left on the table with plated food, beverages and silverware on top of them. Staff did not ask or offer to remove the items from the serving trays and place them onto the table. R28 and R197 were observed eating from the hard plastic meal tray. R197 stated he did not like the hard plastic serving trays and would not eat from one at home. During an observation on 6/25/26 at 8:03 a.m., breakfast meal service was observed on 2nd floor west main dining room. The residents ate in the dining room and their breakfast meal was served on the hard plastic serving tray. The serving trays remained under each resident's dishes during the meal service. The staff that served the meals in the dining room did not ask residents if they wanted the serving tray removed while the residents ate. During an interview on 6/25/26 at 7:49 a.m., nursing assistant (NA)-A stated the nursing assistants			F0550			

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F0550 SS = E	Continued from page 4 helped serve residents in the dining room. NA-A stated the process was to bring the residents the serving tray of food, set the tray in front of the resident, and take the covers off the plates and beverages. NA-A stated staff had not been directed to take the food items off the hard plastic tray. NA-A stated there was no reason why the food was left on the hard plastic tray when served to residents. During an interview on 6/25/26 at 8:59 a.m., registered nurse unit manager (RN)-D stated nursing staff brought the trays to the residents in the dining room during mealtimes. RN-D acknowledged the meals were served to residents in the dining room on the hard plastic tray. RN-D stated he was not sure why the food was left on the hard plastic trays. During an interview on 6/25/26 at 10:37 a.m., director of nursing (DON) stated meals should have been served without the hard plastic trays. DON stated the food should have been taken off the trays when served to residents to create a more homelike environment. R2's quarterly MDS, dated 4/6/26, indicated R2 was cognitively intact. During an observation and interview on 06/22/2026 at 11:27 a.m., staff entered R2's room without ensuring privacy was maintained. An unidentified nursing assistant (NA) knocked once on R2's door, and entered the room without waiting for a response, to inform R2 it was time for lunch. R2 stated staff "just walk right in", expressed fear of changing clothes due to lack of privacy, and reported he did not feel he had adequate privacy in his room. During an interview on 06/24/2026 at 10:33 a.m., NA-E stated that before staff entered a resident's room, staff were expected to knock and wait for a response. During an interview on 06/25/2026 at approximately 9:11 a.m., the nurse manager/ licensed practical nurse (LPN)-C, stated staff were expected to knock and wait for a response prior to entering the room to ensure resident privacy and dignity.			F0550			

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F0550 SS = E	Continued from page 5 During an interview on 06/25/2026 at 11:20 a.m., director of nursing (DON) stated staff were required to knock and wait for a response before entering resident rooms. DON stated this was the facility's expectation to maintain resident privacy. The facility's Dining Environment policy, dated 10/25, indicated the facility would create an appropriate dining environment. The facility's Resident Rights policy, dated 11/2025, indicated federal and state law guarantee residents' basic rights, including the right to privacy.			F0550			
F0628 SS = E	Discharge Process CFR(s): 483.15(c)(2)(iii)(3)-(6)(8)(d)(1)(2); 483.21(c)(2) §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident,			F0628			

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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
F0628 SS = E	Continued from page 6 the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge;			F0628			

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F0628 SS = E	Continued from page 7 (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). §483.15(d) Notice of bed-hold policy and return-			F0628			

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F0628 SS = E	Continued from page 8 §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility			F0628			

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F0628 SS = E	Continued from page 9 failed to provide written information on the duration of the bed-hold and reserve bed payment at the time of transfer for 4 of 4 residents (R21, R147, R203, R260) reviewed for hospitalizations. Findings include: R21's annual Minimum Data Set (MDS), dated 4/19/26, identified R21 with intact cognition, and diagnoses included diabetes, heart disease, kidney disease, and partial amputation of left foot. R21's Clinical Assessment screen identified transferred to the hospital on 6/8/26. R21's electronic medical record (EMR) lacked evidence bed holds were offered, signed, and followed up on. During an interview on 6/22/26 at 11:46 a.m., R21 stated he had never been offered or signed a bed hold form when he transferred to the hospital, and stated, "No one from here reached out to me". R147's quarterly Minimum Data Set (MDS), dated 4/28/26, identified R147 had intact cognition and diagnoses included chronic respiratory failure, quadriplegia, and R147 required suctioning and tracheostomy care. R147's EMR identified R147 was transferred to the hospital on 3/15/26, and 4/3/26. However, review of R147's EMR lacked evidence the facility provided R147 and/or R147's resident representative with written information regarding the facility's bed hold policy at the time of the hospital transfers. During an interview on 6/25/26 at 7:50 a.m., the social services designee (SSD) stated social services completed bed holds when available, and nursing staff completed the process if social services were unavailable. The SSD stated when a bed hold was not obtained by nursing staff at the time of transfer, social services followed up with the resident's representative. The SSD stated the director of nursing (DON) confirmed completion of bed holds. During an interview on 6/25/26 at 10:53 a.m.,			F0628			

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F0628 SS = E	Continued from page 10 registered nurse (RN)-A stated staff determined if the resident was their own responsible party or if the resident's representative needed to be contacted regarding the bed hold. RN-A stated completion of the bed hold process was documented in the resident's progress notes. During an interview on 6/25/26 at 11:07 a.m., the registered nurse case manager (RNCM) stated when a resident was transferred to the hospital, nursing staff notified the resident's representative, discussed the bed hold, and documented the information in the progress notes. The RNCM stated social services were updated and a bed hold form was sent with the resident. The RNCM confirmed R147's EMR lacked evidence bed hold information was provided to R147 and/or R147's resident representative for the hospital transfers on 3/15/26 and 4/3/26. During an interview on 6/25/26 at 1:35 p.m., director of nursing (DON) stated for emergency transfers, social services followed up with the resident and/or resident representative regarding whether they wanted a bed hold and documented the information in the progress notes. The DON stated the process was important to determine if the resident or resident representative wanted to hold the resident's bed, identify the length of time the bed would be held, and ensured clear communication. R203's quarterly MDS, dated 6/2/26, identified R203 with moderate cognitive impairment, and diagnoses included hypertension, peripheral vascular disease, kidney disease, receiving hemodialysis, left below the knee amputation, and diabetes. R203's EMR identified transfers to the hospital on 4/27/26, 5/8/26, and 6/3/26. However, R203's EMR lacked evidence bed holds were offered, signed, and followed up on. During an interview on 6/23/26 at 5:21 p.m., RN-K stated nurses were expected to print out a face sheet, orders, and medication list to send with resident to hospital. In addition, the nurse was expected to start a Transfer Form in the EMR. RN-K stated a signed bed hold form was to accompany the resident to the hospital, and a progress note written after the resident transferred to identify status of the bed hold, such as who was notified.			F0628			

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F0628 SS = E	Continued from page 11 During an interview on 6/23/26 at 5:21 p.m., RN-L stated expectation of nursing staff to print out a face sheet, orders, and medication list to accompany resident to hospital once orders to transfer were obtained. In addition, the nurse was expected to start a Transfer Form in the EMR. RN-L stated the bed hold form was a separate piece of paper “that needs to be signed [by the resident] and followed up if they cannot at the time”. RN-L stated expectation of a progress note following the transfer to indicate whether bed hold was signed or offered, and to be followed up by social services if it is not signed. During an interview on 6/24/26 at 11:10 a.m., RN-M stated expectation of nursing staff to print out a face sheet, orders, and medication list to accompany resident to hospital once orders are obtained, and the nurse was expected to start a Transfer Form in the EMR. RN-M stated the bed hold form was expected to be offered to and signed by the resident or guardian and accompany the resident to the hospital. RN-M stated expectation of the nurse to document in a progress note whether the bed hold was offered or signed, and if it was not then social services were to follow up. RN-M acknowledged the process was not followed for R21 and R203. During an interview on 6/24/26 at 11:44 a.m., SS-D reviewed EMR for R21 and R203 and stated he was unable to locate any signed bed hold forms. SS-D stated, “The process should be to have the patient or guardian sign the bed hold and [facility] scan it in the EMR. We should be following up if it was done or not in a progress note.” SS-D stated the facility failed to document if a written notice was offered and provided to R21 and R203, or their guardians on transfer, including notifying the Office of the State Long Term Care Ombudsman. During an interview on 6/25/26 at 8:41 a.m., R203 stated he had never been offered or signed a bed hold form when he was hospitalized. During an interview on 6/25/26 at 10:51 a.m., DON stated expectation of a signed bed hold to accompany resident at time of transfer. “It should be scanned in the EMR but [process] is not reliable.” DON verified the facility failed to document if a written notice was offered and provided to R21 or R203, or their guardians on transfer, including notifying the Office of the State Long Term Care			F0628			

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F0628 SS = E	Continued from page 12 Ombudsman. R260's admission MDS, dated 3/16/26, identified R260 was cognitively intact, was able to express needs and wishes, and was able to understand others, and diagnoses included surgical amputation, peripheral vascular disease (a disease with narrowing of the blood vessels which impacts blood circulation throughout the body), and malnutrition. R260's care plan, initiated 3/4/26, identified R260 was at risk for falls and was dependent on staff for cares. R260's progress note, dated 3/25/26 at 5:23 a.m., identified R260 was found on the floor at 5:00 a.m., and denied striking head. At that time, the provider and family were advised. The documentation indicated the provider would follow up with patient to assess. R260's progress note, dated 3/25/26 at 5:14 p.m., identified R260 was noted to have swelling to the left side of face and was confused, and waw not able to recognize family member/power of attorney (POA). Notification was sent to the provider triage nurse and resident was transferred to the hospital for evaluation. The progress note indicated the bed hold was signed by the POA. However, R260's EMR lacked evidence of the signed bed hold from 3/25/26. During interview on 6/25/26 at 11:52 a.m., registered nurse/unit manager (RN/UM)-A stated upon transfer to the hospital, a bed hold wase obtained from the responsible party. This is completed either in person, or via the telephone for verbal consent. Once signed, RN/UM-A stated the document was placed in the medical record. During interview on 6/25/2026, at 2:30 p.m., DON provided a handwritten note which identified "3/25/26 at 5:43 p.m. Bed hold per POA of resident". DON acknowledged this documentation lacked indication as to information provided to the POA, including potential fees and right to appeal.			F0628			

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F0628 SS = E	Continued from page 13 The facility's Bed Hold policy, revised 04/2025, indicated community staff shall inform residents upon admission and prior to a transfer for hospitalization (unless for an emergency) or therapeutic leave of the bed-hold policy, and a copy of the resident's bed-hold or release record will be filed in the resident's medical record.			F0628			
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, interview, and document review, the facility failed to ensure controlled substance reconciliation was completed in accordance with established policies and procedures to reduce the risk of diversion and/or theft on 2 of 8 medication carts reviewed. This had the potential to			F0755			

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F0755 SS = E	Continued from page 14 affect 8 residents identified to have controlled substances in the reviewed carts. Findings include: During an observation and interview on 6/23/26 at 1:54 p.m., the 2W “far south” medication cart was reviewed with registered nurse (RN)-A. The mobile cart was locked with a physical key, along with a separately attached metal narcotic box, which was also locked. The narcotic box was opened and contained numerous controlled substances. RN-A explained that the narcotics and controlled substances were counted at each shift exchange, and these reconciliations were recorded on a Narcotic Shift to Shift Signature form. RN-A provided the flow sheets used to track the documented count(s). However, approximately half of the signature spaces were blank. RN-A confirmed the form had approximately half of the spaces filled and stated all the signature spots should have been completed. RN-A stated she did not know why spaces were blank. The facility's 2 West FS (far south) Narcotic Shift to Shift Signature Sheet, for June 2026, indicated there were 132 possible signature spaces, with 106 documented signatures for 6/1/26 through 6/26/26. During an observation and interview on 6/23/26 at 2:03 p.m., with RN-B and RN-C, the 2W “near south” mobile medication cart was observed locked with a physical key, along with a separately attached metal narcotic box, which was also locked. The narcotic box was opened and contained numerous controlled substances. RN-C explained the narcotics and controlled substances were counted at each shift exchange, and these reconciliations were recorded on a form to indicate the count had occurred. RN-C provided the flow sheets used to track the documented count(s). However, approximately half of the signature spaces were blank. The facility's 2 West NS (near south) Narcotic Shift to Shift Signature Sheet, June 2026, indicated there were 132 possible signature spaces for 6/1/26 to 6/22/26. However, there were 41 signatures total on the sheet for 6/1/26 through 6/22/26. During an interview on 6/23/26 at 2:09 p.m., the			F0755			

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F0755 SS = E	Continued from page 15 nurse manager/ licensed practical nurse (LPN)-A stated staff were expected to sign the controlled medication reconciliation form to indicate that controlled medication reconciliation had occurred. LPN-A confirmed approximately half the signatures were missing on the 2W NS form. LPN-A stated that based on documentation, he was unable to confirm that medication reconciliation had occurred. During an interview on 6/24/26 at 10:17 a.m., the director of nursing (DON) stated nursing staff were expected to complete controlled medication reconciliation at each shift change, and the reconciliation should have been documented on the narcotic shift change forms. The facility's Controlled Substances policy, dated 10/2026, indicated the controlled substance records would be reconciled by a physical count of the remaining controlled substance supply at the change of each shift by the oncoming and outgoing licensed nurse/designee.			F0755			
F0804 SS = E	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is NOT MET as evidenced by: Based on observation, and interview, the facility failed to ensure food was served in a timely manner to preserve desired temperatures of food for 5 of 5 residents (R3, R28, R156, R197, R294) reviewed who expressed concerns for food temperatures and palatability. Findings include: R3's quarterly Minimum Data Set (MDS) assessment, dated 3/16/26, identified R3 had intact cognition with an admission date of 11/13/24.			F0804			

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F0804 SS = E	Continued from page 16 During an interview on 6/24/26 at 10:23 a.m., R3 stated she ate in the main dining room on 2W, and she had brought up the concern of cold food to staff previously. R28's quarterly MDS assessment, dated 5/31/26, identified R28 had intact cognition with an admission date of 10/24/25. During an interview on 6/24/26 at 10:23 a.m., R28 stated the food was always cold. It didn't make a difference if you ate in your room or in the dining room. R28 stated he ate in both places and had brought up the concern of cold food to staff previously. R156's quarterly MDS assessment, dated 5/25/26, identified R156 had intact cognition with an admission date of 2/18/26. During an interview on 6/24/26 at 10:23 a.m., R156 stated the food was served cold when it should be hot most of the time. R156 stated he ate in the dining room most of the time and had brought up the concern of cold food to staff previously. R197's quarterly MDS assessment, dated 6/4/26, identified R128 had intact cognition with an admission date of 11/25/25. During an interview on 6/24/26 at 10:23 a.m., R197 stated the French fries were "always cold." R197 stated he ate in the main dining room on 2W most of the time and had brought up the concern of cold food to staff previously. R294's quarterly MDS assessment, dated 4/1/26, identified R294 had intact cognition with an admission date of 1/17/26. During an interview on 6/22/26 at 1:02 p.m., R294 stated the food was served cold when it should have been hot. Furthermore, R294 stated the flavor "wasn't always great". During an observation and interview on 6/24/26 at 12:56 p.m., dining staff, including the dietary manager (DM), were observed serving food from the 3 west dining room. After all resident meals were plated, DM temped the food that remained in the food warmer. The following temperatures were obtained: turkey 164 degrees Fahrenheit (F), green beans 173.8 F and sweet potato 149.5 F. After the temperatures were obtained, the food remained on the warming table. The DM then followed the meal			F0804			

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F0804 SS = E	Continued from page 17 cart into the memory care unit, waited until the last tray was ready to be served, and obtained the following food temperatures from the last tray: turkey 103.5 F, green beans 96.5 F, and sweet potato 102.4 F. DM stated all the food should have been above 140 degrees at the time it was served, regardless of if it was in the dining room or served in the resident room. DM stated food temperatures that were below 140 degrees were in the "danger zone" and increased the potential for food-born illnesses.			F0804			
F0552 SS = D	Right to be Informed/Make Treatment Decisions CFR(s): 483.10(c)(1)(4)(5) §483.10(c) Planning and Implementing Care. The resident has the right to be informed of, and participate in, his or her treatment, including: §483.10(c)(1) The right to be fully informed in language that he or she can understand of his or her total health status, including but not limited to, his or her medical condition. §483.10(c)(4) The right to be informed, in advance, of the care to be furnished and the type of care giver or professional that will furnish care. §483.10(c)(5) The right to be informed in advance, by the physician or other practitioner or professional, of the risks and benefits of proposed care, of treatment and treatment alternatives or treatment options and to choose the alternative or option he or she prefers. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to obtain consent for use of psychotropic medications for 1 of 5 residents (R9) reviewed for unnecessary medications Findings include: R9's admission Minimum Data Set (MDS), dated 4/15/26, indicated R9 had severe cognitive impairment, required assistance with activities of daily living (ADLs), and diagnoses included edema, dementia, hypertension, insomnia and encephalopathy (broad term for any disease, damage, or malfunction that affects the brain).			F0552			

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F0552 SS = D	Continued from page 18 R9's Order Summary Report, printed 6/25/26, indicated R9 had an order dated 4/13/26 for trazodone 25 milligrams (mg) by mouth at bedtime for insomnia. However, review of R9's medical record lacked evidence consent for trazadone was obtained prior to use. During an interview on 6/25/26 at 10:56 a.m., registered nurse (RN)-I stated nurses were expected to complete a form for consent when a psychotropic medication was ordered. RN-I stated a nurse could initially get verbal consent but then needed to have the form signed the next time the person that gave consent was in the facility. During an interview on 6/25/26 at 11:21 a.m., RN-H stated the expectation was for consent for a medication that required it was obtained when a resident admitted on the medication or a new medication was added. RN-H confirmed R9's medical record lacked evidence or consent for trazodone. During an interview on 6/25/26 at 11:46 a.m., director of nursing (DON) stated the consent for psychotropic medications was expected to be obtained when a new psychotropic medication was ordered or when a resident was admitted with a psychotropic medication. The facility's Physician Medication Orders policy did not address obtaining consent for psychotropic medication use.			F0552			
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 §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 document review, the facility failed to assess resident for safety and the ability to self-administer medications for 1 of 1 resident (R21) reviewed for self-administration of medications (SAM).			F0554			

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F0554 SS = D	Continued from page 19 Findings include: R21's annual Minimum Data Set (MDS), dated 4/19/26, identified R21 was cognitively intact, and diagnoses included diabetes, heart disease, and kidney disease. R21's physician progress note, dated 1/20/26, identified R21 medication order for nystatin ointment 100000 unit/gram to groin and intergluteal cleft (the deep vertical groove between the buttocks) topically two times a day for fungal rash/dry skin, and with every brief change. R21's electronic medical record (EMR) identified physician orders for nystatin ointment was discontinued on 5/7/26. During an observation and interview on 6/23/26 at 3:37 p.m., R21 had a nearly empty tube of prescription nystatin ointment, with label attached listing R21's name, and instructions for use as indicated on the 1/20/26 medication order, and the label indicated dates of "Jan 20, 2026, to Feb 20, 2026". R21 stated nystatin remained on his rolling bedside table or top of nightstand since January of 2026. R21 stated he applied the ointment when he felt he needed it. R21 stated staff were aware he had it in his room. R21 stated facility staff had never talked to him about an assessment to determine safety and competence to keep the prescription ointment in his room. During an observation on 6/24/26 at 1:11 p.m., R21's rolling bedside table had a nearly empty tube of the prescription Nystatin ointment. During an interview on 6/24/26 at 11:21 a.m., registered nurse (RN)-M stated nurses were to document an assessment in the resident EMR if a resident wished to keep prescription and over the counter (OTC) medications at bedside. When a resident was assessed as safe to self-administer their medications, a provider order for self-administration was obtained and the care plan was updated. RN-M stated complete and accurate medication orders were important due to potential risk of contraindications.			F0554			

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F0554 SS = D	Continued from page 20 During an interview on 6/24/26 at 11:28 a.m., RN-L stated nursing staff were expected to document an assessment in the resident EMR if a resident wished to keep prescription and/or over-the-counter medications at bedside. RN-L stated residents should not have prescription or OTC medications in their rooms unless an assessment was completed and documented in the EMR. RN-L stated, “we don’t want [residents] medicating themselves and potentially harm[ing] them”. During observation and interview on 6/24/26 at 1:12 p.m., RN-D confirmed the prescription nystatin ointment was in R21’s room and verified it was prescribed to R21. RN-D stated the nystatin ointment “should not be here because we need to know all meds”. RN-D verified a self-administration of medications assessment had not been completed for R21. RN-D stated the discontinued nystatin order meant the nystatin should have been removed from R21’s room when it was discontinued. During an interview on 6/25/26 at 10:56 a.m., director of nursing (DON) stated nurses were expected to document a self-administration assessment for all prescribed and OTC medications left in a resident room. DON stated when a resident was assessed to be safe to self-administer a medication, a provider order for SAM was obtained by staff and documented in the EMR, and the care plan was updated. DON verified R21 was never assessed for safe self-administration of medication, and the order and care plan were never updated. The facility's Self-Administration of Drugs policy, dated 11/2016, indicated residents in our facility who wish to self-administer their medications may do so, if it is determined that they are capable of doing so and clinically appropriate. For self-administering residents, the nursing staff will determine who will be responsible (the resident or the nursing staff) for documenting that medications were taken. The nursing staff will rotate bedside stock and will remove expired, discontinued, or recalled medications.			F0554			
F0558 SS = D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do			F0558			

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F0558 SS = D	Continued from page 21 so would endanger the health or safety of the resident or other residents. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to accommodate resident needs by ensuring a call light was accessible for 2 of 2 residents (R221, R283) reviewed for call lights. Findings include: R221's admission Minimum Data Set (MDS), dated 5/18/26, identified R221 was cognitively intact, and diagnoses included diagnoses of neurogenic bladder, diabetes, and schizophrenia. Additionally, R221 had impairment on one side of upper and lower extremities, required a walker and wheelchair for mobility, and required substantial assistance for dressing and hygiene. During an observation and interview on 6/25/26 at 8:37 a.m., R221 was seated in a wheelchair in her room, facing her bed with the bedside table between her and her bed. R221's call light was wrapped around the upper bedrail of the bed and out of reach. R221 was unable to access her call light, and stated, "it is too far away". R221 attempted to move her wheelchair around the bed stand but was unable to move. Licensed practical nurse (LPN)-B and nursing assistant (NA)-D entered R221's room and verified the call light was not within R221's reach. LPN-B stated the call light "should be in reach". NA-D stated the call light "should be [in reach]". R283's admission MDS, dated 4/13/26, identified R283 with impaired cognition, required assistance with hygiene, and diagnoses of cardiomyopathy, heart disease, kidney disease, diabetes, and depression. During an observation and interview on 6/22/26 at 11:02 a.m., R283 was observed in bed as he watched television (TV). However, R283's call light was wrapped around the wall call light unit and was out of R283's sight and reach. R283 stated if he needed assistance, he would "call out" and it "takes all day to get attention". During an interview on 6/22/26 at 11:06 a.m., nursing assistant (NA)-B verified R283's call light			F0558			

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F0558 SS = D	Continued from page 22 was wrapped around the wall unit and was out of R283's sight and reach. NA-B stated the call light should have been within R283's reach so R283 could "call for help if needs it". During an observation and interview on 6/23/26 at 5:08 p.m., R283 watched TV from his bed. R283's call light was wrapped around the wall and was out of R283's sight and reach. R283 stated, "I don't use it because I can't reach it". During an interview on 6/24/26 at 10:39 a.m., NA-C stated staff were expected to ensure call lights were within reach of every resident when in their rooms. NA-C stated residents could not request help unless the call light was within reach, and it was important for resident safety. During an interview on 6/24/26 at 11:23 a.m., registered nurse (RN)-L stated expectation of call lights to always be in reach of every resident when in their rooms. During an interview on 6/24/26 at 11:19 a.m., RN-M stated call lights should be "ideally within reach". RN-M stated call lights wrapped around the wall unit, and not in reach was not acceptable. RN-M stated the call lights were a "lifeline" for residents to use if they needed assistance. During an interview on 6/25/26 at 10:59 a.m., DON stated expectation of call lights to be in reach of every resident "to have for help if needed". The facility's Answering the Call Light policy, effective 10/2025, indicated when the resident is in bed or confined to a chair, be sure the call light is within easy reach of the resident.			F0558			
F0604 SS = D	Right to be Free from Physical Restraints CFR(s): 483.10(e)(1),483.12(a)(2) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any physical .			F0604			

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F0604 SS = D	Continued from page 23 . . restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(2) Ensure that the resident is free from physical . . . restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to ensure ongoing assessment and evaluation of physical restraints were completed to determine continued need, risks, benefits, and least restrictive interventions for a wheelchair lap tray and set belt for 1 of 1 resident (R147) reviewed for physical restraints. Findings include: R147's quarterly Minimum Data Set (MDS), dated 4/28/26, identified R147 had intact cognition and required assistance with activities of daily living (ADLs). R147's diagnoses included quadriplegia (paralysis affecting all four extremities), muscle weakness, lack of coordination (difficulty controlling body movements), and abnormalities of gait and mobility (difficulty with movement and positioning). The MDS further identified R147 did not use restraints. During an observation on 6/22/26 at 5:16 p.m., R147 was seated in his wheelchair with a seat belt secured and a lap tray attached to the wheelchair. During an observation on 6/25/26 at 11:05 a.m.,			F0604			

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F0604 SS = D	Continued from page 24 R147 propelled throughout the main area in his power wheelchair. R147's wheelchair seat belt was buckled and a lap tray was positioned across the wheelchair. R147's care plan, dated 5/11/26, identified R147 had a seat belt on his wheelchair and R147 was able to lock and release the seat belt independently. The care plan interventions identified R147 was educated on risks versus benefits, and signed consent to use of the seat belt. R147's care plan further indicated R147 understood the seat belt could be removed at any time, the seat belt would be used when R147 was in the wheelchair as desired, and the seat belt did not impede R147's mobility or ability to reposition in the chair. R147's Physical Restraint Quarterly Assessment history, identified the most recent assessment was completed on 2/17/26. R147's electronic medical record (EMR) lacked evidence additional quarterly restraint assessments were completed after 2/17/26, The assessments were used to evaluate continued use of the lap tray and seat belt, verify R147 continued ability to independently remove the devices, determine if the devices continued to meet R147's assessed needs, or identify if less restrictive interventions or restraint elimination were appropriate. During an interview on 6/25/26 at 10:53 a.m., registered nurse (RN)-A stated R147 used a seat belt and lap tray on his wheelchair. RN-A stated the nurse manager was responsible for reassessing the continued need for the devices and R147's ability to use them. During an interview on 6/25/26 at 11:07 a.m., the registered nurse case manager (RNCM) reviewed R147's medical record and confirmed the last Physical Restraint Quarterly Assessment was completed on 2/17/26. The RNCM stated restraint assessments should have been completed quarterly, and confirmed an assessment should have been completed after 2/17/26. The RNCM stated the assessment had not been completed because it had not triggered in the EMR system. The RNCM stated reassessments were important to ensure continued appropriate use, and to verify the resident's needs remained current. During an interview on 6/25/26 at 1:35 p.m., the director of nursing (DON) stated physical restraint assessments were expected to be completed quarterly. The DON stated when residents were transferred to the hospital, assessments were			F0604			

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F0604 SS = D	Continued from page 25 discontinued in the electronic system and could fall off if they were not reviewed upon return to the facility. The DON confirmed R147 should have had another assessment completed after 2/17/26. The DON stated assessments were important to ensure residents remained able to remove the device independently and, if unable to remove the device, alternative interventions would need to be identified to maintain safety and update the care plan. The facility's Use of Physical Restraints policy, dated 6/2025, identified physical restraints were defined as any manual method or physical or mechanical device, material, or equipment attached or adjacent to the resident's body that the individual could not remove easily and restricted freedom of movement or normal access to the body. The policy identified the definition of a restraint was based on the functional status of the resident and not the device. The policy further identified restrained individuals would be reviewed regularly, at least quarterly, to determine whether they were candidates for restraint reduction, less restrictive methods of restraint, or restraint elimination. The policy identified care plans for residents with restraints would include interventions addressing the resident's needs and measures to reduce or eliminate restraint use.			F0604			
F0605 SS = D	Right to be Free from Chemical Restraints CFR(s): 483.10(e)(1),483.12(a)(2),483.45(c)(3)(d)(e) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any . . . chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is			F0605			

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F0605 SS = D	Continued from page 26 not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must-. . . §483.12(a)(2) Ensure that the resident is free from . . . chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic. §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- (1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section.			F0605			

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F0605 SS = D	Continued from page 27 §483.45(e) Psychotropic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that-- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to ensure psychotropic medications were used in accordance with professional standards by failing to ensure PRN (as needed) psychotropic medication orders were limited to 14 days or contained documented clinical rationale and/or practitioner evaluation to support continued use beyond 14 days. The facility also failed to ensure monitoring was implemented to identify potential adverse effects related to antipsychotic medication use, including orthostatic blood pressure monitoring, for 1 of 5 resident (R152) reviewed for unnecessary medications.			F0605			

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F0605 SS = D	Continued from page 28 Findings include: R152's Medicare 5-day Minimum Data Set (MDS) assessment, dated 5/28/26, identified R152 had intact cognition, and diagnoses included respiratory failure, chronic obstructive pulmonary disease (COPD), and tracheostomy status. The MDS further identified R152 received antipsychotic and antianxiety medications. R152's physician orders, dated 6/22/26, included lorazepam (an antianxiety medication) 0.5 milligrams (mg) by mouth every six hours as needed (PRN) for anxiety, with a maximum of three doses per day. The order had a start date of 6/9/26, and an end date of 7/9/26, which allowed the PRN psychotropic medication to remain active for 30 days. However, R152's medical record lacked documented clinical rationale from the practitioner to support the continued use of the PRN psychotropic medication beyond 14 days. R152's physician orders, dated 6/22/26, included quetiapine (an antipsychotic medication) 37.5 mg by mouth twice daily PRN for generalized anxiety. The order had a start date of 6/16/26, and an end date of 7/16/26, which allowed the PRN antipsychotic medication to remain active for 30 days. However, R152's medical record lacked documentation the practitioner evaluated R152 and determined the continued use of the PRN antipsychotic medication beyond 14 days was appropriate. R152's physician orders, dated 6/22/26, treatment administration records (TARs), and clinical documentation revealed R152 received an antipsychotic medication. However, orthostatic blood pressure monitoring was not ordered or completed to monitor for potential adverse effects associated with antipsychotic medication use. During an interview on 6/25/26 at 11:07 a.m., the registered nurse case manager (RNCM) confirmed PRN psychotropic medications should have been limited to 14 days. The RNCM stated if continued use was needed beyond 14 days, the provider should have been contacted for a new order. The RNCM confirmed R152's lorazepam order had an end date of 7/9/26, and the quetiapine order had an end date of 7/16/26. The RNCM stated the quetiapine order indicated the medication was to continue for seven days, but the stop date indicated in the electronic medical record (EMR) did not match the provider's order. The RNCM stated the previous provider order indicated to continue PRN quetiapine			F0605			

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F0605 SS = D	Continued from page 29 for seven additional days and lorazepam three times daily for two weeks. RNCM stated the extended stop dates were likely a transcription error. The RNCM further stated orthostatic blood pressure monitoring should have been implemented due to antipsychotic (quetiapine) use because of potential adverse effects that could lead to safety concerns. The RNCM confirmed R152 did not have orthostatic blood pressure monitoring in place. During an interview on 6/25/26 at 1:40 p.m., the director of nursing (DON) stated antipsychotic medications and PRN psychotropic medications required 14-day stop dates. The DON stated when a resident routinely required PRN psychotropic medication, the facility reviewed the continued need with the provider to determine if changes were needed, and to prevent unnecessary medication use. The DON further stated residents with ordered antipsychotic medications needed to have orthostatic blood pressures completed because the medication could affect blood pressure, resulting in safety concerns and an increased risk for falls. The facility's Psychotropic Medication Use policy, dated 9/15/24, indicated psychotropic medications were to be used safely and appropriately while minimizing risks and adverse effects in accordance with current practice guidelines and regulatory requirements. The policy indicated PRN psychotropic medication orders should be limited to no more than 14 days. The policy further indicated if the physician/prescriber determined a PRN psychotropic medication, excluding antipsychotics, should continue beyond 14 days, the rationale and duration of use should be documented in the resident's medical record. The policy indicated PRN antipsychotic medication orders were limited to 14 days and could not be renewed unless the physician/prescriber evaluated the resident for the appropriateness of continued medication use. The policy further indicated all medications used to treat behaviors should be monitored for efficacy, risks, benefits, and harm or adverse consequences.			F0605			
F0641 SS = D	Accuracy of Assessments CFR(s): 483.20(g)(h)(i)(j) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. §483.20(h) Coordination. A registered nurse must			F0641			

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F0641 SS = D	Continued from page 30 conduct or coordinate each assessment with the appropriate participation of health professionals. §483.20(i) Certification. §483.20(i)(1) A registered nurse must sign and certify that the assessment is completed. §483.20(i)(2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. §483.20(j) Penalty for Falsification. §483.20(j)(1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than \$5,000 for each assessment. §483.20(j)(2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to ensure the Minimum Data Set (MDS) was accurately coded, with the potential for inaccurate federal reimbursement and resident care planning for 3 of 3 residents (R12, R15, R123) reviewed for MDS accuracy. Findings include: R12's readmission Minimum Data Set (MDS) assessment, dated 3/20/26 indicated R12 had not had any falls in the month prior to admission/re-admission, and indicated R12 had not had any fractures related to a fall in the 6 months prior to admission/re-admission. R12's quarterly MDS assessment, dated 6/22/26, indicated R12 had no falls in the previous 90 days.			F0641			

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F0641 SS = D	Continued from page 31 R12's care plan indicated R12 was at risk for falls related to cognition, unsteady gait and weakness. The care plan further indicated a fall with fractured hip on 3/9/26. During an interview on 6/25/26 at 11:17 a.m., licensed practical nurse manager (LPN)-A stated R12's readmission MDS assessment dated 3/20/26, and quarterly MDS assessments were inaccurate due to R12's fall with hip fracture on 3/9/26. During an interview on 6/25/26 at 1:52 p.m., Director of Nursing (DON) confirmed R12 had a fall with fracture on 3/9/26, the MDS assessments dated 3/20/26 and 6/22/26 were inaccurately coded. DON stated it was important for the MDS assessments to be accurate so residents received the care they needed and to prevent potential negative outcomes to residents. R15's significant change MDS, dated 4/18/26, indicated R15 took an anticoagulant and not an antiplatelet. R15's Medication Administration Record (MAR), dated 4/1/26 to 4/30/26, indicated R15 had not received an anticoagulant during the look back period (LBP), but had received 81 milligrams (mg) of aspirin (an antiplatelet medication) daily during the LBP. During an interview on 6/25/26 at 8:44 a.m., MDS coordinator (MDSC)-A, a registered nurse (RN), reviewed R15's medical record and stated R15 had taken an antiplatelet medication, aspirin, and had not received an anticoagulant medication during the LBP. R123's annual MDS, dated 5/28/26, indicated R123 was taking an anticoagulant and not an antiplatelet. R123's May 2026 MAR, dated 5/1/26 to 5/31/26, indicated R123 had not received an anticoagulant during the look back period (LBP) but did receive 81 milligrams (mg) of aspirin (an antiplatelet medication) daily during the LBP. During an interview on 6/25/26 at 7:57 a.m., RN-G			F0641			

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F0641 SS = D	Continued from page 32 reviewed R123's medical record and stated R123 had not been taking an anticoagulant but did take aspirin. During an interview on 6/25/26 at 8:27 a.m., RN-D, a nurse manager, reviewed R123's medical record. RN-D verified R123 had not taken an anticoagulant since 2021 when it was discontinued. RN-D stated R123 was and had been taking aspirin and verified aspirin was not an anticoagulant. During an interview on 6/25/26 at 8:51 a.m., MDSC-A, reviewed R123's medical record and stated R123 had taken an antiplatelet medication (aspirin), and not an anticoagulant medication during the LBP. MDSC-A verified the MDS was coded incorrectly. During an interview on 6/25/26 at 10:35 a.m., DON stated it was important the MDS was accurate as it affected reimbursement and MDS assessment information directed the care plan and interventions. The facility's MDS Assessment Coordinator policy, dated 3/2027, indicated that each individual who completed a portion of the MDS must certify the accuracy of the assessment.			F0641			
F0677 SS = D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review, the facility failed to ensure routine personal hygiene and grooming (i.e., shaving) was provided to 1 of 1 residents (R12) reviewed for Activities of Daily Living (ADLs) who were dependent on staff for their care. Findings include: R12's admission Minimum Data Set (MDS) assessment, dated 3/6/26, indicated R12 was cognitively intact, required partial to moderate assistance with personal hygiene, and had not refused or rejected cares.			F0677			

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F0677 SS = D	Continued from page 33 R12's care plan, reviewed 6/24/26, indicated R12 required the assistance of one staff for personal hygiene. During an observation and interview on 6/22/26 at 2:04 p.m., R12 had scruffy facial hair, approximately ¾ of an inch long, covering his face and neck. R12 stated he preferred to be clean shaven. An electric razor was plugged into the wall on the floor next to R12's bed. During an observation on 6/23/26 at 10:27 a.m., R12 continued to have scruffy facial hair covering his face and neck. During an observation on 6/23/26 at 3:15 p.m., R12 had scruffy facial and neck hair present, and the electric shaver was noted on floor. During an observation and interview on 6/24/26 at 10:19 a.m., R12 continued to have scruffy facial and neck hair. R12 asked for assistance and stated he did not 'like this scruff on my face'. The electric razors were still plugged into wall and lying on the floor. During an interview on 6/24/26 at 10:46 a.m., nursing assistant (NA-D) stated she was familiar with R12's care and identified personal hygiene as shaving, assisting with denture care, cleaning face and hair brushing. NA-D stated facility staff assisted R12 with personal hygiene and specifically assisted with shaving on his bath days. NA-D stated she was unaware of R12 refusing cares. During an interview on 6/25/26 at 11:09 a.m., licensed practical nurse manager (LPN-A) stated the NA staff was responsible for the completion of personal hygiene for residents, and that a resident who was listed as requiring substantial maximal assistance, the NA staff completed the task (shaving) for the R12. LPN-A stated personal hygiene/grooming would normally be completed on bath day, however, if the resident did not receive a full bath, personal hygiene, like shaving, would be completed. During an interview on 6/25/26 at 1:52 p.m., director of nursing (DON) stated personal hygiene/cares included hair care, oral care, nail care and shaving. DON stated floor staff were responsible for completing these tasks on bath days for residents. DON stated residents' personal preferences should be honored and if a resident desired to be clean-shaven, staff were expected to make every			F0677			

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F0677 SS = D	Continued from page 34 effort to do so. DON stated she expected resident preferences to be met whenever possible. DON stated it was important to provide personal care in a manner of resident preference because residents have the right to feel good about the way they look.			F0677			
F0689 SS = D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review, the facility failed to ensure fall interventions were implemented to prevent further falls and potential injury for 1 of 3 residents (R6) reviewed for falls. Additionally, the facility failed to comprehensively assess to prevent potential injury for 1 of 1 residents (R44) reviewed for smoking. Findings include: R6's annual Minimum Data Set (MDS), dated 6/8/26, indicated R6 was cognitively intact, had not rejected cares, was independent with activities of daily living (ADLs), and diagnoses included arthritis and depression. R6's progress note, dated 5/14/26 at 5:13 a.m., indicated that R6 slid from bed and was found on the floor with no injuries observed. R6's fall risk management, dated 5/14/26, indicated R6 had fallen out of bed and was found on her bedside floor by staff. The report indicated R6 stated she was rolling in her bed when she had fallen. The report indicated R6 thought the bed was too small, causing her to fall off her bed, and R6 was given a new and bigger bed to reduce the risk of falling.			F0689			

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F0689 SS = D	Continued from page 35 R6's care plan, dated 5/18/26, indicated R6 was at risk for falls related to gait and balance problems and had fallen on 7/8/25, 1/25/26, 2/10/26, and 5/14/26. The care plan indicated that related to a fall on 5/14/26, R6 was "given a bigger bed". R6's progress note, dated 6/22/26 at 5:22 a.m., indicated R6 was found lying on the floor beside her bed, and R6 had stated she was lying on her side in bed and attempted to roll toward the side of the bed and rolled out of bed. The progress note indicated that R6 did not have any injuries at the time of the assessment. During multiple observations on 6/23/26, other beds on the unit were observed and compared to R6's bed. R6's bed appeared to be the standard bed size. During an interview on 6/22/26 at 1:38 p.m., R6 stated she had fallen out of bed a couple of times when trying to reposition herself in bed, and felt her bed was too small. R6 stated she thought she was going to get a bigger bed but never did. During an observation and interview on 6/23/26 at 12:53 p.m., registered nurse (RN)-B stated R6 had a history of falls and R6 was supposed to have given a bigger bed. RN-B stated it appeared R6 had not received a larger bed because the one R6 had was a "normal-sized" bed. During an interview on 6/23/26 at 1:02 p.m., licensed practical nurse (LPN)-A, the nurse manager for the unit, stated as the fall intervention for R6's fall on 5/14/26, LPN-A ordered a larger bed and thought R6 had received it. LPN-A stated it appeared R6 had not received a larger bed and LPN-A needed to talk to the director of maintenance (DM) to determine what happened. During an interview on 6/23/26 at 1:07 p.m., the DM stated R6's bed was the standard-sized bed, and R6 had not been provided with a larger one. During a follow-up interview on 6/24/26 at 1:37 p.m., the DM stated there had been a miscommunication between maintenance and nursing. The DM stated nursing had indicated that a larger mattress was needed, but R6 already had the			F0689			

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F0689 SS = D	Continued from page 36 largest mattress size for her bed frame. The DM stated the ticket had then been “closed out” and a larger bed was not ordered. R44's admission Minimum Data Set (MDS), dated 5/13/26, indicated resident was cognitively intact and received supervision to moderate assistance with all activities of daily living (ADLs). R44's Face Sheet, printed 6/25/26, indicated R44 diagnoses included malignant neoplasm of unspecified kidney, dependence on renal dialysis, anxiety, and traumatic subdural hemorrhage without loss of consciousness. During an observation and interview on 6/22/26 at 3:07 p.m., R44 was in his room with his significant other, and two packs of cigarettes were observed on a corner table. R44 stated he smoked several times each day. No burn holes in R44's clothing were observed. During an observation on 6/24/26, at 11:46 a.m., R44 self-propelled in his wheelchair from his room to the designated outside smoking area, at the rear of the facility. R44 independently lit his cigarette, held it safely, extinguished his cigarette safely, and placed the cigarette butt in the smoking pole (a tall container where residents placed their cigarette butts). During an observation on 6/24/2026 at 12:04 p.m., R44 was seated in his room as he ate his noon meal. Two packs of cigarettes were on the corner table beside R44. During an observation on 6/24/26, at 3:58 p.m., R44 again wheeled himself in his wheelchair from his room to the designated outside smoking area. R44 managed the entire smoking process correctly and safely. R44's Smoking Evaluation, dated 5/14/26, indicated R44 did not wish to smoke during his stay, and R44 did not utilize oxygen. The remainder of the assessment was blank. R44's Smoking Evaluation, dated 5/24/26, indicated			F0689			

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F0689 SS = D	Continued from page 37 R44 did not wish to smoke during his stay, and the remainder of the assessment was blank. R44's Comprehensive Care Plan lacked information related to smoking. During an interview on 6/25/26 at 7:30 a.m., registered nurse (RN)-E stated R44 smoked independently at least four times a day. RN-E stated when R44 first admitted, he was not smoking and went outside "to get some fresh air." When staff noted R44 was smoking, staff approached R44 and he told staff, "I don't have that much more time to live, so I'm going to smoke." During an interview on 6/25/26 at 8:19 a.m., clinical manager (RN)-F stated he was not the clinical manager for R44's wing when R44 was admitted. and was not aware R44 lacked a comprehensive assessment of his smoking abilities. RN-F stated the facility's expectation was that any resident who smoked, whether known at the time of admission or observed afterwards, was assessed by the facility staff for resident safety. During an interview on 6/25/26 at 8:30 a.m., the director of nursing (DON) stated nursing staff were expected to assess and keep "eyes on" residents who wished to smoke to determine the resident's ability to smoke safely. If a resident was assessed as safe to smoke independently, they would not need supervision, unless there was a change in their status and needed to be reassessed. The facility's Managing Falls and Fall Risk policy, dated 6/2026, indicated that facility staff would attempt to identify appropriate interventions to reduce the risk of falls. The policy indicated that if a systematic evaluation of a resident's fall risk identifies several possible interventions, the staff may choose to prioritize interventions. The facility's Accident Prevention - Smoking Policy, revised 10/2022, indicated the facility shall establish and maintain safe resident smoking practices. Residents whom wish to smoke will be evaluated for "safe smoking" per community protocol. Any smoking-related privileges, restrictions, and concerns (for example, need for close monitoring) shall be noted on the care plan, and all personnel			F0689			

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F0689 SS = D	Continued from page 38 caring for the resident shall be alerted to these issues, per community protocol.			F0689			
F0690 SS = D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review, the facility failed to ensure appropriate provider orders were obtained to maintain an indwelling urinary catheter for 1 of 1 residents (R246) reviewed for catheter care. Findings include:			F0690			

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F0690 SS = D	Continued from page 39 R246's admission Minimum Data Set (MDS), dated 6/16/26 indicated R246 had moderate cognitive impairment, required assistance with activities of daily living (ADLs), and diagnoses included diabetes, atrial fibrillation, hypertension, dementia, and myelodysplastic syndrome (type of cancer in which the bone marrow does not make enough healthy blood cells). R246's Order Summary identified an order dated 6/4/26, for an indwelling (foley) caterer for comfort. However, the order failed to indicate the catheter size and balloon size needed for catheter replacement. R246's treatment administration record (TAR), dated 6/1/26 to 6/30/26 indicated an order for an indwelling (foley) catheter for comfort. However, the orders failed to include catheter size and balloon size needed for catheter replacement. R246's care plan, initiated 6/22/26, indicated R246 had an indwelling foley catheter. However, the care plan lacked the size of catheter and balloon size needed for catheter replacement. During interview on 0/25/26 at 10:56 a.m., registered nurse (RN)-I stated all orders for catheters were expected to include the size of the catheter and amount of normal saline needed to inflate the balloon. RN-I verified R246's orders did not indicate the catheter size and balloon size. During interview on 6/25/26 at 11:21 a.m., RN-H stated all catheter orders should have contained the diagnosis, catheter size and how much to fill the balloon. RN-H verified R246's orders lacked specifics regarding the size of the catheter and balloon size. During interview on 6/25/26 at 11:46 a.m., director of nursing (DON) stated indwelling urinary catheter orders were expected to include the diagnosis, size of the catheter and how much normal saline was to be used to fill the balloon. DON stated R246's orders looked as though no one had updated the order with the required information. DON stated it was important the correct catheter size and balloon volume were used to decrease discomfort.			F0690			

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F0690 SS = D	Continued from page 40			F0690			
	A facility policy was requested for catheter orders, but was not received.						
F0692 SS = D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident-			F0692			
	§483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise;						
	§483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health;						
	§483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet.						
	This REQUIREMENT is NOT MET as evidenced by:						
	Based on interview and document review, the facility failed to ensure timely and effective interventions were implemented for significant, unplanned weight loss and failed to ensure consistency between physician orders and care plan directives related to weight monitoring for 1 of 1 residents (R256) reviewed for weight loss.						
	Findings include:						
	R256's annual Minimum Data Set (MDS) assessment, dated 5/25/26, indicated R256 had severe cognitive impairment, was dependent on staff for all activities of daily living (ADLs), including feeding, and had a diagnosis of weight loss. R256 received a mechanically altered diet and was not on a prescribed weight-loss regimen.						
	R256's physician order, dated 5/1/23, indicated an order for monthly weights. Additional orders included a house supplement shake 4 oz twice daily,						

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F0692 SS = D	Continued from page 41 initiated 1/9/24, for nutritional supplementation and ProStat Advanced Wound Care Liquid daily, initiated, 6/27/25 for wound healing. R256's weight records indicated R256 weighed 153.2 pounds (lbs) on 4/3/26 and 127 lbs on 6/3/26. These weights indicated a weight loss of 26.2 lbs (17.1%) over 2 months. R256's care plan, revised 3/1/23, identified R256 was at risk for altered nutritional/hydration status related to dysphagia, with altered textures, aphasia, hemiplegia, impaired mobility, and cardiac disease. Interventions included feeding assistance and weekly weights. However, R256's care plan directed weekly weights while R256's physician orders directed monthly weights. R256's nutrition progress note, dated 5/22/26, indicated R256's current weight was 127 lbs and identified a recent weight change within the last 30 days. The note indicated no notable change in oral intake over the 30-day lookback period and recommended continuation of the current plan of care. Despite ongoing weight loss trends, no new interventions or escalation of nutritional interventions were implemented at that time. During an interview on 6/24/26 at approximately 2:00 p.m., the registered dietitian (RD) stated residents were generally weighed monthly, but high-risk residents with weight loss were weighed weekly. The RD acknowledged the R256's weight loss trend and stated current interventions were not effective. The RD stated R256 could have received up to three nutritional shakes per day, and weekly weight monitoring should have been initiated to better evaluate trends. During an interview on 6/25/26 at 9:11 a.m., the Licensed Practical Nurse (LPN)-Unit Manager stated weights were typically obtained monthly per physician order. The LPN stated when discrepancies occurred between care plans and orders, staff followed physician orders, and care plans were expected to be updated accordingly. The LPN further stated the R256's weight loss had not been escalated as a concern requiring intervention change. During an interview on 6/25/26 at 11:20 a.m., the director of nursing (DON) stated the resident was monitored as a high-risk resident with weight loss. DON acknowledged R256 continued ongoing nutritional decline and needed for further evaluation of interventions.			F0692			

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F0692 SS = D	Continued from page 42			F0692			
F0695 SS = D	The facility's Weight Assessment and Intervention policy, dated 10/2025, indicated significant unplanned weight loss was greater than 7.5% weight loss in 3 months and care planning should include individualized identification of the cause of the weight loss, goals and benchmarks and interventions should consider resident choices, preferences, and abilities. 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 document review, the facility failed to ensure respiratory care and services were provided according to professional standards of practice and physician orders when the facility failed to ensure tracheostomy orders, included the specific type and size of tracheostomy tube, for 2 of 2 residents (R147 and R152) reviewed for tracheostomy care. In addition, the facility failed to obtain physician orders for oxygen therapy, including prescribed flow rate and administration parameters, for 1 of 3 residents (R152) reviewed for oxygen therapy, and the facility failed to ensure oxygen was administered according to physician orders for 1 of 3 residents (R14) reviewed for oxygen therapy. Findings included: R14 R14's quarterly Minimum Data Set (MDS), dated 4/22/26, identified R14 had intact cognition and required staff assistance with activities of daily living (ADLs). R14's diagnoses included respiratory failure, tracheostomy status (a surgically created opening in the neck to assist with breathing), and acute respiratory failure with hypoxia (low oxygen levels). R14's care plan, dated 5/6/26, identified R14 had a			F0695			

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F0695 SS = D	Continued from page 43 tracheostomy related to impaired breathing mechanics and used a Volera/Metaneb device for secretion management. The care plan directed staff to provide humidified oxygen as prescribed with a goal oxygen saturation greater than or equal to 92%, monitor respiratory status, suction as necessary, and maintain emergency tracheostomy equipment at bedside. R14's physician orders, dated 6/22/26, included an order, initiated 2/24/26, for oxygen at 5 liters per minute (LPM) per tracheostomy collar continuously for hypoxia. During observations on 6/22/26 through 6/25/26, R14's oxygen was set as follows, instead of 5 LPN as per physician orders: On 6/22/26 at 2:04 p.m., R14's oxygen was set at 3 LPM. Additionally, the oxygen tubing contained condensation and was not labeled or dated to identify when it was last changed. On 6/22/26 at 2:04 p.m., R14's oxygen was set at 3 LPM. On 6/23/26 at 1:16 p.m., R14's oxygen was set at 3 LPM. On 6/24/26 at 8:20 a.m., R14's oxygen was set at 3 LPM. On 6/25/26 at 10:53 a.m., R14's oxygen remained set at 3 LPM. R147 R147's quarterly MDS, dated 4/28/26, identified R147 had intact cognition and required staff assistance with ADLs. R147's diagnoses included chronic respiratory failure, respiratory failure, and tracheostomy status. The MDS identified R147 required suctioning and tracheostomy care. R147's care plan, dated 5/11/26, identified R147 had altered respiratory status and difficulty breathing related to tracheostomy status. The care plan directed staff to maintain a clear airway, suction as ordered or required, monitor for signs and symptoms of respiratory distress, and provide oxygen as ordered and needed. Review of R147's physician orders, dated 6/22/26, identified an order initiated 6/12/26, "Name of Trach _____ Size of Trach _____ every shift for Tracheostomy care." However, the type or size of			F0695			

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F0695 SS = D	Continued from page 44 tracheostomy tube used by R147 was not identified. R152 R152's Medicare 5-day MDS, dated 5/28/26, identified R152 had intact cognition and required staff assistance with ADLs. R152's diagnoses included acute respiratory failure with hypoxia, chronic obstructive pulmonary disease (COPD), respiratory failure, and tracheostomy status. The MDS identified R152 received oxygen therapy and required suctioning and tracheostomy care. R152's care plan, dated 5/25/26, identified R152 had a tracheostomy related to impaired breathing mechanics and had a history of adjusting oxygen flow settings despite redirection. The care plan directed staff to check the oxygen flow rate when entering the resident's room, administer humidified oxygen as prescribed, monitor respiratory status, suction as necessary, and maintain emergency tracheostomy equipment at bedside. R152's physician orders, dated 6/22/26, identified an order initiated 6/12/26, "Name of Trach _____ Size of Trach _____ every shift for Tracheostomy care," However, the type or size of tracheostomy tube used by R152 was not identified. Additionally, R152's electronic medical record (EMR) had not included a current physician order for oxygen therapy, prescribed liter flow, delivery method, frequency, or parameters. During observations from 6/22/26 through 6/25/26, R152 received oxygen without a physician order: On 6/22/26 at 3:14 p.m., oxygen was set at 5 LPM. On 6/23/26 at 1:19 p.m., oxygen was set at 4.5 LPM. On 6/24/26 at 8:27 a.m., oxygen was set at 4 LPM. On 6/25/26 at 7:39 a.m., oxygen was set at 6 LPM. During an interview on 6/25/26 at 10:53 a.m., registered nurse (RN)-A stated staff checked physician orders to verify oxygen liter flow and tracheostomy information. RN-A reviewed R14's orders and confirmed R14's oxygen was set at 3 LPM instead of the ordered 5 LPM. RN-A reviewed R152's record and confirmed there was no oxygen order and no order identified the specific type and size of tracheostomy tube. During an interview on 6/25/26 at 11:07 a.m., the registered nurse case manager (RNCM) confirmed			F0695			

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F0695 SS = D	Continued from page 45 R152 did not have an oxygen order or an order identifying the tracheostomy type and size. The RNCM stated oxygen orders should have identified the prescribed liter flow, and tracheostomy orders should have included the type and size. RNCM stated the information was important in vsdr T253'd tracheostomy required replacement during an emergency. During an interview on 6/25/26 at 1:35 p.m., the Director of Nursing (DON) stated she expected the tracheostomy type and size to be included in physician orders. The DON stated she expected oxygen orders to include oxygen use, liter flow, tubing changes, and oxygen saturation monitoring. The DON stated complete respiratory orders were important so staff knew how to appropriately care for residents. The facility's Oxygen Administration policy, dated 3/2026, directed staff to verify there was a physician order for oxygen administration and review the physician orders and care plan before providing oxygen. The policy directed staff to ensure the proper oxygen flow rate was administered and documentation included oxygen flow rate, route, frequency, duration of treatment, and resident response. The facility's Tracheostomy Care policy, dated 3/2026, directed staff to check physician orders prior to providing tracheostomy care. The policy directed staff to ensure emergency tracheostomy equipment was available at bedside and identified a replacement tracheostomy tube must be available at the bedside at all times.			F0695			
F0697 SS = D	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to ensure non-pharmacological pain interventions were offered, implemented, and documented when administering as-needed pain medication for 1 of 1			F0697			

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F0697 SS = D	Continued from page 46 resident (R142) reviewed for pain management. Findings include: R142's diagnoses list, dated 6/12/26, included malignant neoplasm of the prostate with secondary malignant neoplasms of the bone, lung, and lymph nodes, and neoplasm-related pain. R142's Pain Assessment Instrument (PAINAD), dated 6/14/26, documented R142 had no pain. R142's pain assessment, dated 6/16/26, indicated R142 was cognitively intact and had experienced frequent pain during the previous five days. R142's physician orders, dated 6/12/26, included the following as needed (PRN) medications for pain: hydromorphone 8 milligrams (mg) every 2 hours PRN for pain, ibuprofen 600mg every 8 hours PRN for pain, methocarbamol 500-1000mg every 6 hours PRN for muscle spasms, and baclofen 2.5mg two times daily PRN for muscle pain. R142's June 2026 Medication Administration Record (MAR), revealed R142 received PRN hydromorphone up to four times daily 6/12/26 through 6/24/26. Additionally, R142 received PRN ibuprofen one time, and methocarbamol 1000mg one time, between 6/12/26 and 6/24/26. R142's EMR revealed the facility failed to provide and document non-pharmacological pain interventions before or after administration of as-needed pain medication. R142's hospice care plan, initiated 6/15/26, addressed the resident's terminal prognosis related to metastatic prostate cancer. However, individualized, non-pharmacological pain interventions were not identified. During an observation on 6/24/26 at 8:10 a.m., R142's call light was activated. Nurse Manager/Licensed Practical Nurse (LPN)-C responded to the call light. During the encounter, R142 requested pain medication. However, LPN-C did not offer or implement non-pharmacological pain intervention while R142's request was addressed.			F0697			

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F0697 SS = D	Continued from page 47 During an observation on 6/24/26 at 8:15 a.m., LPN-D administered scheduled pain medication, and subsequently administered PRN hydromorphone after R142 requested additional pain medication. However, LPN-D failed to offer or implement any non-pharmacological pain interventions before the PRN narcotic was administered. During an observation and interview on 6/24/26 at 8:32 a.m., nursing assistant (NA)-F assisted R142 with morning cares. NA-F stated R142 frequently experienced significant pain. R142 stated, "I don't think just pills will get this pain away". R142 further stated massage had helped in the past but had not been offered since R142 admitted to the facility. During an interview on 6/24/26 at 10:47 a.m., R142 stated his pain remained “poorly controlled” despite the receipt of pain medication. R142 stated ongoing pain was discussed with the hospice nurse, but no changes had been made. During an observation and interview on 6/24/26 at 1:42 p.m., R142 was in bed and appeared lethargic. R142 stated he felt "out of it" and did not feel well. During an interview on 6/24/26 at 1:28 p.m., registered nurse (RN)-O stated non-pharmacological interventions were documented under behavior management, and staff were expected to document interventions attempted and their effectiveness in a progress note. During an interview on 6/25/26 at 9:11 a.m., LPN-C stated staff were expected to implement non-pharmacological pain interventions, document interventions attempted in progress notes, and document whether those interventions were effective. LPN-C stated staff were expected to communicate with the provider or hospice when scheduled pain medications had not adequately controlled a resident's pain. During an interview on 6/24/26 at 2:53 p.m., the hospice RN case manager stated facility staff had not communicated concerns that R142 continued to experience uncontrolled pain.			F0697			

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F0697 SS = D	Continued from page 48 During an interview on 6/25/26 at 11:20 a.m., the director of nursing (DON), stated the R142's care plan should have identified individualized non-pharmacological pain interventions were to be attempted. The DON stated nursing staff were expected to document in a nurse's note or progress note the non-pharmacological interventions offered and whether the interventions were effective in managing the resident's pain. The facility's Pain Assessment and Management policy, dated 5/2026, directed staff to monitor the frequency of as-needed (PRN) pain medication use and to notify the practitioner when PRN pain medications were being administered around the clock so routine scheduled pain medication could be considered. The policy further indicated pharmacological interventions alone do not typically address the cause of pain and may result in adverse effects. The policy indicated non-pharmacological interventions may be appropriate, either independently or in conjunction with pain medications, as part of pain management.			F0697			
F0726 SS = D	Competent Nursing Staff CFR(s): §483.35(a)(3)(4)(c) §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.71. §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs.			F0726			

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F0726 SS = D	Continued from page 49 §483.35(c) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review, the facility failed to ensure licensed nursing staff demonstrated competency by administering the incorrect dose of a controlled medication and inaccurately documenting controlled substance administration for 1 of 3 residents (R142) reviewed for medication administration. Findings include: R142's diagnoses list, dated 6/12/26, included malignant neoplasm of the prostate with secondary malignant neoplasms of the bone, lung, and lymph nodes, and neoplasm-related pain. R142's physician orders, dated 6/12/26, included an order for Methadone HCl 10 milligram (mg) tablets - 50 milligrams (mg) every morning, 20 mg daily (midday), and 40 mg at bedtime for pain. During observation on 6/24/26 at 8:15 a.m., Licensed Practical Nurse (LPN)-D entered R142's room to administer scheduled medications. During the medication pass, R142 requested as-needed pain medication and LPN-D why there were only two pain pills in his medication cup as he should have five pills. LPN-D told R142 that the medication cup contained his morning dose. Review of R142's methadone medication card revealed all three varying doses of methadone were packaged in the same medication card, with each bubble containing either two, four or five 10mg-tablets. LPN-D stated she removed methadone tablets from the medication card in the order they were packaged, rather than verifying the prescribed dose before administration. LPN-D acknowledged she had administered 20 mg (two 10mg-tablets) instead of the ordered 50 milligrams (five 10mg-tablets) for the scheduled 6/24/26 morning dose. Following R142's medication administration on			F0726			

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F0726 SS = D	Continued from page 50 6/24/26 at 8:15 a.m., LPN-D documented the controlled substance incorrectly in the narcotic accountability record when she recorded an incorrect remaining tablet count. After LPN-D acknowledged she had administered Methadone 20mg instead of 50mg as ordered for R142's morning medication administration, LPN-D corrected the documentation after the error was acknowledged.. During observation and interview on 6/24/26 at approximately 8:45 a.m., LPN-D returned to R142's room with three additional methadone 10mg-tablets, stated hospice had been contacted, and hospice instructed LPN-D to administer the remaining tablets to complete the prescribed morning dose. During an interview on 6/25/26 at 9:11 a.m., Nurse Manager LPN-C stated licensed nurses were expected to follow the five rights of medication administration, verify medication directions prior to administration, review medication parameters, and maintain accurate narcotic accountability records by documenting the correct quantities administered and remaining. LPN-C stated the nurse should have recognized that multiple methadone doses were packaged within the same medication card. During an interview on 6/25/26 at 11:20 a.m., the Director of Nursing (DON), stated licensed nurses were expected to follow the five rights of medication administration by ensuring the right resident, right medication, right dose, right route, and right time before medications were administered. The DON stated nurses were expected to accurately document controlled substance administration and follow up with nurse management if concerns with medication packaging were noted. The facility's Medication Administration policy, dated 10/2025, directed staff to administer medications safely, timely, and as prescribed. The policy required licensed staff to administer medications in accordance with physician orders, verify the right resident, right medication, right dose, right time, and right route before administration by checking the medication label three times, and accurately document medication administration following administration. The policy further directed staff to contact the resident's physician if a prescribed dosage was believed to be inappropriate or excessive and indicated newly authorized staff were not permitted to administer medications until they had been oriented to the facility's medication administration system.			F0726			

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F0756 SS = D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to ensure recommendations from the consulting pharmacist were acted upon timely to reduce the risk of adverse effects for 1 of 5 residents (R9) reviewed for unnecessary medication use.			F0756			

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F0756 SS = D	Continued from page 52 Findings include: R9's admission Minimum Data Set (MDS), dated 4/15/26, indicated R9 had severe cognitive impairment, required assistance with activities of daily living (ADLs), and diagnoses included edema, dementia, hypertension, insomnia and encephalopathy (broad term for any disease, damage, or malfunction that affects the brain). R9's Pharmacy Consultation Report, dated 5/19/26, indicated the facility needed to obtain a psychotropic consent for a new order of trazadone (a psychotropic medication) for insomnia. Additionally, the report indicated the facility needed to monitor R9's sleep while R9 received trazadone. However, R9's medical record lacked evidence that the facility obtained psychotropic consent for R9's trazodone. Additionally, R9's medical record lacked evidence sleep monitoring was completed as recommended. During an interview on 6/25/26 at 11:21 a.m., registered nurse (RN)-H stated nurses obtained consent for a psychotropic medication when a resident was admitted to the facility, or when a new psychotropic medication was ordered. RN-H stated she processed the pharmacy recommendations for the nursing department. RN-H verified R9's medical record lacked evidence of psychotropic consent for trazodone. Additionally, RN-H acknowledged sleep monitoring had not been initiated for R9. RN-H stated the sleep monitoring was important to monitor if R9 was sleeping too much or not sleeping enough. During an interview on 6/25/26 at 11:46 a.m., director of nursing (DON) stated the nurse managers were responsible for completing nursing department pharmacy recommendations. DON stated the nurse managers were expected to complete nursing pharmacy recommendations within a week. A policy for follow up and review of consulting pharmacist recommendations was requested, however, not received.			F0756			

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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 §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 document review, the facility failed to ensure adequate monitoring was completed for 1 of 5 residents (R255) reviewed for unnecessary medications. Findings include: R255's admission Minimum Data Set (MDS), dated 4/30/26, indicated R255 had severe cognitive impairment, required substantial assistance with activities of daily living (ADLs), and diagnoses included hypertension, chronic kidney disease, dementia, diabetes, and anxiety. R255's order summary report, printed 6/25/26, included an order dated 5/12/26 for metoprolol succinate extended release 50 milligrams (mg) by mouth one time daily, hold for systolic blood pressure (SBP) less than 100 or heart rate (HR) less than 60.			F0757			

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F0757 SS = D	Continued from page 54 R255's medication administration records (MAR) for May 2026 and June 2026, indicated R255's blood pressure was monitored. However, R255's MARs failed to indicate R255's heart rate was monitored and recorded as per provider order. During an interview on 6/25/26 at 10:56 a.m., registered nurse (RN)-I stated staff were expected to check a resident's blood pressure and/or heart rate if the orders had parameters to hold a medication. RN-I verified R255's orders indicated metoprolol was to be held if the SBP was less than 100 or HR less than 60. RN-I stated R255's MAR indicated staff needed to obtain R255's blood pressure prior to the administration of R255's metoprolol. RN-I acknowledged R255's MAR failed to prompt staff to obtain R255's heart rate prior. During an interview on 6/25/26 at 11:05 a.m., RN-J stated when a medication required a heart rate and blood pressure to be taken, the order should have triggered staff to check and record the reading. RN-J stated R255's order did not indicate the HR was to be recorded. During an interview on 6/25/26 at 11:46 a.m., director of nursing (DON) stated when an order was entered into the system supplementary documentation was expected to be added to the order to require both the heart rate and blood pressure to be recorded. DON reviewed R255's orders, stated the supplementary pulse (heart rate) was not selected to require the HR to be recorded, so the metoprolol could have been administered if R255's HR was less than 60. The facility's Physician Medication Orders policy, reviewed 10/2025, did not address medication parameters.			F0757			
F0770 SS = D	Laboratory Services CFR(s): 483.50(a)(1)(i) §483.50(a) Laboratory Services. §483.50(a)(1) The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services.			F0770			

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F0770 SS = D	Continued from page 55 (i) If the facility provides its own laboratory services, the services must meet the applicable requirements for laboratories specified in part 493 of this chapter. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to coordinate blood draws as ordered by the provider for 1 of 2 residents (R25) reviewed for dialysis. Findings include: R25's admission Minimum Data Set (MDS) assessment, completed on 5/12/26, indicated R25 was cognitively intact, was able to communicate wishes to others, understood others, and diagnoses included renal insufficiency with dependence on dialysis and anemia. R25's progress note on 6/8/26, at 1:56 p.m., indicated a call was received from the lab to alert facility R25 had a critical lab value of hemoglobin (hgb-the oxygen carrying cells in the blood) was low at 6.9 (normal hemoglobin level is 12 - 16). The note indicated that the provider was updated. The progress notes lacked indication of subsequent blood draws following the last blood draw on 6/15/26. During interview on 6/22/26 at 1:19 p.m., R25 stated he felt good and denied any symptoms of nausea or vomiting, although stated he was tired after dialysis. R25 stated he had his Hgb checked while at dialysis and his most recent lab value was at 8.2. R25 was unable to recall when that was completed. R25 stated the lab tech did come to draw blood on Monday, 6/22/26, however, R25 stated he had requested lab draws be done on his dialysis days as they were already accessing his site for dialysis. However, R25's narrative notes lacked any indication that the lab work had been attempted and declined by resident. Additionally, the documentation lacked indication that there had been follow up with dialysis facility to request labs while at dialysis, or subsequent follow up with the provider to inform them this had not been completed. R25's June 2026 Medication Administration Record (MAR)/Treatment Administration Record (TAR), identified the nurse on Sunday evening, 6/21/26, prepared a lab slip for weekly CBC (complete blood count-a test which reviews hemoglobin, white count and other measurements to assess status) to be drawn Monday, 6/22/26. However, R25's records,			F0770			

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F0770 SS = D	Continued from page 56 lacked evidence labs had been drawn. During observation and interview on 6/24/26 at 10:05 a.m., health unit coordinator (HUC)-B reviewed the lab book to see if blood had been drawn on 6/22/26 as ordered. HUC-B identified the lab draw had not been documented as having been done, nor was there documentation it had been declined, or of any subsequent follow up with the provider. HUC-B stated documentation was completed by the nurses. HUC-B stated a CBC had been drawn on 6/15/26 as ordered, however, there had been no subsequent follow up. HUC-B stated she was unaware if labs were able to be drawn during routine dialysis run. During interview on 6/24/26 at 1:57 p.m., the dialysis registered nurse (DRN)-A stated it was possible to draw lab work while at the dialysis facility, however, the request needed to be completed by nursing or lab, to allow coordination. DRN-A verified via email on 6/24/26 at 5:51 p.m., R25's hgb was last drawn at the dialysis facility on 6/18/26 and was at 8.2. During interview on 6/25/26 at 8:01 a.m., registered nurse/unit manager (RN/UM)-A stated R25 was admitted to the unit with orders for routine blood work. RN/UM-A stated she was unsure why the labs were not drawn on 6/22/26, and identified the documentation lacked rationale for missed draw or request for change in blood draw process at dialysis. During interview on 6/25/26 at 2:26 p.m., the director of nursing (DON) stated it was her expectation that if labs were not drawn as ordered, the nursing staff would investigate as to why it had not been completed as ordered and follow up with provider. DON stated refusal of lab draws, and subsequent follow up were to be documented to reflect this in the medical record. DON stated if it were the request to have labs done during the dialysis session, this was to be coordinated with the dialysis facility. The facility's Lab and Diagnostic Test Results-Clinical Guidelines policy, last reviewed 6/25, identified labs were ordered by the physician, and staff were to process test requisitions and arrange for tests per community and contracted lab protocol. The policy defined that a nurse was to review all results and alert the provider accordingly. The facility's Guidelines for Charting and Documentation policy, last reviewed 6/25, identified the purpose of charting was to document a complete			F0770			

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F0770 SS = D	Continued from page 57 account of the resident's care, treatment, and response to the care. The policy outlined refusal of treatments were to be documented and the information recorded was to include the date and time the treatment, the treatment refused, resident's response and reason for refusal, the date/time the provider was notified, and the provider response.			F0770			
F0790 SS = D	Routine/Emergency Dental Srvcs in SNFs CFR(s): 483.55(a)(1)-(5) §483.55 Dental services. The facility must assist residents in obtaining routine and 24-hour emergency dental care. §483.55(a) Skilled Nursing Facilities A facility- §483.55(a)(1) Must provide or obtain from an outside resource, in accordance with with §483.70(f) of this part, routine and emergency dental services to meet the needs of each resident; §483.55(a)(2) May charge a Medicare resident an additional amount for routine and emergency dental services; §483.55(a)(3) Must have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility; §483.55(a)(4) Must if necessary or if requested, assist the resident; (i) In making appointments; and (ii) By arranging for transportation to and from the dental services location; and §483.55(a)(5) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink			F0790			

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F0790 SS = D	Continued from page 58 adequately while awaiting dental services and the extenuating circumstances that led to the delay. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review, the facility failed to ensure oral health needs were met for 1 of 1 residents (R2) reviewed for denture fit and function resulting in the resident not consistently receiving or using dentures despite documented issues with improper fit and the resident's expressed desire to use them. Additionally, the facility failed to ensure routine dental service recommendations were followed to promote oral hygiene and reduce the risk of complications for 1 of 1 residents (R21) reviewed for dental services. Findings include: R2's quarterly Minimum Data Set (MDS) assessment, dated 4/6/26 indicated R2 was cognitively intact and required partial to moderate assistance with most activities of daily living (ADLs). R2's dental note, dated 10/1/24, documented R2's dentures did not fit properly and required adjustment, with the provider noting additional adjustments may be needed as the resident continued to adapt to new dentures. R2's MDS oral/dental assessment, dated 12/22/25, indicated the R2's dentures did not fit correctly and recommended evaluation for adjustment. R2's care plan, dated 2/22/23 and revised 8/8/25, identified oral/dental health problems and directed staff to provide mouth care as part of ADL assistance. However, the care plan lacked any specific interventions that addressed denture use, management, or follow-up. R2's electronic medical record (EMR) lacked documentation of dental follow-up or evaluation regarding dentures after December 2025. During an observation and interview on 6/22/26 at approximately 11:19 a.m., R2 was observed without dentures in place, and stated the dentures frequently fell out of his mouth and did not fit right. R2 stated staff stopped attempting to assist with denture use			F0790			

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F0790 SS = D	Continued from page 59 so he no longer consistently wore them. R2 stated he wanted to continue using dentures as he was also experiencing gum tenderness. During an interview on 6/24/26 at 10:33 a.m., Nursing Assistant (NA)-E stated R2 needed assistance of one staff for ADLs. NA-E confirmed staff provided oral care, but did not assist with placement or use of dentures, and did not think R2 wore dentures. During an interview on 6/24/26 at 10:53 a.m., the Health Unit Coordinator (HUC) stated the facility utilized both onsite and outside dental providers. HUC stated scheduling was variable and sometimes providers arrived without prior notice. The HUC was not aware of when R2 last received dental services or follow-up regarding dentures. During an interview on 6/24/26 at 1:28 p.m., the Registered Nurse (RN)-O, confirmed R2's treatment record did not indicate R2 currently used dentures, and RN-O was unaware of any denture use. During an interview on 6/25/26 at 9:11 a.m., the Licensed Practical Nurse/Unit Manager (LPN) stated R2 had dentures and LPN was unaware of concerns regarding improper fit. LPN acknowledged no dental follow-up had been completed after R2's 12/2025 dental assessment. R21's annual Minimum Data Set (MDS), dated 4/19/26, identified R21 with intact cognition, no behaviors or limitations in upper and lower extremities, required set up for oral hygiene, and diagnoses included diabetes, heart disease, kidney disease, and partial amputation of left foot. R21's electronic medical record (EMR), including R21's care plan, physician orders and progress notes, failed to identify the provision of denture adhesive. During observation and interview with R21 on 6/22/26 at 11:55 a.m., R21 stated he had both upper and lower dentures and, "they don't fit like they should, and they [facility] were supposed to get back to me about six weeks ago to put something on the bottom dentures but that has not happened" and "the bottom ones fit so bad that I worry I will lose them." No denture adhesive was in R21's room or			F0790			

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F0790 SS = D	Continued from page 60 bathroom. During interview with nursing assistant (NA)-D on 6/23/26 at 3:01 p.m., NA-D stated expectation of nursing assistants to review the resident's EMR prior to providing cares. "I look in computer for what residents need". NA-D stated denture adhesive was expected to be included if needed by the resident. During interview with R21 on 6/23/26 at 3:37 p.m., R21 stated facility failed to offer or provide denture adhesive to ensure his dentures stayed in his mouth. "I have asked several times and it has not been offered". R21's Dental Health Screening assessment, dated 5/8/25, identified "please provide denture adhesive for this resident". R21's Dental Health Screening assessment, dated 3/16/26, identified "He is concerned that his dentures are loose. He has asked for adhesive but has not received anything from the home." During interview with registered nurse (RN)-D on 6/24/26 at 1:19 p.m., RN-D verified R21 had upper and lower dentures. RN-D verified denture adhesive was not in R21's room, and his care plan did not indicate denture adhesive was needed. RN-D stated it "should be in there so we can make sure he gets what he needs". During interview on 6/25/26 at 11:02 a.m., the Director of Nursing (DON) acknowledged the facility did not have a reliable process to ensure residents were consistently offered dental services as required, and stated there was a lack of an effective system to ensure dental recommendations were followed, documented, and incorporated into the care plan. DON stated the systemic breakdown resulted in failure to ensure ongoing assessment and management of R2's oral health needs. Regarding R21, DON stated, "We are supposed to follow recommendations and document that in a progress note and update the care plan and kardex if changes or updates are needed. We do not have a good process now to ensure dental visits are offered as we should because people can miss out on basic routine dental care." The facility's Dentures, Cleaning and Storing policy, dated 10/2025, indicted damaged, broken, ill-fitting, or lost dentures should be documented in the EMR (electronic medical record) and reported to the licensed nurse or social services, as required by facility policy.			F0790			

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F0790 SS = D	Continued from page 61			F0790			
F0880 SS = D	The facility's Medication Orders and Treatment, Dental Services policy, effective 10/2025, indicated medication orders and treatment will be administered by nursing service personnel as soon as the order has been received. Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (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:			F0880			

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F0880 SS = D	Continued from page 62 (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to implement infection prevention and control practices by ensuring staff performed hand hygiene and changed gloves between contaminated and clean resident care tasks during incontinent care for 1 of 1 residents (R142) reviewed for incontinence care. Findings include: R142's admission Minimum Data Set (MDS) assessment was in progress following admission to the facility on 6/12/26. R142's diagnoses, dated 6/12/26, included malignant neoplasm of the prostate with secondary malignant neoplasms of the bone, lung, and lymph nodes, and neoplasm-related pain. R142's pain assessment, dated 6/16/26, indicated			F0880			

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F0880 SS = D	Continued from page 63 R142 was cognitively intact with a Brief Interview for Mental Status (BIMS) score of 14 and had experienced frequent pain during the previous five days. R142's care plan, dated 6/12/26, indicated the resident had a self-care deficit related to a diagnosis of cancer and required moderate assistance with most activities of daily living (ADLs). During observation on 6/24/26 at 8:32 a.m., Nursing Assistant (NA)-F provided incontinence care for R142. NA-F removed R142's soiled brief and cleansed the resident's perineal area using disposable wipes while wearing gloves. Without removing the contaminated gloves, NA-F applied a clean brief. While still wearing the contaminated gloves, NA-F repositioned R142, removed the soiled linens, placed clean sheets and pillowcases on the bed, and handled other clean linen and environmental surfaces. NA-F wore the same contaminated gloves throughout the care provided. During an interview on 6/25/26 at 8:44 a.m., the Infection Preventionist (IP) stated staff were expected to change gloves after completing a dirty task, such as providing perineal care or changing a soiled brief, before moving to a clean task, such as dressing a resident or handling clean linens. The IP further stated staff were expected to perform hand hygiene after removing contaminated gloves and before donning a new pair of gloves. The IP explained these practices were necessary to prevent contamination of clean surfaces, equipment, and resident care items. During an interview on 6/25/26 at 11:20 a.m., the Director of Nursing (DON), confirmed staff were expected to change gloves and perform hand hygiene between dirty and clean care tasks as described by the IP. The facility's Handwashing/Hand Hygiene policy, dated 10/2025, identified hand hygiene as the primary means of preventing the spread of infection and directed staff to perform hand hygiene before and after bathroom care and resident personal hygiene.			F0880			
F0732 SS = C	Posted Nurse Staffing Information CFR(s): §483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information.			F0732			

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F0732 SS = C	Continued from page 64 §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. (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			F0732			

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F0732 SS = C	Continued from page 65 State law, whichever is greater. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review, the facility failed to ensure the staff posting was updated each shift as required, resulting in outdated staffing information being consistently posted over multiple days. This had the ability to affect all 241 residents residing in the care facility. Findings include: From 6/22/26 through 6/25/26, the facility's nurse staffing post was observed to be outdated on multiple occasions. On 6/22/26 at 10:02 a.m., the posted nurse staffing information was dated Friday, 6/19/26. On 6/24/26 at 7:53 a.m., the posted nurse staffing information was dated 6/23/26. On 6/25/26 at 7:50 a.m., the posted nurse staffing information was dated 6/24/26. The posted nurse staffing information had not been updated daily or per shift as required. During an interview on 6/25/26 at 7:46 a.m., front desk staff (O)-1 stated staffing updates were typically maintained by the staffing office. During an interview on 6/25/26 at 7:50am, the staffing coordinator (SC) stated the scheduling staff were responsible for updating the posting on weekdays, and on weekends the house manager was expected to ensure the posting was updated. During an interview on 6/25/26 at 11:20 a.m., the Director of Nursing (DON) stated the expectation was that staff postings were updated each shift to reflect current staffing levels, and on weekends the house supervisor was responsible for ensuring the posted nursing staff information remained accurate and timely. The facility's Posting Direct Care Daily Staffing Numbers policy, dated 10/2025, indicated at the beginning of each shift, the number of Licensed Nurses (RNs, LPNs, and LVNs) and the number of unlicensed nursing personnel (CNAs) directly responsible for resident care will be posted in a prominent location (accessible to residents and visitors) and in a clear and readable format.			F0732			

Minnesota Department of Health

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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 6/22/26 through 6/25/26, 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. The following facility reported incidents were reviewed: NO licensing orders were issued.			20000			

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 H51831153 (iQIES Incident #2978781 with associated Complaint 2976996) H51833022C (iQIES Incident #3049974). The following complaints were reviewed: NO licensing orders were issued. H51831153 (iQIES Incident #2978781 with associated Complaint 2976996) H51831582C (iQIES Complaint #1008831); H51831594C (iQIES Complaint # 2693077); H51831593C (iQIES Complaint #2698232); H51831590C (iQIES Complaint #2701147); H51831587C (iQIES Complaint #2715252); H51831589C (iQIES Complaint #2715569); H51831581C (iQIES Complaint # 2715590); H51831591C (iQIES Complaint #2718107); H51831586C (iQIES Complaint #2722942); H51831585C (iQIES Complaint #2732806); H51831583C (iQIES Complaint #248538709 and 2785303); H51831660C iQIES Complaint #2995084); H51832859C (assigned iQIES Complaint #3038052); H51833012C (iQIES Complaint #3050588 and Incident #3050195). 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."			20000			

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20000	Continued from page 2 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/infobulletins/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			
20300	Competency CFR(s): MN Rule 4658.0105 A nursing home must ensure that direct care staff are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through the comprehensive resident assessments and described in the comprehensive plan of care, and are able to perform their assigned duties. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review, the facility failed to ensure licensed nursing staff demonstrated competency by administering the incorrect dose of a controlled medication and inaccurately documenting controlled substance administration for 1 of 3 residents (R142) reviewed for medication administration. Findings include: R142's diagnoses list, dated 6/12/26, included malignant neoplasm of the prostate with secondary	20300			

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20300	Continued from page 3 malignant neoplasms of the bone, lung, and lymph nodes, and neoplasm-related pain. R142's physician orders, dated 6/12/26, included an order for Methadone HCl 10 milligram (mg) tablets - 50 milligrams (mg) every morning, 20 mg daily (midday), and 40 mg at bedtime for pain. During observation on 6/24/26 at 8:15 a.m., Licensed Practical Nurse (LPN)-D entered R142's room to administer scheduled medications. During the medication pass, R142 requested as-needed pain medication and LPN-D why there were only two pain pills in his medication cup as he should have five pills. LPN-D told R142 that the medication cup contained his morning dose. Review of R142's methadone medication card revealed all three varying doses of methadone were packaged in the same medication card, with each bubble containing either two, four or five 10mg-tablets. LPN-D stated she removed methadone tablets from the medication card in the order they were packaged, rather than verifying the prescribed dose before administration. LPN-D acknowledged she had administered 20 mg (two 10mg-tablets) instead of the ordered 50 milligrams (five 10mg-tablets) for the scheduled 6/24/26 morning dose. Following R142's medication administration on 6/24/26 at 8:15 a.m., LPN-D documented the controlled substance incorrectly in the narcotic accountability record when she recorded an incorrect remaining tablet count. After LPN-D acknowledged she had administered Methadone 20mg instead of 50mg as ordered for R142's morning medication administration, LPN-D corrected the documentation after the error was acknowledged.. During observation and interview on 6/24/26 at approximately 8:45 a.m., LPN-D returned to R142's room with three additional methadone 10mg-tablets, stated hospice had been contacted, and hospice instructed LPN-D to administer the remaining tablets to complete the prescribed morning dose. During an interview on 6/25/26 at 9:11 a.m., Nurse Manager LPN-C stated licensed nurses were expected to follow the five rights of medication administration, verify medication directions prior to administration, review medication parameters, and maintain accurate narcotic accountability records by documenting the correct quantities administered and remaining. LPN-C stated the nurse should have			20300			

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20300	Continued from page 4 recognized that multiple methadone doses were packaged within the same medication card. During an interview on 6/25/26 at 11:20 a.m., the Director of Nursing (DON), stated licensed nurses were expected to follow the five rights of medication administration by ensuring the right resident, right medication, right dose, right route, and right time before medications were administered. The DON stated nurses were expected to accurately document controlled substance administration and follow up with nurse management if concerns with medication packaging were noted. The facility's Medication Administration policy, dated 10/2025, directed staff to administer medications safely, timely, and as prescribed. The policy required licensed staff to administer medications in accordance with physician orders, verify the right resident, right medication, right dose, right time, and right route before administration by checking the medication label three times, and accurately document medication administration following administration. The policy further directed staff to contact the resident's physician if a prescribed dosage was believed to be inappropriate or excessive and indicated newly authorized staff were not permitted to administer medications until they had been oriented to the facility's medication administration system. SUGGESTED METHOD OF CORRECTION: The administrator or designee could develop and/or revise and implement policies and procedures related to nursing oversight and implement a training program for newly hired and/or existing nursing staff. The administrator or designee should ensure oversight is provided to ensure appropriate competency and orientation is provided upon hire, yearly, and as needed. The director of nursing or designee should re-educate staff on the policies and procedures and have a system for evaluating and monitoring consistent implementation of these policies. Audits should be brought to the facility's Quality Assurance Committee for review to determine compliance or the need for further monitoring. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.			20300			
20550	Comprehensive Resident Assessment; Review CFR(s): MN Rule 4658.0400 Subp. 4			20550			

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20550	Continued from page 5 Subp. 4. Review of assessments. A nursing home must examine each resident at least quarterly and must revise the resident's comprehensive assessment to ensure the continued accuracy of the assessment. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to ensure the Minimum Data Set (MDS) was accurately coded, with the potential for inaccurate federal reimbursement and resident care planning for 3 of 3 residents (R12, R15, R123) reviewed for MDS accuracy. Findings include: R12's readmission Minimum Data Set (MDS) assessment, dated 3/20/26 indicated R12 had not had any falls in the month prior to admission/re-admission, and indicated R12 had not had any fractures related to a fall in the 6 months prior to admission/re-admission. R12's quarterly MDS assessment, dated 6/22/26, indicated R12 had no falls in the previous 90 days. R12's care plan indicated R12 was at risk for falls related to cognition, unsteady gait and weakness. The care plan further indicated a fall with fractured hip on 3/9/26. During an interview on 6/25/26 at 11:17 a.m., licensed practical nurse manager (LPN)-A stated R12's readmission MDS assessment dated 3/20/26, and quarterly MDS assessments were inaccurate due to R12's fall with hip fracture on 3/9/26. During an interview on 6/25/26 at 1:52 p.m., Director of Nursing (DON) confirmed R12 had a fall with fracture on 3/9/26, the MDS assessments dated 3/20/26 and 6/22/26 were inaccurately coded. DON stated it was important for the MDS assessments to be accurate so residents received the care they needed and to prevent potential negative outcomes to residents. R15's significant change MDS, dated 4/18/26, indicated R15 took an anticoagulant and not an			20550			

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20550	Continued from page 6 antiplatelet. R15's Medication Administration Record (MAR), dated 4/1/26 to 4/30/26, indicated R15 had not received an anticoagulant during the look back period (LBP), but had received 81 milligrams (mg) of aspirin (an antiplatelet medication) daily during the LBP. During an interview on 6/25/26 at 8:44 a.m., MDS coordinator (MDSC)-A, a registered nurse (RN), reviewed R15's medical record and stated R15 had taken an antiplatelet medication, aspirin, and had not received an anticoagulant medication during the LBP. R123's annual MDS, dated 5/28/26, indicated R123 was taking an anticoagulant and not an antiplatelet. R123's May 2026 MAR, dated 5/1/26 to 5/31/26, indicated R123 had not received an anticoagulant during the look back period (LBP) but did receive 81 milligrams (mg) of aspirin (an antiplatelet medication) daily during the LBP. During an interview on 6/25/26 at 7:57 a.m., RN-G reviewed R123's medical record and stated R123 had not been taking an anticoagulant but did take aspirin. During an interview on 6/25/26 at 8:27 a.m., RN-D, a nurse manager, reviewed R123's medical record. RN-D verified R123 had not taken an anticoagulant since 2021 when it was discontinued. RN-D stated R123 was and had been taking aspirin and verified aspirin was not an anticoagulant. During an interview on 6/25/26 at 8:51 a.m., MDSC-A, reviewed R123's medical record and stated R123 had taken an antiplatelet medication (aspirin), and not an anticoagulant medication during the LBP. MDSC-A verified the MDS was coded incorrectly. During an interview on 6/25/26 at 10:35 a.m., DON stated it was important the MDS was accurate as it affected reimbursement and MDS assessment information directed the care plan and interventions.			20550			

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20550	Continued from page 7 The facility's MDS Assessment Coordinator policy, dated 3/2027, indicated that each individual who completed a portion of the MDS must certify the accuracy of the assessment. SUGGESTED METHOD OF CORRECTION: The administrator or designee could review applicable procedures and policies to ensure the timely and accurate capture of resident information pertaining to the Minimum Data Set (MDS); then educate staff and audit to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.		20550				
20830	Adequate and Proper Nursing Care; General CFR(s): MN Rule 4658.0520 Subp. 1 Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review, the facility failed to ensure fall interventions were implemented to prevent further falls and potential injury for 1 of 3 residents (R6) reviewed for falls. Additionally, the facility failed to comprehensively assess to prevent potential injury for 1 of 1 residents (R44) reviewed for smoking. Findings include: R6's annual Minimum Data Set (MDS), dated 6/8/26, indicated R6 was cognitively intact, had not rejected cares, was independent with activities of daily living (ADLs), and diagnoses included arthritis and depression. R6's progress note, dated 5/14/26 at 5:13 a.m., indicated that R6 slid from bed and was found on the floor with no injuries observed.		20830				

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20830	Continued from page 8 R6's fall risk management, dated 5/14/26, indicated R6 had fallen out of bed and was found on her bedside floor by staff. The report indicated R6 stated she was rolling in her bed when she had fallen. The report indicated R6 thought the bed was too small, causing her to fall off her bed, and R6 was given a new and bigger bed to reduce the risk of falling. R6's care plan, dated 5/18/26, indicated R6 was at risk for falls related to gait and balance problems and had fallen on 7/8/25, 1/25/26, 2/10/26, and 5/14/26. The care plan indicated that related to a fall on 5/14/26, R6 was "given a bigger bed". R6's progress note, dated 6/22/26 at 5:22 a.m., indicated R6 was found lying on the floor beside her bed, and R6 had stated she was lying on her side in bed and attempted to roll toward the side of the bed and rolled out of bed. The progress note indicated that R6 did not have any injuries at the time of the assessment. During multiple observations on 6/23/26, other beds on the unit were observed and compared to R6's bed. R6's bed appeared to be the standard bed size. During an interview on 6/22/26 at 1:38 p.m., R6 stated she had fallen out of bed a couple of times when trying to reposition herself in bed, and felt her bed was too small. R6 stated she thought she was going to get a bigger bed but never did. During an observation and interview on 6/23/26 at 12:53 p.m., registered nurse (RN)-B stated R6 had a history of falls and R6 was supposed to have given a bigger bed. RN-B stated it appeared R6 had gotten a larger bed because the one R6 had was a "normal-sized" bed. During an interview on 6/23/26 at 1:02 p.m., licensed practical nurse (LPN)-A, the nurse manager for the unit, stated as the fall intervention for R6's fall on 5/14/26, LPN-A ordered a larger bed and thought R6 had received it. LPN-A stated it appeared R6 had not received a larger bed and LPN-A needed to talk to the director of maintenance (DM) to determine what happened.			20830			

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20830	Continued from page 9 During an interview on 6/23/26 at 1:07 p.m., the DM stated R6's bed was the standard-sized bed, and R6 had not been provided with a larger one. During a follow-up interview on 6/24/26 at 1:37 p.m., the DM stated there had been a miscommunication between maintenance and nursing. The DM stated nursing had indicated that a larger mattress was needed, but R6 already had the largest mattress size for her bed frame. The DM stated the ticket had then been "closed out" and a larger bed was not ordered. R44's admission Minimum Data Set (MDS), dated 5/13/26, indicated resident was cognitively intact and received supervision to moderate assistance with all activities of daily living (ADLs). R44's Face Sheet, printed 6/25/26, indicated R44 diagnoses included malignant neoplasm of unspecified kidney, dependence on renal dialysis, anxiety, and traumatic subdural hemorrhage without loss of consciousness. During an observation and interview on 6/22/26 at 3:07 p.m., R44 was in his room with his significant other, and two packs of cigarettes were observed on a corner table. R44 stated he smoked several times each day. No burn holes in R44's clothing were observed. During an observation on 6/24/26, at 11:46 a.m., R44 self-propelled in his wheelchair from his room to the designated outside smoking area, at the rear of the facility. R44 independently lit his cigarette, held it safely, extinguished his cigarette safely, and placed the cigarette butt in the smoking pole (a tall container where residents placed their cigarette butts). During an observation on 6/24/2026 at 12:04 p.m., R44 was seated in his room as he ate his noon meal. Two packs of cigarettes were on the corner table beside R44. During an observation on 6/24/26, at 3:58 p.m., R44 again wheeled himself in his wheelchair from his room to the designated outside smoking area. R44 managed the entire smoking process correctly and			20830			

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20830	Continued from page 10 safely. R44's Smoking Evaluation, dated 5/14/26, indicated R44 did not wish to smoke during his stay, and R44 did not utilize oxygen. The remainder of the assessment was blank. R44's Smoking Evaluation, dated 5/24/26, indicated R44 did not wish to smoke during his stay, and the remainder of the assessment was blank. R44's Comprehensive Care Plan lacked information related to smoking. During an interview on 6/25/26 at 7:30 a.m., registered nurse (RN)-E stated R44 smoked independently at least four times a day. RN-E stated when R44 first admitted, he was not smoking and went outside "to get some fresh air." When staff noted R44 was smoking, staff approached R44 and he told staff, "I don't have that much more time to live, so I'm going to smoke." During an interview on 6/25/26 at 8:19 a.m., clinical manager (RN)-F stated he was not the clinical manager for R44's wing when R44 was admitted. and was not aware R44 lacked a comprehensive assessment of his smoking abilities. RN-F stated the facility's expectation was that any resident who smoked, whether known at the time of admission or observed afterwards, was assessed by the facility staff for resident safety. During an interview on 6/25/26 at 8:30 a.m., the director of nursing (DON) stated nursing staff were expected to assess and keep "eyes on" residents who wished to smoke to determine the resident's ability to smoke safely. If a resident was assessed as safe to smoke independently, they would not need supervision, unless there was a change in their status and needed to be reassessed. The facility's Managing Falls and Fall Risk policy, dated 6/2026, indicated that facility staff would attempt to identify appropriate interventions to reduce the risk of falls. The policy indicated that if a systematic evaluation of a resident's fall risk identifies several possible interventions, the staff may choose to prioritize interventions.			20830			

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20830	Continued from page 11 The facility's Accident Prevention - Smoking Policy, revised 10/2022, indicated the facility shall establish and maintain safe resident smoking practices. Residents whom wish to smoke will be evaluated for "safe smoking" per community protocol. Any smoking-related privileges, restrictions, and concerns (for example, need for close monitoring) shall be noted on the care plan, and all personnel caring for the resident shall be alerted to these issues, per community protocol. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON), or designee, could review and revise (as needed) applicable policies and procedures pertaining to fall interventions and smoking safety; then educate staff on the completion of these safety assessments/interventions; then audit to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.		20830				
20960	Dietary Service - Food Quality CFR(s): MN Rule 4658.0600 Subp. 1 Subpart 1. Food quality. Food must have taste, aroma, and appearance that encourages resident consumption of food. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, and interview, the facility failed to ensure food was served in a timely manner to preserve desired temperatures of food for 5 of 5 residents (R3, R28, R156, R197, R294) reviewed who expressed concerns for food temperatures and palatability. This had the potential to affect all residents who consumed food from the facility kitchen. Findings include: R3's quarterly Minimum Data Set (MDS) assessment, dated 3/16/26, identified R3 had intact cognition with an admission date of 11/13/24. During an interview on 6/24/26 at 10:23 a.m., R3 stated she ate in the main dining room on 2W, and she had brought up the concern of cold food to staff previously.		20960				

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20960	Continued from page 12 R28's quarterly MDS assessment, dated 5/31/26, identified R28 had intact cognition with an admission date of 10/24/25. During an interview on 6/24/26 at 10:23 a.m., R28 stated the food was always cold. It didn't make a difference if you ate in your room or in the dining room. R28 stated he ate in both places and had brought up the concern of cold food to staff previously. R156's quarterly MDS assessment, dated 5/25/26, identified R156 had intact cognition with an admission date of 2/18/26. During an interview on 6/24/26 at 10:23 a.m., R156 stated the food was served cold when it should be hot most of the time. R156 stated he ate in the dining room most of the time and had brought up the concern of cold food to staff previously. R197's quarterly MDS assessment, dated 6/4/26, identified R128 had intact cognition with an admission date of 11/25/25. During an interview on 6/24/26 at 10:23 a.m., R197 stated the French fries were "always cold." R197 stated he ate in the main dining room on 2W most of the time and had brought up the concern of cold food to staff previously. R294's quarterly MDS assessment, dated 4/1/26, identified R294 had intact cognition with an admission date of 1/17/26. During an interview on 6/22/26 at 1:02 p.m., R294 stated the food was served cold when it should have been hot. Furthermore, R294 stated the flavor "wasn't always great". During an observation and interview on 6/24/26 at 12:56 p.m., dining staff, including the dietary manager (DM), were observed serving food from the 3 west dining room. After all resident meals were plated, DM temped the food that remained in the food warmer. The following temperatures were obtained: turkey 164 degrees Fahrenheit (F), green beans 173.8 F and sweet potato 149.5 F. After the temperatures were obtained, the food remained on the warming table. The DM then followed the meal cart into the memory care unit, waited until the last tray was ready to be served, and obtained the following food temperatures from the last tray: turkey 103.5 F, green beans 96.5 F, and sweet potato 102.4 F. DM stated all the food should have been			20960			

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20960	Continued from page 13 above 140 degrees at the time it was served, regardless of if it was in the dining room or served in the resident room. DM stated food temperatures that were below 140 degrees were in the "danger zone" and increased the potential for food-born illnesses. SUGGESTED METHOD OF CORRECTION: The administrator, registered dietician, or designee could ensure proper temperature for meals served. The facility could update or create policies and procedures, and educate staff on proper temperature for meals served to residents. The administrator, registered dietician, or designee could perform audits for a designated amount of time as determined by the Quality Assurance Performance Improvement (QAPI) committee to ensure proper temperatures of meals served to residents. The facility could report those findings to QAPI for further recommendations and determine the need for further monitoring or compliance. TIME PERIOD FOR CORRECTION: 21 days		20960				
20965	Dietary Service -Nutritional Status CFR(s): MN Rule 4658.0600 Subp. 2 Subpart. 2. Nutritional status. The nursing home must ensure that a resident is offered a diet which supplies the caloric and nutrient needs as determined by the comprehensive resident assessment. Substitutes of similar nutritive value must be offered to residents who refuse food served. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to ensure timely and effective interventions were implemented for significant, unplanned weight loss and failed to ensure consistency between physician orders and care plan directives related to weight monitoring for 1 of 1 residents (R256) reviewed for weight loss. Findings include: R256's annual Minimum Data Set (MDS) assessment, dated 5/25/26, indicated R256 had severe cognitive impairment, was dependent on staff for all activities of daily living (ADLs), including feeding, and had a diagnosis of weight loss. R256 received a mechanically altered diet and was not on a prescribed weight-loss regimen.		20965				

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20965	Continued from page 14 R256's physician order, dated 5/1/23, indicated an order for monthly weights. Additional orders included a house supplement shake 4 oz twice daily, initiated 1/9/24, for nutritional supplementation and ProStat Advanced Wound Care Liquid daily, initiated, 6/27/25 for wound healing. R256's weight records indicated R256 weighed 153.2 pounds (lbs) on 4/3/26 and 127 lbs on 6/3/26. These weights indicated a weight loss of 26.2 lbs (17.1%) over 2 months. R256's care plan, revised 3/1/23, identified R256 was at risk for altered nutritional/hydration status related to dysphagia, with altered textures, aphasia, hemiplegia, impaired mobility, and cardiac disease. Interventions included feeding assistance and weekly weights. However, R256's care plan directed weekly weights while R256's physician orders directed monthly weights. R256's nutrition progress note, dated 5/22/26, indicated R256's current weight was 127 lbs and identified a recent weight change within the last 30 days. The note indicated no notable change in oral intake over the 30-day lookback period and recommended continuation of the current plan of care. Despite ongoing weight loss trends, no new interventions or escalation of nutritional interventions were implemented at that time. During an interview on 6/24/26 at approximately 2:00 p.m., the registered dietitian (RD) stated residents were generally weighed monthly, but high-risk residents with weight loss were weighed weekly. The RD acknowledged the R256's weight loss trend and stated current interventions were not effective. The RD stated R256 could have received up to three nutritional shakes per day, and weekly weight monitoring should have been initiated to better evaluate trends. During an interview on 6/25/26 at 9:11 a.m., the Licensed Practical Nurse (LPN)-Unit Manager stated weights were typically obtained monthly per physician order. The LPN stated when discrepancies occurred between care plans and orders, staff followed physician orders, and care plans were expected to be updated accordingly. The LPN further stated the R256's weight loss had not been escalated as a concern requiring intervention change. During an interview on 6/25/26 at 11:20 a.m., the director of nursing (DON) stated the resident was monitored as a high-risk resident with weight loss.			20965			

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20965	Continued from page 15 DON acknowledged R256 continued ongoing nutritional decline and needed for further evaluation of interventions. The facility's Weight Assessment and Intervention policy, dated 10/2025, indicated significant unplanned weight loss was greater than 7.5% weight loss in 3 months and care planning should include individualized identification of the cause of the weight loss, goals and benchmarks and interventions should consider resident choices, preferences, and abilities. SUGGESTED METHOD OF CORRECTION: The administrator, registered dietician, or designee should ensure dietary interventions are implemented in a timely manner. The facility should review and/or update or create policies and procedures and educate staff on specific requirements or interventions related to weight and nutrition. The administrator, registered dietician, or designee should perform audits for a measurable amount of time as determined by the Quality Assurance Performance Improvement (QAPI) committee to ensure food items given, offered, or consumed by residents are implemented as identified or ordered. The facility should report those findings to QAPI for further recommendations and determine the need for further monitoring or compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.		20965				
21340	Providing Routine & Emergency Oral Health Ser CFR(s): MN Rule 4658.0725 Subp. 4 Subp. 4. Dental records. For each dental visit, the clinical record must include the name of the dentist or dental hygienist, date of the service, specific dental services provided, medications administered, medical or dental consultations, and follow-up orders. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review, the facility failed to ensure oral health needs were met for 1 of 1 residents (R2) reviewed for denture fit and function resulting in the resident not consistently receiving or using dentures despite documented issues with improper fit and the resident's expressed desire to use them.		21340				

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21340	Continued from page 16 Additionally, the facility failed to ensure routine dental service recommendations were followed to promote oral hygiene and reduce the risk of complications for 1 of 1 residents (R21) reviewed for dental services. Findings include: R2's quarterly Minimum Data Set (MDS) assessment, dated 4/6/26 indicated R2 was cognitively intact and required partial to moderate assistance with most activities of daily living (ADLs). R2's dental note, dated 10/1/24, documented R2's dentures did not fit properly and required adjustment, with the provider noting additional adjustments may be needed as the resident continued to adapt to new dentures. R2's MDS oral/dental assessment, dated 12/22/25, indicated the R2's dentures did not fit correctly and recommended evaluation for adjustment. R2's care plan, dated 2/22/23 and revised 8/8/25, identified oral/dental health problems and directed staff to provide mouth care as part of ADL assistance. However, the care plan lacked any specific interventions that addressed denture use, management, or follow-up. R2's electronic medical record (EMR) lacked documentation of dental follow-up or evaluation regarding dentures after December 2025. During an observation and interview on 6/22/26 at approximately 11:19 a.m., R2 was observed without dentures in place, and stated the dentures frequently fell out of his mouth and did not fit right. R2 stated staff stopped attempting to assist with denture use so he no longer consistently wore them. R2 stated he wanted to continue using dentures as he was also experiencing gum tenderness. During an interview on 6/24/26 at 10:33 a.m., Nursing Assistant (NA)-E stated R2 needed assistance of one staff for ADLs. NA-E confirmed staff provided oral care, but did not assist with placement or use of dentures, and did not think R2 wore dentures.			21340			

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21340	Continued from page 17 During an interview on 6/24/26 at 10:53 a.m., the Health Unit Coordinator (HUC) stated the facility utilized both onsite and outside dental providers. HUC stated scheduling was variable and sometimes providers arrived without prior notice. The HUC was not aware of when R2 last received dental services or follow-up regarding dentures. During an interview on 6/24/26 at 1:28 p.m., the Registered Nurse (RN)-O, confirmed R2's treatment record did not indicate R2 currently used dentures, and RN-O was unaware of any denture use. During an interview on 6/25/26 at 9:11 a.m., the Licensed Practical Nurse/Unit Manager (LPN) stated R2 had dentures and LPN was unaware of concerns regarding improper fit. LPN acknowledged no dental follow-up had been completed after R2's 12/2025 dental assessment. R21's annual Minimum Data Set (MDS), dated 4/19/26, identified R21 with intact cognition, no behaviors or limitations in upper and lower extremities, required set up for oral hygiene, and diagnoses included diabetes, heart disease, kidney disease, and partial amputation of left foot. R21's electronic medical record (EMR), including R21's care plan, physician orders and progress notes, failed to identify the provision of denture adhesive. During observation and interview with R21 on 6/22/26 at 11:55 a.m., R21 stated he had both upper and lower dentures and, "they don't fit like they should, and they [facility] were supposed to get back to me about six weeks ago to put something on the bottom dentures but that has not happened" and "the bottom ones fit so bad that I worry I will lose them." No denture adhesive was in R21's room or bathroom. During interview with nursing assistant (NA)-D on 6/23/26 at 3:01 p.m., NA-D stated expectation of nursing assistants to review the resident's EMR prior to providing cares. "I look in computer for what residents need". NA-D stated denture adhesive was expected to be included if needed by the resident. During interview with R21 on 6/23/26 at 3:37 p.m., R21 stated facility failed to offer or provide denture adhesive to ensure his dentures stayed in his			21340			

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21340	Continued from page 18 mouth. "I have asked several times and it has not been offered". R21's Dental Health Screening assessment, dated 5/8/25, identified "please provide denture adhesive for this resident". R21's Dental Health Screening assessment, dated 3/16/26, identified "He is concerned that his dentures are loose. He has asked for adhesive but has not received anything from the home." During interview with registered nurse (RN)-D on 6/24/26 at 1:19 p.m., RN-D verified R21 had upper and lower dentures. RN-D verified denture adhesive was not in R21's room, and his care plan did not indicate denture adhesive was needed. RN-D stated it "should be in there so we can make sure he gets what he needs". During interview on 6/25/26 at 11:02 a.m., the Director of Nursing (DON) acknowledged the facility did not have a reliable process to ensure residents were consistently offered dental services as required, and stated there was a lack of an effective system to ensure dental recommendations were followed, documented, and incorporated into the care plan. DON stated the systemic breakdown resulted in failure to ensure ongoing assessment and management of R2's oral health needs. Regarding R21, DON stated, "We are supposed to follow recommendations and document that in a progress note and update the care plan and kardex if changes or updates are needed. We do not have a good process now to ensure dental visits are offered as we should because people can miss out on basic routine dental care." The facility's Dentures, Cleaning and Storing policy, dated 10/2025, indicted damaged, broken, ill-fitting, or lost dentures should be documented in the EMR (electronic medical record) and reported to the licensed nurse or social services, as required by facility policy. The facility's Medication Orders and Treatment, Dental Services policy, effective 10/2025, indicated medication orders and treatment will be administered by nursing service personnel as soon as the order has been received. SUGGESTED METHOD OF CORRECTION: The administrator or designee could develop/revise and implement policies and procedures related to dental recommendations and educate staff on these			21340			

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21340	Continued from page 19 requirements. The quality assessment and assurance committee could perform random audits to ensure compliance.			21340			
	TIME PERIOD FOR CORRECTION: Twenty One (21) days						
21426	Tuberculosis Prevention And Control CFR(s): MN St. Statute 144A.04 Subd. 3 (a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines. (b) Written compliance with this subdivision must be maintained by the nursing home. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to ensure tuberculosis (TB) screening was completed and documented according to Minnesota tuberculosis screening requirements and facility policy for 3 of 3 residents (R12, R152, and R255) reviewed for TB screening. Findings included: R12 was admitted to the facility on 12/18/25. R12's December 2025 medication administration record (MAR) identified the first step Mantoux tuberculosis test was completed. However, the January 2026 MAR lacked documentation the required second step Mantoux tuberculosis test was administered and completed. R152 was admitted to the facility on 4/9/26. R152's April 2026 MAR identified the first step Mantoux tuberculosis test was completed. The second step Mantoux tuberculosis test was administered on			21426			

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21426	Continued from page 20 4/23/26. However, the MAR lacked documentation the second step Mantoux test was read and the results were documented. R255 was admitted to the facility on 4/23/26. R255's April 2026 MAR lacked documentation the required first and second step Mantoux tuberculosis testing was completed. The MAR identified R255 refused Mantoux testing after two attempts. However, the electronic health record (EHR) lacked documentation staff continued attempts to complete the screening, notified the provider, or obtained an alternative TB screening method. During an interview on 6/25/26 at 8:44 a.m., the infection preventionist (IP) reviewed R12, R152, and R255's medical records and confirmed the required tuberculosis screening process was not completed. IP confirmed R12's second step Mantoux tuberculosis test was not administered, R152's second step Mantoux tuberculosis test was administered but not documented as read, and R255 refused Mantoux testing after two attempts with no further follow-up completed. IP stated staff were expected to complete the first Mantoux test upon admission, and the second step within the required timeframe. If testing was refused, staff were expected to continue to make attempts, notify the provider if refusal continued, and alternative screening options should have been pursued, such as a TB blood test or chest x-ray, to identify potential active tuberculosis and prevent transmission within the facility. During an interview on 6/25/26 at 1:40 p.m., the director of nursing (DON) stated residents who were able to complete the two-step Mantoux testing series were expected to have the testing completed. The DON stated if a resident refused testing, staff were expected to follow up with alternative screening options, including a TB blood test or chest x-ray. The DON stated completion of TB screening was important to ensure residents were screened for tuberculosis. The facility's Tuberculosis (TB) Screening Residents policy, revised 1/2025, identified the facility would screen all residents for tuberculosis infection and disease. The policy identified residents without documentation of a negative tuberculin skin test (TST), blood assay for Mycobacterium tuberculosis (BAMT), or chest x-ray (CXR) within the previous 12 months would receive a baseline two-step TST or one-step BAMT upon admission. The policy further identified if the first TST was negative, a follow-up TST would be administered one to three weeks after			21426			

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21426	Continued from page 21 the initial test was read. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could develop and/or revise, and implement policies and procedures related to resident TB screening. The DON or designee should ensure oversight to ensure completion and follow up of TB screening, and provide education/re-education as needed. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.			21426			
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 document review, the facility failed to assess resident for safety and the ability to self-administer medications for 1 of 1 resident (R21) reviewed for self-administration of medications (SAM). Findings include: R21's annual Minimum Data Set (MDS), dated 4/19/26, identified R21 was cognitively intact, and diagnoses included diabetes, heart disease, and kidney disease. R21's physician progress note, dated 1/20/26, identified R21 medication order for nystatin ointment 100000 unit/gram to groin and intergluteal cleft (the deep vertical groove between the buttocks) topically two times a day for fungal rash/dry skin, and with every brief change. R21's electronic medical record (EMR) identified physician orders for nystatin ointment was discontinued on 5/7/26. During an observation and interview on 6/23/26 at			21565			

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21565	Continued from page 22 3:37 p.m., R21 had a nearly empty tube of prescription nystatin ointment, with label attached listing R21's name, and instructions for use as indicated on the 1/20/26 medication order, and the label indicated dates of "Jan 20, 2026, to Feb 20, 2026". R21 stated nystatin remained on his rolling bedside table or top of nightstand since January of 2026. R21 stated he applied the ointment when he felt he needed it. R21 stated staff were aware he had it in his room. R21 stated facility staff had never talked to him about an assessment to determine safety and competence to keep the prescription ointment in his room. During an observation on 6/24/26 at 1:11 p.m., R21's rolling bedside table had a nearly empty tube of the prescription Nystatin ointment. During an interview on 6/24/26 at 11:21 a.m., RN-M stated nurses were to document an assessment in the resident EMR if a resident wished to keep prescription and over the counter (OTC) medications at bedside. When a resident was assessed as safe to self-administer their medications, a provider order for self-administration was obtained and the care plan was updated. RN-M stated complete and accurate medication orders were important due to potential risk of contraindications. During an interview on 6/24/26 at 11:28 a.m., RN-L stated nursing staff were expected to document an assessment in the resident EMR if a resident wished to keep prescription and/or over-the-counter medications at bedside. RN-L stated residents should not have prescription or OTC medications in their rooms unless an assessment was completed and documented in the EMR. RN-L stated, "we don't want [residents] medicating themselves and potentially harm[ing] them". During observation and interview on 6/24/26 at 1:12 p.m., RN-D confirmed the prescription nystatin ointment was in R21's room and verified it was prescribed to R21. RN-D stated the nystatin ointment "should not be here because we need to know all meds". RN-D verified a self-administration of medications assessment had not been completed for R21. RN-D stated the discontinued nystatin order meant the nystatin should have been removed from R21's room when it was discontinued. During an interview on 6/25/26 at 10:56 a.m.,			21565			

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21565	Continued from page 23 director of nursing (DON) stated nurses were expected to document a self-administration assessment for all prescribed and OTC medications left in a resident room. DON stated when a resident was assessed to be safe to self-administer a medication, a provider order for SAM was obtained by staff and documented in the EMR, and the care plan was updated. DON verified R21 was never assessed for safe self-administration of medication, and the order and care plan were never updated. The facility's Self-Administration of Drugs policy, dated 11/2016, indicated residents in our facility who wish to self-administer their medications may do so, if it is determined that they are capable of doing so and clinically appropriate. For self-administering residents, the nursing staff will determine who will be responsible (the resident or the nursing staff) for documenting that medications were taken. The nursing staff will rotate bedside stock and will remove expired, discontinued, or recalled medications. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review applicable policies and procedures to ensure residents' are assessed timely with self administration of all prescribed and over the counter medications; then provide staff education. The quality assurance committee could monitor for compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.			21565			
21615	MedicineCabinet & Preparation Area;ScheduleII CFR(s): MN Rule 4658.1340 Subp. 2 Subp. 2. Storage of Schedule II drugs. A nursing home must provide separately locked compartments, permanently affixed to the physical plant or medication cart for storage of controlled drugs listed in Minnesota Statutes, section 152.02, subdivision 3. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to ensure controlled substance reconciliation was completed in accordance with established policies and procedures			21615			

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21615	Continued from page 24 to reduce the risk of diversion and/or theft on 2 of 8 medication carts reviewed. This had the potential to affect 8 residents identified to have controlled substances in the reviewed carts. Findings include: During an observation and interview on 6/23/26 at 1:54 p.m., the 2W “far south” medication cart was reviewed with registered nurse (RN)-A. The mobile cart was locked with a physical key, along with a separately attached metal narcotic box, which was also locked. The narcotic box was opened and contained numerous controlled substances. RN-A explained that the narcotics and controlled substances were counted at each shift exchange, and these reconciliations were recorded on a Narcotic Shift to Shift Signature form. RN-A provided the flow sheets used to track the documented count(s). However, approximately half of the signature spaces were blank. RN-A confirmed the form had approximately half of the spaces filled and stated all the signature spots should have been completed. RN-A stated she did not know why spaces were blank. The facility's 2 West FS (far south) Narcotic Shift to Shift Signature Sheet, for June 2026, indicated there were 132 possible signature spaces, with 106 documented signatures for 6/1/26 through 6/26/26. During an observation and interview on 6/23/26 at 2:03 p.m., with RN-B and RN-C, the 2W “near south” mobile medication cart was observed locked with a physical key, along with a separately attached metal narcotic box, which was also locked. The narcotic box was opened and contained numerous controlled substances. RN-C explained the narcotics and controlled substances were counted at each shift exchange, and these reconciliations were recorded on a form to indicate the count had occurred. RN-C provided the flow sheets used to track the documented count(s). However, approximately half of the signature spaces were blank. The facility's 2 West NS (near south) Narcotic Shift to Shift Signature Sheet, June 2026, indicated there were 132 possible signature spaces for 6/1/26 to 6/22/26. However, there were 41 signatures total on the sheet for 6/1/26 through 6/22/26.			21615			

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21615	Continued from page 25 During an interview on 6/23/26 at 2:09 p.m., the nurse manager/ licensed practical nurse (LPN)-A stated staff were expected to sign the controlled medication reconciliation form to indicate that controlled medication reconciliation had occurred. LPN-A confirmed approximately half the signatures were missing on the 2W NS form. LPN-A stated that based on documentation, he was unable to confirm that medication reconciliation had occurred. During an interview on 6/24/26 at 10:17 a.m., the director of nursing (DON) stated nursing staff were expected to complete controlled medication reconciliation at each shift change, and the reconciliation should have been documented on the narcotic shift change forms. The facility's Controlled Substances policy, dated 10/2026, indicated the controlled substance records would be reconciled by a physical count of the remaining controlled substance supply at the change of each shift by the oncoming and outgoing licensed nurse/designee. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could develop, review, and/or revise policies and procedures to ensure narcotic medications were signed into the bound narcotic book using the index page to minimize the potential for diversion. The Director of Nursing or designee could educate all appropriate staff on the policies and procedures.The Director of Nursing or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.			21615			
21805	Patients & Residents of HC Fac.Bill of Rights CFR(s): MN St. Statute 144.651 Subd. 5 Subd. 5. Courteous treatment. Patients and residents have the right to be treated with courtesy and respect for their individuality by employees of or persons providing service in a health care facility. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review, the facility failed to provide a dignified dining			21805			

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21805	Continued from page 26 experience for 7 of 7 residents (R28, R124, R128, R197, R233, R244, R257) when meals were served on hard plastic trays in the dining room. Further, the facility failed to ensure resident's right to privacy and dignity for 1 of 1 residents (R2) when staff failed to knock and wait for permission before entering the resident's room. Findings include: R28's quarterly Minimum Data Set (MDS) assessment, dated 5/31/26, indicated R28 had intact cognition, and an admission date of 10/24/25. R124's quarterly MDS assessment, dated 4/13/26, indicated R124 had severely impaired cognition, no hallucinations or delusions, and an admission date of 11/21/18. R128's annual MDS assessment, dated 5/16/26, indicated R128 had short-term and long-term memory issues, severely impaired daily decision making, and an admission date of 11/13/20. R197's quarterly MDS assessment, dated 6/4/26, indicated R128 had intact cognition, and an admission date of 11/25/25. R233's quarterly MDS assessment, dated 4/28/26, indicated R233 had moderately impaired cognition and an admission date of 10/18/24. R244's quarterly MDS assessment, dated 5/1/26, indicated R244 had short term and long-term memory issues, severely impaired daily decision making, and an admission date of 4/5/19. R257's annual MDS assessment, dated 6/14/26, indicated R257 had moderately impaired cognition, no hallucinations or delusions, and an admission date of 8/26/22. During an observation of lunch service on 6/23/26 at 12:59 p.m., 5 residents (R124, R128, R233, R244, R257) were observed eating in the small dining room on the 2W unit, with two staff observed assisting residents at the tables. Positioned on the table in front of each resident was a meal on a hard plastic			21805			

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21805	Continued from page 27 serving tray. Each hard plastic tray had a food plate, silverware, and beverage containers on it. The warming lids from the plates were tipped upside down on the table in front of the residents. During an observation of lunch service on 6/24/26 at 11:46 a.m., the lunch meal service was observed on the 2nd floor west main dining room. The dining room had a steam serving table with food items. The staff placed the food items, beverages, and silverware onto a hard plastic serving tray. The meals were then delivered to each resident at their table. However, the hard plastic servicing trays were then left on the table with plated food, beverages and silverware on top of them. Staff did not ask or offer to remove the items from the serving trays and place them onto the table. R28 and R197 were observed eating from the hard plastic meal tray. R197 stated he did not like the hard plastic serving trays and would not eat from one at home. During an observation on 6/25/26 at 8:03 a.m., breakfast meal service was observed on 2nd floor west main dining room. The residents ate in the dining room and their breakfast meal was served on the hard plastic serving tray. The serving trays remained under each resident's dishes during the meal service. The staff that served the meals in the dining room did not ask residents if they wanted the serving tray removed while the residents ate. During an interview on 6/25/26 at 7:49 a.m., nursing assistant (NA)-A stated the nursing assistants helped serve residents in the dining room. NA-A stated the process was to bring the residents the serving tray of food, set the tray in front of the resident, and take the covers off the plates and beverages. NA-A stated staff had not been directed to take the food items off the hard plastic tray. NA-A stated there was no reason why the food was left on the hard plastic tray when served to residents. During an interview on 6/25/26 at 8:59 a.m., registered nurse unit manager (RN)-D stated nursing staff brought the trays to the residents in the dining room during mealtimes. RN-D acknowledged the meals were served to residents in the dining room on the hard plastic tray. RN-D stated he was not sure why the food was left on the hard plastic trays. During an interview on 6/25/26 at 10:37 a.m.,			21805			

Minnesota Department of Health

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21805	Continued from page 28 director of nursing (DON) stated meals should have been served without the hard plastic trays. DON stated the food should have been taken off the trays when served to residents to create a more homelike environment. R2's quarterly Minimum Data Set (MDS) assessment, dated 4/6/26, indicated R2 was cognitively intact and and admitted to the facility on 2/21/23. During an observation and interview on 06/22/2026 at 11:27 a.m., staff entered R2's room without ensuring privacy was maintained. An unidentified nursing assistant (NA) knocked once on R2's door, and entered the room without waiting for a response, to inform R2 it was time for lunch. R2 stated staff "just walk right in", expressed fear of changing clothes due to lack of privacy, and reported he did not feel he had adequate privacy in his room. During an interview on 06/24/2026 at 10:33 a.m., NA-E stated that before staff entered a resident's room, staff were expected to knock and wait for a response. During an interview on 06/25/2026 at approximately 9:11 a.m., the nurse manager/ licensed practical nurse (LPN)-C, stated staff were expected to knock and wait for a response prior to entering the room to ensure resident privacy and dignity. During an interview on 06/25/2026 at 11:20 a.m., director of nursing (DON) stated staff were required to knock and wait for a response before entering resident rooms. DON stated this was the facility's expectation to maintain resident privacy. The facility's Dining Environment policy, dated 10/25, indicated the facility would create an appropriate dining environment. The facility's Resident Rights policy, dated 11/2025, indicated federal and state law guarantee residents' basic rights, including the right to privacy. SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON), or designee could develop and implement a plan of care by the interdisciplinary team to ensure residents experience			21805			

Minnesota Department of Health

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21805	Continued from page 29 a dignified homelike dining experience along with ensuring residents dignity is being maintained at all times (knocking on doors and waiting for response prior to entering). The facility could update policies and procedures, educate staff on these changes, and audit to ensure resident(s) dignity are maintained. The results of these audits will be reviewed by the quality assurance committee to ensure compliance.		21805				
21810	TIME PERIOD FOR CORRECTION: Twenty-one (21) days. Patients & Residents of HC Fac.Bill of Rights CFR(s): MN St. Statute 144.651 Subd. 6 Subd. 6. Appropriate health care. Patients and residents shall have the right to appropriate medical and personal care based on individual needs. Appropriate care for residents means care designed to enable residents to achieve their highest level of physical and mental functioning. This right is limited where the service is not reimbursable by public or private resources. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and record review, the facility failed to accommodate resident needs by ensuring a call light was accessible for 2 of 2 residents (R221, R283) reviewed for call lights. Findings include: R221's admission Minimum Data Set (MDS), dated 5/18/26, identified R221 was cognitively intact, and diagnoses included diagnoses of neurogenic bladder, diabetes, and schizophrenia. Additionally, R221 had impairment on one side of upper and lower extremities, required a walker and wheelchair for mobility, and required substantial assistance for dressing and hygiene. During an observation and interview on 6/25/26 at 8:37 a.m., R221 was seated in a wheelchair in her room, facing her bed with the bedside table between her and her bed. R221's call light was wrapped around the upper bedrail of the bed and out of reach. R221 was unable to access her call light, and stated, "it is too far away". R221 attempted to move her wheelchair around the bed stand but was unable to move. Licensed practical nurse (LPN)-B and		21810				

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21810	Continued from page 30 nursing assistant (NA)-D entered R221's room and verified the call light was not within R221's reach. LPN-B stated the call light "should be in reach". NA-D stated the call light "should be [in reach]". R283's admission MDS, dated 4/13/26, identified R283 with impaired cognition, required assistance with hygiene, and diagnoses of cardiomyopathy, heart disease, kidney disease, diabetes, and depression. During an observation and interview on 6/22/26 at 11:02 a.m., R283 was observed in bed as he watched television (TV). However, R283's call light was wrapped around the wall call light unit and was out of R283's sight and reach. R283 stated if he needed assistance, he would "call out" and it "takes all day to get attention". During an interview on 6/22/26 at 11:06 a.m., nursing assistant (NA)-B verified R283's call light was wrapped around the wall unit and was out of R283's sight and reach. NA-B stated the call light should have been within R283's reach so R283 could "call for help if needs it". During an observation and interview on 6/23/26 at 5:08 p.m., R283 watched TV from his bed. R283's call light was wrapped around the wall and was out of R283's sight and reach. R283 stated, "I don't use it because I can't reach it". During an interview on 6/24/26 at 10:39 a.m., NA-C stated staff were expected to ensure call lights were within reach of every resident when in their rooms. NA-C stated residents could not request help unless the call light was within reach, and it was important for resident safety. During an interview on 6/24/26 at 11:23 a.m., registered nurse (RN)-L stated expectation of call lights to always be in reach of every resident when in their rooms. During an interview on 6/24/26 at 11:19 a.m., RN-M stated call lights should be "ideally within reach". RN-M stated call lights wrapped around the wall unit, and not in reach was not acceptable. RN-M stated the call lights were a "lifeline" for residents			21810			

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21810	Continued from page 31 to use if they needed assistance. During an interview on 6/25/26 at 10:59 a.m., DON stated expectation of call lights to be in reach of every resident “to have for help if needed”. The facility's Answering the Call Light policy, effective 10/2025, indicated when the resident is in bed or confined to a chair, be sure the call light is within easy reach of the resident. SUGGESTED METHODS OF CORRECTION: The director of nursing (DON) or designee could develop, review, and /or revise policies and procedures to ensure all residents have their call lights within reach. The DON or designee could educate all appropriate staff. The DON or designee could develop monitoring systems to ensure ongoing compliance and report those results to the quality assurance committee. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.			21810			
21925	Patients & Residents of HC Fac.Bill of Rights CFR(s): MN St. Statute 144.651 Subd. 29 Subd. 29. Transfers and discharges. Residents shall not be arbitrarily transferred or discharged. Residents must be notified, in writing, of the proposed discharge or transfer and its justification no later than 30 days before discharge from the facility and seven days before transfer to another room within the facility. This notice shall include the resident's right to contest the proposed action, with the address and telephone number of the area nursing home ombudsman pursuant to the Older Americans Act, section 307(a)(12). The resident, informed of this right, may choose to relocate before the notice period ends. The notice period may be shortened in situations outside the facility's control, such as a determination by utilization review, the accommodation of newly-admitted residents, a change in the resident's medical or treatment program, the resident's own or another resident's welfare, or nonpayment for stay unless prohibited by the public program or programs paying for the resident's care, as documented in the medical record. Facilities shall make a reasonable effort to accommodate new residents without disrupting room assignments.			21925			

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21925	Continued from page 32 This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to provide written information on the duration of the bed-hold and reserve bed payment at the time of transfer for 4 of 4 residents (R21, R147, R203, R260) reviewed for hospitalizations. Findings include: R21's annual Minimum Data Set (MDS), dated 4/19/26, identified R21 with intact cognition, and diagnoses included diabetes, heart disease, kidney disease, and partial amputation of left foot. R21's Clinical Assessment screen identified transferred to the hospital on 6/8/26. R21's electronic medical record (EMR) lacked evidence bed holds were offered, signed, and followed up on. During an interview on 6/22/26 at 11:46 a.m., R21 stated he had never been offered or signed a bed hold form when he transferred to the hospital, and stated, "No one from here reached out to me". R147's quarterly Minimum Data Set (MDS), dated 4/28/26, identified R147 had intact cognition and diagnoses included chronic respiratory failure, quadriplegia, and R147 required suctioning and tracheostomy care. R147's EMR identified R147 was transferred to the hospital on 3/15/26, and 4/3/26. However, review of R147's EMR lacked evidence the facility provided R147 and/or R147's resident representative with written information regarding the facility's bed hold policy at the time of the hospital transfers. During an interview on 6/25/26 at 7:50 a.m., the social services designee (SSD) stated social services completed bed holds when available, and nursing staff completed the process if social services were unavailable. The SSD stated when a bed hold was not obtained by nursing staff at the time of transfer, social services followed up with the resident's			21925			

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21925	Continued from page 33 representative. The SSD stated the director of nursing (DON) confirmed completion of bed holds. During an interview on 6/25/26 at 10:53 a.m., registered nurse (RN)-A stated staff determined if the resident was their own responsible party or if the resident's representative needed to be contacted regarding the bed hold. RN-A stated completion of the bed hold process was documented in the resident's progress notes. During an interview on 6/25/26 at 11:07 a.m., the registered nurse case manager (RNCM) stated when a resident was transferred to the hospital, nursing staff notified the resident's representative, discussed the bed hold, and documented the information in the progress notes. The RNCM stated social services were updated and a bed hold form was sent with the resident. The RNCM confirmed R147's EMR lacked evidence bed hold information was provided to R147 and/or R147's resident representative for the hospital transfers on 3/15/26 and 4/3/26. During an interview on 6/25/26 at 1:35 p.m., director of nursing (DON) stated for emergency transfers, social services followed up with the resident and/or resident representative regarding whether they wanted a bed hold and documented the information in the progress notes. The DON stated the process was important to determine if the resident or resident representative wanted to hold the resident's bed, identify the length of time the bed would be held, and ensured clear communication. R203's quarterly MDS, dated 6/2/26, identified R203 with moderate cognitive impairment, and diagnoses included hypertension, peripheral vascular disease, kidney disease, receiving hemodialysis, left below the knee amputation, and diabetes. R203's EMR identified transfers to the hospital on 4/27/26, 5/8/26, and 6/3/26. However, R203's EMR lacked evidence bed holds were offered, signed, and followed up on. During an interview on 6/23/26 at 5:21 p.m., RN-K stated nurses were expected to print out a face sheet, orders, and medication list to send with resident to hospital. In addition, the nurse was			21925			

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21925	Continued from page 34 expected to start a Transfer Form in the EMR. RN-K stated a signed bed hold form was to accompany the resident to the hospital, and a progress note written after the resident transferred to identify status of the bed hold, such as who was notified. During an interview on 6/23/26 at 5:21 p.m., RN-L stated expectation of nursing staff to print out a face sheet, orders, and medication list to accompany resident to hospital once orders to transfer were obtained. In addition, the nurse was expected to start a Transfer Form in the EMR. RN-L stated the bed hold form was a separate piece of paper “that needs to be signed [by the resident] and followed up if they cannot at the time”. RN-L stated expectation of a progress note following the transfer to indicate whether bed hold was signed or offered, and to be followed up by social services if it is not signed. During an interview on 6/24/26 at 11:10 a.m., RN-M stated expectation of nursing staff to print out a face sheet, orders, and medication list to accompany resident to hospital once orders are obtained, and the nurse was expected to start a Transfer Form in the EMR. RN-M stated the bed hold form was expected to be offered to and signed by the resident or guardian and accompany the resident to the hospital. RN-M stated expectation of the nurse to document in a progress note whether the bed hold was offered or signed, and if it was not then social services were to follow up. RN-M acknowledged the process was not followed for R21 and R203. During an interview on 6/24/26 at 11:44 a.m., SS-D reviewed EMR for R21 and R203 and stated he was unable to locate any signed bed hold forms. SS-D stated, “The process should be to have the patient or guardian sign the bed hold and [facility] scan it in the EMR. We should be following up if it was done or not in a progress note.” SS-D stated the facility failed to document if a written notice was offered and provided to R21 and R203, or their guardians on transfer, including notifying the Office of the State Long Term Care Ombudsman. During an interview on 6/25/26 at 8:41 a.m., R203 stated he had never been offered or signed a bed hold form when he was hospitalized. During an interview on 6/25/26 at 10:51 a.m., DON stated expectation of a signed bed hold to accompany resident at time of transfer. “It should be			21925			

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21925	Continued from page 35 scanned in the EMR but [process] is not reliable.” DON verified the facility failed to document if a written notice was offered and provided to R21 or R203, or their guardians on transfer, including notifying the Office of the State Long Term Care Ombudsman. R260's admission MDS, dated 3/16/26, identified R260 was cognitively intact, was able to express needs and wishes, and was able to understand others, and diagnoses included surgical amputation, peripheral vascular disease (a disease with narrowing of the blood vessels which impacts blood circulation throughout the body), and malnutrition. R260's care plan, initiated 3/4/26, identified R260 was at risk for falls and was dependent on staff for cares. R260's progress note, dated 3/25/26 at 5:23 a.m., identified R260 was found on the floor at 5:00 a.m., and denied striking head. At that time, the provider and family were advised. The documentation indicated the provider would follow up with patient to assess. R260's progress note, dated 3/25/26 at 5:14 p.m., identified R260 was noted to have swelling to the left side of face and was confused, and waw not able to recognize family member/power of attorney (POA). Notification was sent to the provider triage nurse and resident was transferred to the hospital for evaluation. The progress note indicated the bed hold was signed by the POA. However, R260's EMR lacked evidence of the signed bed hold from 3/25/26. During interview on 6/25/26 at 11:52 a.m., registered nurse/unit manager (RN/UM)-A stated upon transfer to the hospital, a bed hold wase obtained from the responsible party. This is completed either in person, or via the telephone for verbal consent. Once signed, RN/UM-A stated the document was placed in the medical record. During interview on 6/25/2026, at 2:30 p.m., DON provided a handwritten note which identified “3/25/26 at 5:43 p.m. Bed hold per POA of			21925			

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21925	Continued from page 36 resident". DON acknowledged this documentation lacked indication as to information provided to the POA, including potential fees and right to appeal. The facility's Bed Hold policy, revised 04/2025, indicated community staff shall inform residents upon admission and prior to a transfer for hospitalization (unless for an emergency) or therapeutic leave of the bed-hold policy, and a copy of the resident's bed-hold or release record will be filed in the resident's medical record SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON), or designee could review and/or develop policy and procedures that written notification was provided to the resident and their representative before a transfer. The facility could educate staff on these policies and audit periodically. The results of these audits will be reviewed by the quality assessment committee to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty One (21) days			21925			



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
August 19, 2026

Administrator
NORTH RIDGE HEALTH AND REHAB
5430 BOONE AVENUE NORTH
NEW HOPE, MN 55428

RE: CCN: 245183
Cycle Start Date: June 18, 2026

Dear Administrator:

On July 17, 2026, we notified you a remedy was imposed. On July 31, 2026 and August 11, 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 August 4, 2026.

As authorized by CMS the remedy of:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective September 18, 2026 did not go into effect. (42 CFR 488.417 (b))

In our letter of July 17, 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 was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from September 18, 2026 due to denial of payment for new admissions. Since your facility attained substantial compliance on August 4, 2026, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, 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 that reads 'Kamala Fiske-Downing'.

Kamala Fiske-Downing
Compliance Analyst | Federal Enforcement

Health Regulation Division

Minnesota Department of Health

Kamala.Fiske-Downing@state.mn.us



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

August 19, 2026

Administrator
NORTH RIDGE HEALTH AND REHAB
5430 BOONE AVENUE NORTH
NEW HOPE, MN 55428

Re: Reinspection Results
Event ID: 1F34F7-H2

Dear Administrator:

On August 11, 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 June 25, 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 'Kamala Fiske-Downing'.

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



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Feel free to contact me if you have questions.

Sincerely,

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Kamala Fiske-Downing
Compliance Analyst | Federal Enforcement

Health Regulation Division

Minnesota Department of Health

Kamala.Fiske-Downing@state.mn.us



Protecting, Maintaining and Improving the Health of All Minnesotans

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August 19, 2026

Administrator
NORTH RIDGE HEALTH AND REHAB
5430 BOONE AVENUE NORTH
NEW HOPE, MN 55428

Re: Reinspection Results
Event ID: 1F34F7-H2

Dear Administrator:

On August 11, 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 June 25, 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 'Kamala Fiske-Downing'.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245183		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 06/25/2026	
NAME OF PROVIDER OR SUPPLIER NORTH RIDGE HEALTH AND REHAB				STREET ADDRESS, CITY, STATE, ZIP CODE 5430 BOONE AVENUE NORTH , NEW HOPE, Minnesota, 55428			
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E0000	Initial Comments On 6/22/26 through 6/25/26, 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			
F0000	INITIAL COMMENTS On 6/22/26 through 6/25/26, a standard recertification survey (S5183042-0) 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 with NO deficiencies cited: H51833022C (3049974) H51831582C (1008831) H51831594C (2693077) H51831593C (2698232) H51831590C (2701147) H51831587C (2715252) H51831589C (2715569) H51831581C (2715590) H51831591C (2718107) H51831586C (2722942)			F0000			

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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F0000	Continued from page 1 H51831585C (2732806) H51831583C (2785303) H51831660C (2995084) H51832859C (3038052) H51833012C (3050588 / 3050195) The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.			F0000			
F0550 SS = E	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights.			F0550			

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F0550 SS = E	Continued from page 2 The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review, the facility failed to provide a dignified dining experience for 7 of 7 residents (R28, R124, R128, R197, R233, R244, R257) when meals were served on hard plastic trays in the dining room. Further, the facility failed to ensure resident's right to privacy and dignity for 1 of 1 residents (R2) when staff failed to knock and wait for permission before entering the resident's room. Findings include: R28's quarterly Minimum Data Set assessment (MDS), dated 5/31/26, indicated R28 had intact cognition, and an admission date of 10/24/25. R124's quarterly MDS, dated 4/13/26, indicated R124 had severely impaired cognition, no hallucinations or delusions, and an admission date of 11/21/18. R128's annual MDS, dated 5/16/26, indicated R128 had short-term and long-term memory issues, severely impaired daily decision making, and an admission date of 11/13/20. R197's quarterly MDS, dated 6/4/26, indicated R128 had intact cognition, and an admission date of 11/25/25. R233's quarterly MDS, dated 4/28/26, indicated R233 had moderately impaired cognition and an			F0550			

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F0550 SS = E	Continued from page 3 admission date of 10/18/24. R244's quarterly MDS, dated 5/1/26, indicated R244 had short term and long-term memory issues, severely impaired daily decision making, and an admission date of 4/5/19. R257's annual MDS, dated 6/14/26, indicated R257 had moderately impaired cognition, no hallucinations or delusions, and an admission date of 8/26/22. During an observation of lunch service on 6/23/26 at 12:59 p.m., five residents (R124, R128, R233, R244, R257) were observed eating in the small dining room on the 2W unit, with two staff observed assisting residents at the tables. Positioned on the table in front of each resident was a meal on a hard plastic serving tray. Each hard plastic tray had a food plate, silverware, and beverage containers on it. The warming lids from the plates were tipped upside down on the table in front of the residents. During an observation of lunch service on 6/24/26 at 11:46 a.m., the lunch meal service was observed on the 2nd floor west main dining room. The dining room had a steam serving table with food items. The staff placed the food items, beverages, and silverware onto a hard plastic serving tray. The meals were then delivered to each resident at their table. However, the hard plastic servicing trays were then left on the table with plated food, beverages and silverware on top of them. Staff did not ask or offer to remove the items from the serving trays and place them onto the table. R28 and R197 were observed eating from the hard plastic meal tray. R197 stated he did not like the hard plastic serving trays and would not eat from one at home. During an observation on 6/25/26 at 8:03 a.m., breakfast meal service was observed on 2nd floor west main dining room. The residents ate in the dining room and their breakfast meal was served on the hard plastic serving tray. The serving trays remained under each resident's dishes during the meal service. The staff that served the meals in the dining room did not ask residents if they wanted the serving tray removed while the residents ate. During an interview on 6/25/26 at 7:49 a.m., nursing assistant (NA)-A stated the nursing assistants			F0550			

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F0550 SS = E	Continued from page 4 helped serve residents in the dining room. NA-A stated the process was to bring the residents the serving tray of food, set the tray in front of the resident, and take the covers off the plates and beverages. NA-A stated staff had not been directed to take the food items off the hard plastic tray. NA-A stated there was no reason why the food was left on the hard plastic tray when served to residents. During an interview on 6/25/26 at 8:59 a.m., registered nurse unit manager (RN)-D stated nursing staff brought the trays to the residents in the dining room during mealtimes. RN-D acknowledged the meals were served to residents in the dining room on the hard plastic tray. RN-D stated he was not sure why the food was left on the hard plastic trays. During an interview on 6/25/26 at 10:37 a.m., director of nursing (DON) stated meals should have been served without the hard plastic trays. DON stated the food should have been taken off the trays when served to residents to create a more homelike environment. R2's quarterly MDS, dated 4/6/26, indicated R2 was cognitively intact. During an observation and interview on 06/22/2026 at 11:27 a.m., staff entered R2's room without ensuring privacy was maintained. An unidentified nursing assistant (NA) knocked once on R2's door, and entered the room without waiting for a response, to inform R2 it was time for lunch. R2 stated staff "just walk right in", expressed fear of changing clothes due to lack of privacy, and reported he did not feel he had adequate privacy in his room. During an interview on 06/24/2026 at 10:33 a.m., NA-E stated that before staff entered a resident's room, staff were expected to knock and wait for a response. During an interview on 06/25/2026 at approximately 9:11 a.m., the nurse manager/ licensed practical nurse (LPN)-C, stated staff were expected to knock and wait for a response prior to entering the room to ensure resident privacy and dignity.			F0550			

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F0550 SS = E	Continued from page 5 During an interview on 06/25/2026 at 11:20 a.m., director of nursing (DON) stated staff were required to knock and wait for a response before entering resident rooms. DON stated this was the facility's expectation to maintain resident privacy. The facility's Dining Environment policy, dated 10/25, indicated the facility would create an appropriate dining environment. The facility's Resident Rights policy, dated 11/2025, indicated federal and state law guarantee residents' basic rights, including the right to privacy.			F0550			
F0628 SS = E	Discharge Process CFR(s): 483.15(c)(2)(iii)(3)-(6)(8)(d)(1)(2); 483.21(c)(2) §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident,			F0628			

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F0628 SS = E	Continued from page 6 the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge;			F0628			

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F0628 SS = E	Continued from page 7 (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). §483.15(d) Notice of bed-hold policy and return-			F0628			

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F0628 SS = E	Continued from page 8 §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility			F0628			

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F0628 SS = E	Continued from page 9 failed to provide written information on the duration of the bed-hold and reserve bed payment at the time of transfer for 4 of 4 residents (R21, R147, R203, R260) reviewed for hospitalizations. Findings include: R21's annual Minimum Data Set (MDS), dated 4/19/26, identified R21 with intact cognition, and diagnoses included diabetes, heart disease, kidney disease, and partial amputation of left foot. R21's Clinical Assessment screen identified transferred to the hospital on 6/8/26. R21's electronic medical record (EMR) lacked evidence bed holds were offered, signed, and followed up on. During an interview on 6/22/26 at 11:46 a.m., R21 stated he had never been offered or signed a bed hold form when he transferred to the hospital, and stated, "No one from here reached out to me". R147's quarterly Minimum Data Set (MDS), dated 4/28/26, identified R147 had intact cognition and diagnoses included chronic respiratory failure, quadriplegia, and R147 required suctioning and tracheostomy care. R147's EMR identified R147 was transferred to the hospital on 3/15/26, and 4/3/26. However, review of R147's EMR lacked evidence the facility provided R147 and/or R147's resident representative with written information regarding the facility's bed hold policy at the time of the hospital transfers. During an interview on 6/25/26 at 7:50 a.m., the social services designee (SSD) stated social services completed bed holds when available, and nursing staff completed the process if social services were unavailable. The SSD stated when a bed hold was not obtained by nursing staff at the time of transfer, social services followed up with the resident's representative. The SSD stated the director of nursing (DON) confirmed completion of bed holds. During an interview on 6/25/26 at 10:53 a.m.,			F0628			

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F0628 SS = E	Continued from page 10 registered nurse (RN)-A stated staff determined if the resident was their own responsible party or if the resident's representative needed to be contacted regarding the bed hold. RN-A stated completion of the bed hold process was documented in the resident's progress notes. During an interview on 6/25/26 at 11:07 a.m., the registered nurse case manager (RNCM) stated when a resident was transferred to the hospital, nursing staff notified the resident's representative, discussed the bed hold, and documented the information in the progress notes. The RNCM stated social services were updated and a bed hold form was sent with the resident. The RNCM confirmed R147's EMR lacked evidence bed hold information was provided to R147 and/or R147's resident representative for the hospital transfers on 3/15/26 and 4/3/26. During an interview on 6/25/26 at 1:35 p.m., director of nursing (DON) stated for emergency transfers, social services followed up with the resident and/or resident representative regarding whether they wanted a bed hold and documented the information in the progress notes. The DON stated the process was important to determine if the resident or resident representative wanted to hold the resident's bed, identify the length of time the bed would be held, and ensured clear communication. R203's quarterly MDS, dated 6/2/26, identified R203 with moderate cognitive impairment, and diagnoses included hypertension, peripheral vascular disease, kidney disease, receiving hemodialysis, left below the knee amputation, and diabetes. R203's EMR identified transfers to the hospital on 4/27/26, 5/8/26, and 6/3/26. However, R203's EMR lacked evidence bed holds were offered, signed, and followed up on. During an interview on 6/23/26 at 5:21 p.m., RN-K stated nurses were expected to print out a face sheet, orders, and medication list to send with resident to hospital. In addition, the nurse was expected to start a Transfer Form in the EMR. RN-K stated a signed bed hold form was to accompany the resident to the hospital, and a progress note written after the resident transferred to identify status of the bed hold, such as who was notified.			F0628			

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F0628 SS = E	Continued from page 11 During an interview on 6/23/26 at 5:21 p.m., RN-L stated expectation of nursing staff to print out a face sheet, orders, and medication list to accompany resident to hospital once orders to transfer were obtained. In addition, the nurse was expected to start a Transfer Form in the EMR. RN-L stated the bed hold form was a separate piece of paper “that needs to be signed [by the resident] and followed up if they cannot at the time”. RN-L stated expectation of a progress note following the transfer to indicate whether bed hold was signed or offered, and to be followed up by social services if it is not signed. During an interview on 6/24/26 at 11:10 a.m., RN-M stated expectation of nursing staff to print out a face sheet, orders, and medication list to accompany resident to hospital once orders are obtained, and the nurse was expected to start a Transfer Form in the EMR. RN-M stated the bed hold form was expected to be offered to and signed by the resident or guardian and accompany the resident to the hospital. RN-M stated expectation of the nurse to document in a progress note whether the bed hold was offered or signed, and if it was not then social services were to follow up. RN-M acknowledged the process was not followed for R21 and R203. During an interview on 6/24/26 at 11:44 a.m., SS-D reviewed EMR for R21 and R203 and stated he was unable to locate any signed bed hold forms. SS-D stated, “The process should be to have the patient or guardian sign the bed hold and [facility] scan it in the EMR. We should be following up if it was done or not in a progress note.” SS-D stated the facility failed to document if a written notice was offered and provided to R21 and R203, or their guardians on transfer, including notifying the Office of the State Long Term Care Ombudsman. During an interview on 6/25/26 at 8:41 a.m., R203 stated he had never been offered or signed a bed hold form when he was hospitalized. During an interview on 6/25/26 at 10:51 a.m., DON stated expectation of a signed bed hold to accompany resident at time of transfer. “It should be scanned in the EMR but [process] is not reliable.” DON verified the facility failed to document if a written notice was offered and provided to R21 or R203, or their guardians on transfer, including notifying the Office of the State Long Term Care			F0628			

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F0628 SS = E	Continued from page 12 Ombudsman. R260's admission MDS, dated 3/16/26, identified R260 was cognitively intact, was able to express needs and wishes, and was able to understand others, and diagnoses included surgical amputation, peripheral vascular disease (a disease with narrowing of the blood vessels which impacts blood circulation throughout the body), and malnutrition. R260's care plan, initiated 3/4/26, identified R260 was at risk for falls and was dependent on staff for cares. R260's progress note, dated 3/25/26 at 5:23 a.m., identified R260 was found on the floor at 5:00 a.m., and denied striking head. At that time, the provider and family were advised. The documentation indicated the provider would follow up with patient to assess. R260's progress note, dated 3/25/26 at 5:14 p.m., identified R260 was noted to have swelling to the left side of face and was confused, and waw not able to recognize family member/power of attorney (POA). Notification was sent to the provider triage nurse and resident was transferred to the hospital for evaluation. The progress note indicated the bed hold was signed by the POA. However, R260's EMR lacked evidence of the signed bed hold from 3/25/26. During interview on 6/25/26 at 11:52 a.m., registered nurse/unit manager (RN/UM)-A stated upon transfer to the hospital, a bed hold wase obtained from the responsible party. This is completed either in person, or via the telephone for verbal consent. Once signed, RN/UM-A stated the document was placed in the medical record. During interview on 6/25/2026, at 2:30 p.m., DON provided a handwritten note which identified "3/25/26 at 5:43 p.m. Bed hold per POA of resident". DON acknowledged this documentation lacked indication as to information provided to the POA, including potential fees and right to appeal.			F0628			

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F0628 SS = E	Continued from page 13 The facility's Bed Hold policy, revised 04/2025, indicated community staff shall inform residents upon admission and prior to a transfer for hospitalization (unless for an emergency) or therapeutic leave of the bed-hold policy, and a copy of the resident's bed-hold or release record will be filed in the resident's medical record.			F0628			
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, interview, and document review, the facility failed to ensure controlled substance reconciliation was completed in accordance with established policies and procedures to reduce the risk of diversion and/or theft on 2 of 8 medication carts reviewed. This had the potential to			F0755			

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F0755 SS = E	Continued from page 14 affect 8 residents identified to have controlled substances in the reviewed carts. Findings include: During an observation and interview on 6/23/26 at 1:54 p.m., the 2W “far south” medication cart was reviewed with registered nurse (RN)-A. The mobile cart was locked with a physical key, along with a separately attached metal narcotic box, which was also locked. The narcotic box was opened and contained numerous controlled substances. RN-A explained that the narcotics and controlled substances were counted at each shift exchange, and these reconciliations were recorded on a Narcotic Shift to Shift Signature form. RN-A provided the flow sheets used to track the documented count(s). However, approximately half of the signature spaces were blank. RN-A confirmed the form had approximately half of the spaces filled and stated all the signature spots should have been completed. RN-A stated she did not know why spaces were blank. The facility's 2 West FS (far south) Narcotic Shift to Shift Signature Sheet, for June 2026, indicated there were 132 possible signature spaces, with 106 documented signatures for 6/1/26 through 6/26/26. During an observation and interview on 6/23/26 at 2:03 p.m., with RN-B and RN-C, the 2W “near south” mobile medication cart was observed locked with a physical key, along with a separately attached metal narcotic box, which was also locked. The narcotic box was opened and contained numerous controlled substances. RN-C explained the narcotics and controlled substances were counted at each shift exchange, and these reconciliations were recorded on a form to indicate the count had occurred. RN-C provided the flow sheets used to track the documented count(s). However, approximately half of the signature spaces were blank. The facility's 2 West NS (near south) Narcotic Shift to Shift Signature Sheet, June 2026, indicated there were 132 possible signature spaces for 6/1/26 to 6/22/26. However, there were 41 signatures total on the sheet for 6/1/26 through 6/22/26. During an interview on 6/23/26 at 2:09 p.m., the			F0755			

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F0755 SS = E	Continued from page 15 nurse manager/ licensed practical nurse (LPN)-A stated staff were expected to sign the controlled medication reconciliation form to indicate that controlled medication reconciliation had occurred. LPN-A confirmed approximately half the signatures were missing on the 2W NS form. LPN-A stated that based on documentation, he was unable to confirm that medication reconciliation had occurred. During an interview on 6/24/26 at 10:17 a.m., the director of nursing (DON) stated nursing staff were expected to complete controlled medication reconciliation at each shift change, and the reconciliation should have been documented on the narcotic shift change forms. The facility's Controlled Substances policy, dated 10/2026, indicated the controlled substance records would be reconciled by a physical count of the remaining controlled substance supply at the change of each shift by the oncoming and outgoing licensed nurse/designee.			F0755			
F0804 SS = E	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is NOT MET as evidenced by: Based on observation, and interview, the facility failed to ensure food was served in a timely manner to preserve desired temperatures of food for 5 of 5 residents (R3, R28, R156, R197, R294) reviewed who expressed concerns for food temperatures and palatability. Findings include: R3's quarterly Minimum Data Set (MDS) assessment, dated 3/16/26, identified R3 had intact cognition with an admission date of 11/13/24.			F0804			

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F0804 SS = E	Continued from page 16 During an interview on 6/24/26 at 10:23 a.m., R3 stated she ate in the main dining room on 2W, and she had brought up the concern of cold food to staff previously. R28's quarterly MDS assessment, dated 5/31/26, identified R28 had intact cognition with an admission date of 10/24/25. During an interview on 6/24/26 at 10:23 a.m., R28 stated the food was always cold. It didn't make a difference if you ate in your room or in the dining room. R28 stated he ate in both places and had brought up the concern of cold food to staff previously. R156's quarterly MDS assessment, dated 5/25/26, identified R156 had intact cognition with an admission date of 2/18/26. During an interview on 6/24/26 at 10:23 a.m., R156 stated the food was served cold when it should be hot most of the time. R156 stated he ate in the dining room most of the time and had brought up the concern of cold food to staff previously. R197's quarterly MDS assessment, dated 6/4/26, identified R128 had intact cognition with an admission date of 11/25/25. During an interview on 6/24/26 at 10:23 a.m., R197 stated the French fries were "always cold." R197 stated he ate in the main dining room on 2W most of the time and had brought up the concern of cold food to staff previously. R294's quarterly MDS assessment, dated 4/1/26, identified R294 had intact cognition with an admission date of 1/17/26. During an interview on 6/22/26 at 1:02 p.m., R294 stated the food was served cold when it should have been hot. Furthermore, R294 stated the flavor "wasn't always great". During an observation and interview on 6/24/26 at 12:56 p.m., dining staff, including the dietary manager (DM), were observed serving food from the 3 west dining room. After all resident meals were plated, DM temped the food that remained in the food warmer. The following temperatures were obtained: turkey 164 degrees Fahrenheit (F), green beans 173.8 F and sweet potato 149.5 F. After the temperatures were obtained, the food remained on the warming table. The DM then followed the meal			F0804			

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F0804 SS = E	Continued from page 17 cart into the memory care unit, waited until the last tray was ready to be served, and obtained the following food temperatures from the last tray: turkey 103.5 F, green beans 96.5 F, and sweet potato 102.4 F. DM stated all the food should have been above 140 degrees at the time it was served, regardless of if it was in the dining room or served in the resident room. DM stated food temperatures that were below 140 degrees were in the "danger zone" and increased the potential for food-born illnesses.			F0804			
F0552 SS = D	Right to be Informed/Make Treatment Decisions CFR(s): 483.10(c)(1)(4)(5) §483.10(c) Planning and Implementing Care. The resident has the right to be informed of, and participate in, his or her treatment, including: §483.10(c)(1) The right to be fully informed in language that he or she can understand of his or her total health status, including but not limited to, his or her medical condition. §483.10(c)(4) The right to be informed, in advance, of the care to be furnished and the type of care giver or professional that will furnish care. §483.10(c)(5) The right to be informed in advance, by the physician or other practitioner or professional, of the risks and benefits of proposed care, of treatment and treatment alternatives or treatment options and to choose the alternative or option he or she prefers. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to obtain consent for use of psychotropic medications for 1 of 5 residents (R9) reviewed for unnecessary medications Findings include: R9's admission Minimum Data Set (MDS), dated 4/15/26, indicated R9 had severe cognitive impairment, required assistance with activities of daily living (ADLs), and diagnoses included edema, dementia, hypertension, insomnia and encephalopathy (broad term for any disease, damage, or malfunction that affects the brain).			F0552			

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F0552 SS = D	Continued from page 18 R9's Order Summary Report, printed 6/25/26, indicated R9 had an order dated 4/13/26 for trazodone 25 milligrams (mg) by mouth at bedtime for insomnia. However, review of R9's medical record lacked evidence consent for trazadone was obtained prior to use. During an interview on 6/25/26 at 10:56 a.m., registered nurse (RN)-I stated nurses were expected to complete a form for consent when a psychotropic medication was ordered. RN-I stated a nurse could initially get verbal consent but then needed to have the form signed the next time the person that gave consent was in the facility. During an interview on 6/25/26 at 11:21 a.m., RN-H stated the expectation was for consent for a medication that required it was obtained when a resident admitted on the medication or a new medication was added. RN-H confirmed R9's medical record lacked evidence or consent for trazodone. During an interview on 6/25/26 at 11:46 a.m., director of nursing (DON) stated the consent for psychotropic medications was expected to be obtained when a new psychotropic medication was ordered or when a resident was admitted with a psychotropic medication. The facility's Physician Medication Orders policy did not address obtaining consent for psychotropic medication use.			F0552			
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 §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 document review, the facility failed to assess resident for safety and the ability to self-administer medications for 1 of 1 resident (R21) reviewed for self-administration of medications (SAM).			F0554			

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F0554 SS = D	Continued from page 19 Findings include: R21's annual Minimum Data Set (MDS), dated 4/19/26, identified R21 was cognitively intact, and diagnoses included diabetes, heart disease, and kidney disease. R21's physician progress note, dated 1/20/26, identified R21 medication order for nystatin ointment 100000 unit/gram to groin and intergluteal cleft (the deep vertical groove between the buttocks) topically two times a day for fungal rash/dry skin, and with every brief change. R21's electronic medical record (EMR) identified physician orders for nystatin ointment was discontinued on 5/7/26. During an observation and interview on 6/23/26 at 3:37 p.m., R21 had a nearly empty tube of prescription nystatin ointment, with label attached listing R21's name, and instructions for use as indicated on the 1/20/26 medication order, and the label indicated dates of "Jan 20, 2026, to Feb 20, 2026". R21 stated nystatin remained on his rolling bedside table or top of nightstand since January of 2026. R21 stated he applied the ointment when he felt he needed it. R21 stated staff were aware he had it in his room. R21 stated facility staff had never talked to him about an assessment to determine safety and competence to keep the prescription ointment in his room. During an observation on 6/24/26 at 1:11 p.m., R21's rolling bedside table had a nearly empty tube of the prescription Nystatin ointment. During an interview on 6/24/26 at 11:21 a.m., registered nurse (RN)-M stated nurses were to document an assessment in the resident EMR if a resident wished to keep prescription and over the counter (OTC) medications at bedside. When a resident was assessed as safe to self-administer their medications, a provider order for self-administration was obtained and the care plan was updated. RN-M stated complete and accurate medication orders were important due to potential risk of contraindications.			F0554			

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F0554 SS = D	Continued from page 20 During an interview on 6/24/26 at 11:28 a.m., RN-L stated nursing staff were expected to document an assessment in the resident EMR if a resident wished to keep prescription and/or over-the-counter medications at bedside. RN-L stated residents should not have prescription or OTC medications in their rooms unless an assessment was completed and documented in the EMR. RN-L stated, “we don’t want [residents] medicating themselves and potentially harm[ing] them”. During observation and interview on 6/24/26 at 1:12 p.m., RN-D confirmed the prescription nystatin ointment was in R21’s room and verified it was prescribed to R21. RN-D stated the nystatin ointment “should not be here because we need to know all meds”. RN-D verified a self-administration of medications assessment had not been completed for R21. RN-D stated the discontinued nystatin order meant the nystatin should have been removed from R21’s room when it was discontinued. During an interview on 6/25/26 at 10:56 a.m., director of nursing (DON) stated nurses were expected to document a self-administration assessment for all prescribed and OTC medications left in a resident room. DON stated when a resident was assessed to be safe to self-administer a medication, a provider order for SAM was obtained by staff and documented in the EMR, and the care plan was updated. DON verified R21 was never assessed for safe self-administration of medication, and the order and care plan were never updated. The facility's Self-Administration of Drugs policy, dated 11/2016, indicated residents in our facility who wish to self-administer their medications may do so, if it is determined that they are capable of doing so and clinically appropriate. For self-administering residents, the nursing staff will determine who will be responsible (the resident or the nursing staff) for documenting that medications were taken. The nursing staff will rotate bedside stock and will remove expired, discontinued, or recalled medications.			F0554			
F0558 SS = D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do			F0558			

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F0558 SS = D	Continued from page 21 so would endanger the health or safety of the resident or other residents. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to accommodate resident needs by ensuring a call light was accessible for 2 of 2 residents (R221, R283) reviewed for call lights. Findings include: R221's admission Minimum Data Set (MDS), dated 5/18/26, identified R221 was cognitively intact, and diagnoses included diagnoses of neurogenic bladder, diabetes, and schizophrenia. Additionally, R221 had impairment on one side of upper and lower extremities, required a walker and wheelchair for mobility, and required substantial assistance for dressing and hygiene. During an observation and interview on 6/25/26 at 8:37 a.m., R221 was seated in a wheelchair in her room, facing her bed with the bedside table between her and her bed. R221's call light was wrapped around the upper bedrail of the bed and out of reach. R221 was unable to access her call light, and stated, "it is too far away". R221 attempted to move her wheelchair around the bed stand but was unable to move. Licensed practical nurse (LPN)-B and nursing assistant (NA)-D entered R221's room and verified the call light was not within R221's reach. LPN-B stated the call light "should be in reach". NA-D stated the call light "should be [in reach]". R283's admission MDS, dated 4/13/26, identified R283 with impaired cognition, required assistance with hygiene, and diagnoses of cardiomyopathy, heart disease, kidney disease, diabetes, and depression. During an observation and interview on 6/22/26 at 11:02 a.m., R283 was observed in bed as he watched television (TV). However, R283's call light was wrapped around the wall call light unit and was out of R283's sight and reach. R283 stated if he needed assistance, he would "call out" and it "takes all day to get attention". During an interview on 6/22/26 at 11:06 a.m., nursing assistant (NA)-B verified R283's call light			F0558			

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F0558 SS = D	Continued from page 22 was wrapped around the wall unit and was out of R283's sight and reach. NA-B stated the call light should have been within R283's reach so R283 could "call for help if needs it". During an observation and interview on 6/23/26 at 5:08 p.m., R283 watched TV from his bed. R283's call light was wrapped around the wall and was out of R283's sight and reach. R283 stated, "I don't use it because I can't reach it". During an interview on 6/24/26 at 10:39 a.m., NA-C stated staff were expected to ensure call lights were within reach of every resident when in their rooms. NA-C stated residents could not request help unless the call light was within reach, and it was important for resident safety. During an interview on 6/24/26 at 11:23 a.m., registered nurse (RN)-L stated expectation of call lights to always be in reach of every resident when in their rooms. During an interview on 6/24/26 at 11:19 a.m., RN-M stated call lights should be "ideally within reach". RN-M stated call lights wrapped around the wall unit, and not in reach was not acceptable. RN-M stated the call lights were a "lifeline" for residents to use if they needed assistance. During an interview on 6/25/26 at 10:59 a.m., DON stated expectation of call lights to be in reach of every resident "to have for help if needed". The facility's Answering the Call Light policy, effective 10/2025, indicated when the resident is in bed or confined to a chair, be sure the call light is within easy reach of the resident.			F0558			
F0604 SS = D	Right to be Free from Physical Restraints CFR(s): 483.10(e)(1),483.12(a)(2) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any physical .			F0604			

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F0604 SS = D	Continued from page 23 . . restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(2) Ensure that the resident is free from physical . . . restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to ensure ongoing assessment and evaluation of physical restraints were completed to determine continued need, risks, benefits, and least restrictive interventions for a wheelchair lap tray and set belt for 1 of 1 resident (R147) reviewed for physical restraints. Findings include: R147's quarterly Minimum Data Set (MDS), dated 4/28/26, identified R147 had intact cognition and required assistance with activities of daily living (ADLs). R147's diagnoses included quadriplegia (paralysis affecting all four extremities), muscle weakness, lack of coordination (difficulty controlling body movements), and abnormalities of gait and mobility (difficulty with movement and positioning). The MDS further identified R147 did not use restraints. During an observation on 6/22/26 at 5:16 p.m., R147 was seated in his wheelchair with a seat belt secured and a lap tray attached to the wheelchair. During an observation on 6/25/26 at 11:05 a.m.,			F0604			

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F0604 SS = D	Continued from page 24 R147 propelled throughout the main area in his power wheelchair. R147's wheelchair seat belt was buckled and a lap tray was positioned across the wheelchair. R147's care plan, dated 5/11/26, identified R147 had a seat belt on his wheelchair and R147 was able to lock and release the seat belt independently. The care plan interventions identified R147 was educated on risks versus benefits, and signed consent to use of the seat belt. R147's care plan further indicated R147 understood the seat belt could be removed at any time, the seat belt would be used when R147 was in the wheelchair as desired, and the seat belt did not impede R147's mobility or ability to reposition in the chair. R147's Physical Restraint Quarterly Assessment history, identified the most recent assessment was completed on 2/17/26. R147's electronic medical record (EMR) lacked evidence additional quarterly restraint assessments were completed after 2/17/26, The assessments were used to evaluate continued use of the lap tray and seat belt, verify R147 continued ability to independently remove the devices, determine if the devices continued to meet R147's assessed needs, or identify if less restrictive interventions or restraint elimination were appropriate. During an interview on 6/25/26 at 10:53 a.m., registered nurse (RN)-A stated R147 used a seat belt and lap tray on his wheelchair. RN-A stated the nurse manager was responsible for reassessing the continued need for the devices and R147's ability to use them. During an interview on 6/25/26 at 11:07 a.m., the registered nurse case manager (RNCM) reviewed R147's medical record and confirmed the last Physical Restraint Quarterly Assessment was completed on 2/17/26. The RNCM stated restraint assessments should have been completed quarterly, and confirmed an assessment should have been completed after 2/17/26. The RNCM stated the assessment had not been completed because it had not triggered in the EMR system. The RNCM stated reassessments were important to ensure continued appropriate use, and to verify the resident's needs remained current. During an interview on 6/25/26 at 1:35 p.m., the director of nursing (DON) stated physical restraint assessments were expected to be completed quarterly. The DON stated when residents were transferred to the hospital, assessments were			F0604			

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F0604 SS = D	Continued from page 25 discontinued in the electronic system and could fall off if they were not reviewed upon return to the facility. The DON confirmed R147 should have had another assessment completed after 2/17/26. The DON stated assessments were important to ensure residents remained able to remove the device independently and, if unable to remove the device, alternative interventions would need to be identified to maintain safety and update the care plan. The facility's Use of Physical Restraints policy, dated 6/2025, identified physical restraints were defined as any manual method or physical or mechanical device, material, or equipment attached or adjacent to the resident's body that the individual could not remove easily and restricted freedom of movement or normal access to the body. The policy identified the definition of a restraint was based on the functional status of the resident and not the device. The policy further identified restrained individuals would be reviewed regularly, at least quarterly, to determine whether they were candidates for restraint reduction, less restrictive methods of restraint, or restraint elimination. The policy identified care plans for residents with restraints would include interventions addressing the resident's needs and measures to reduce or eliminate restraint use.			F0604			
F0605 SS = D	Right to be Free from Chemical Restraints CFR(s): 483.10(e)(1),483.12(a)(2),483.45(c)(3)(d)(e) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any . . . chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is			F0605			

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F0605 SS = D	Continued from page 26 not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must-. . . §483.12(a)(2) Ensure that the resident is free from chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic. §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- (1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section.			F0605			

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F0605 SS = D	Continued from page 27 §483.45(e) Psychotropic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that-- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to ensure psychotropic medications were used in accordance with professional standards by failing to ensure PRN (as needed) psychotropic medication orders were limited to 14 days or contained documented clinical rationale and/or practitioner evaluation to support continued use beyond 14 days. The facility also failed to ensure monitoring was implemented to identify potential adverse effects related to antipsychotic medication use, including orthostatic blood pressure monitoring, for 1 of 5 resident (R152) reviewed for unnecessary medications.			F0605			

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F0605 SS = D	Continued from page 28 Findings include: R152's Medicare 5-day Minimum Data Set (MDS) assessment, dated 5/28/26, identified R152 had intact cognition, and diagnoses included respiratory failure, chronic obstructive pulmonary disease (COPD), and tracheostomy status. The MDS further identified R152 received antipsychotic and antianxiety medications. R152's physician orders, dated 6/22/26, included lorazepam (an antianxiety medication) 0.5 milligrams (mg) by mouth every six hours as needed (PRN) for anxiety, with a maximum of three doses per day. The order had a start date of 6/9/26, and an end date of 7/9/26, which allowed the PRN psychotropic medication to remain active for 30 days. However, R152's medical record lacked documented clinical rationale from the practitioner to support the continued use of the PRN psychotropic medication beyond 14 days. R152's physician orders, dated 6/22/26, included quetiapine (an antipsychotic medication) 37.5 mg by mouth twice daily PRN for generalized anxiety. The order had a start date of 6/16/26, and an end date of 7/16/26, which allowed the PRN antipsychotic medication to remain active for 30 days. However, R152's medical record lacked documentation the practitioner evaluated R152 and determined the continued use of the PRN antipsychotic medication beyond 14 days was appropriate. R152's physician orders, dated 6/22/26, treatment administration records (TARs), and clinical documentation revealed R152 received an antipsychotic medication. However, orthostatic blood pressure monitoring was not ordered or completed to monitor for potential adverse effects associated with antipsychotic medication use. During an interview on 6/25/26 at 11:07 a.m., the registered nurse case manager (RNCM) confirmed PRN psychotropic medications should have been limited to 14 days. The RNCM stated if continued use was needed beyond 14 days, the provider should have been contacted for a new order. The RNCM confirmed R152's lorazepam order had an end date of 7/9/26, and the quetiapine order had an end date of 7/16/26. The RNCM stated the quetiapine order indicated the medication was to continue for seven days, but the stop date indicated in the electronic medical record (EMR) did not match the provider's order. The RNCM stated the previous provider order indicated to continue PRN quetiapine			F0605			

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F0605 SS = D	Continued from page 29 for seven additional days and lorazepam three times daily for two weeks. RNCM stated the extended stop dates were likely a transcription error. The RNCM further stated orthostatic blood pressure monitoring should have been implemented due to antipsychotic (quetiapine) use because of potential adverse effects that could lead to safety concerns. The RNCM confirmed R152 did not have orthostatic blood pressure monitoring in place. During an interview on 6/25/26 at 1:40 p.m., the director of nursing (DON) stated antipsychotic medications and PRN psychotropic medications required 14-day stop dates. The DON stated when a resident routinely required PRN psychotropic medication, the facility reviewed the continued need with the provider to determine if changes were needed, and to prevent unnecessary medication use. The DON further stated residents with ordered antipsychotic medications needed to have orthostatic blood pressures completed because the medication could affect blood pressure, resulting in safety concerns and an increased risk for falls. The facility's Psychotropic Medication Use policy, dated 9/15/24, indicated psychotropic medications were to be used safely and appropriately while minimizing risks and adverse effects in accordance with current practice guidelines and regulatory requirements. The policy indicated PRN psychotropic medication orders should be limited to no more than 14 days. The policy further indicated if the physician/prescriber determined a PRN psychotropic medication, excluding antipsychotics, should continue beyond 14 days, the rationale and duration of use should be documented in the resident's medical record. The policy indicated PRN antipsychotic medication orders were limited to 14 days and could not be renewed unless the physician/prescriber evaluated the resident for the appropriateness of continued medication use. The policy further indicated all medications used to treat behaviors should be monitored for efficacy, risks, benefits, and harm or adverse consequences.			F0605			
F0641 SS = D	Accuracy of Assessments CFR(s): 483.20(g)(h)(i)(j) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. §483.20(h) Coordination. A registered nurse must			F0641			

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F0641 SS = D	Continued from page 30 conduct or coordinate each assessment with the appropriate participation of health professionals. §483.20(i) Certification. §483.20(i)(1) A registered nurse must sign and certify that the assessment is completed. §483.20(i)(2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. §483.20(j) Penalty for Falsification. §483.20(j)(1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than \$5,000 for each assessment. §483.20(j)(2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to ensure the Minimum Data Set (MDS) was accurately coded, with the potential for inaccurate federal reimbursement and resident care planning for 3 of 3 residents (R12, R15, R123) reviewed for MDS accuracy. Findings include: R12's readmission Minimum Data Set (MDS) assessment, dated 3/20/26 indicated R12 had not had any falls in the month prior to admission/re-admission, and indicated R12 had not had any fractures related to a fall in the 6 months prior to admission/re-admission. R12's quarterly MDS assessment, dated 6/22/26, indicated R12 had no falls in the previous 90 days.			F0641			

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F0641 SS = D	Continued from page 31 R12's care plan indicated R12 was at risk for falls related to cognition, unsteady gait and weakness. The care plan further indicated a fall with fractured hip on 3/9/26. During an interview on 6/25/26 at 11:17 a.m., licensed practical nurse manager (LPN)-A stated R12's readmission MDS assessment dated 3/20/26, and quarterly MDS assessments were inaccurate due to R12's fall with hip fracture on 3/9/26. During an interview on 6/25/26 at 1:52 p.m., Director of Nursing (DON) confirmed R12 had a fall with fracture on 3/9/26, the MDS assessments dated 3/20/26 and 6/22/26 were inaccurately coded. DON stated it was important for the MDS assessments to be accurate so residents received the care they needed and to prevent potential negative outcomes to residents. R15's significant change MDS, dated 4/18/26, indicated R15 took an anticoagulant and not an antiplatelet. R15's Medication Administration Record (MAR), dated 4/1/26 to 4/30/26, indicated R15 had not received an anticoagulant during the look back period (LBP), but had received 81 milligrams (mg) of aspirin (an antiplatelet medication) daily during the LBP. During an interview on 6/25/26 at 8:44 a.m., MDS coordinator (MDSC)-A, a registered nurse (RN), reviewed R15's medical record and stated R15 had taken an antiplatelet medication, aspirin, and had not received an anticoagulant medication during the LBP. R123's annual MDS, dated 5/28/26, indicated R123 was taking an anticoagulant and not an antiplatelet. R123's May 2026 MAR, dated 5/1/26 to 5/31/26, indicated R123 had not received an anticoagulant during the look back period (LBP) but did receive 81 milligrams (mg) of aspirin (an antiplatelet medication) daily during the LBP. During an interview on 6/25/26 at 7:57 a.m., RN-G			F0641			

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F0641 SS = D	Continued from page 32 reviewed R123's medical record and stated R123 had not been taking an anticoagulant but did take aspirin. During an interview on 6/25/26 at 8:27 a.m., RN-D, a nurse manager, reviewed R123's medical record. RN-D verified R123 had not taken an anticoagulant since 2021 when it was discontinued. RN-D stated R123 was and had been taking aspirin and verified aspirin was not an anticoagulant. During an interview on 6/25/26 at 8:51 a.m., MDSC-A, reviewed R123's medical record and stated R123 had taken an antiplatelet medication (aspirin), and not an anticoagulant medication during the LBP. MDSC-A verified the MDS was coded incorrectly. During an interview on 6/25/26 at 10:35 a.m., DON stated it was important the MDS was accurate as it affected reimbursement and MDS assessment information directed the care plan and interventions. The facility's MDS Assessment Coordinator policy, dated 3/2027, indicated that each individual who completed a portion of the MDS must certify the accuracy of the assessment.			F0641			
F0677 SS = D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review, the facility failed to ensure routine personal hygiene and grooming (i.e., shaving) was provided to 1 of 1 residents (R12) reviewed for Activities of Daily Living (ADLs) who were dependent on staff for their care. Findings include: R12's admission Minimum Data Set (MDS) assessment, dated 3/6/26, indicated R12 was cognitively intact, required partial to moderate assistance with personal hygiene, and had not refused or rejected cares.			F0677			

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F0677 SS = D	Continued from page 33 R12's care plan, reviewed 6/24/26, indicated R12 required the assistance of one staff for personal hygiene. During an observation and interview on 6/22/26 at 2:04 p.m., R12 had scruffy facial hair, approximately ¾ of an inch long, covering his face and neck. R12 stated he preferred to be clean shaven. An electric razor was plugged into the wall on the floor next to R12's bed. During an observation on 6/23/26 at 10:27 a.m., R12 continued to have scruffy facial hair covering his face and neck. During an observation on 6/23/26 at 3:15 p.m., R12 had scruffy facial and neck hair present, and the electric shaver was noted on floor. During an observation and interview on 6/24/26 at 10:19 a.m., R12 continued to have scruffy facial and neck hair. R12 asked for assistance and stated he did not 'like this scruff on my face'. The electric razors were still plugged into wall and lying on the floor. During an interview on 6/24/26 at 10:46 a.m., nursing assistant (NA-D) stated she was familiar with R12's care and identified personal hygiene as shaving, assisting with denture care, cleaning face and hair brushing. NA-D stated facility staff assisted R12 with personal hygiene and specifically assisted with shaving on his bath days. NA-D stated she was unaware of R12 refusing cares. During an interview on 6/25/26 at 11:09 a.m., licensed practical nurse manager (LPN-A) stated the NA staff was responsible for the completion of personal hygiene for residents, and that a resident who was listed as requiring substantial maximal assistance, the NA staff completed the task (shaving) for the R12. LPN-A stated personal hygiene/grooming would normally be completed on bath day, however, if the resident did not receive a full bath, personal hygiene, like shaving, would be completed. During an interview on 6/25/26 at 1:52 p.m., director of nursing (DON) stated personal hygiene/cares included hair care, oral care, nail care and shaving. DON stated floor staff were responsible for completing these tasks on bath days for residents. DON stated residents' personal preferences should be honored and if a resident desired to be clean-shaven, staff were expected to make every			F0677			

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F0677 SS = D	Continued from page 34 effort to do so. DON stated she expected resident preferences to be met whenever possible. DON stated it was important to provide personal care in a manner of resident preference because residents have the right to feel good about the way they look.			F0677			
F0689 SS = D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review, the facility failed to ensure fall interventions were implemented to prevent further falls and potential injury for 1 of 3 residents (R6) reviewed for falls. Additionally, the facility failed to comprehensively assess to prevent potential injury for 1 of 1 residents (R44) reviewed for smoking. Findings include: R6's annual Minimum Data Set (MDS), dated 6/8/26, indicated R6 was cognitively intact, had not rejected cares, was independent with activities of daily living (ADLs), and diagnoses included arthritis and depression. R6's progress note, dated 5/14/26 at 5:13 a.m., indicated that R6 slid from bed and was found on the floor with no injuries observed. R6's fall risk management, dated 5/14/26, indicated R6 had fallen out of bed and was found on her bedside floor by staff. The report indicated R6 stated she was rolling in her bed when she had fallen. The report indicated R6 thought the bed was too small, causing her to fall off her bed, and R6 was given a new and bigger bed to reduce the risk of falling.			F0689			

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F0689 SS = D	Continued from page 35 R6's care plan, dated 5/18/26, indicated R6 was at risk for falls related to gait and balance problems and had fallen on 7/8/25, 1/25/26, 2/10/26, and 5/14/26. The care plan indicated that related to a fall on 5/14/26, R6 was "given a bigger bed". R6's progress note, dated 6/22/26 at 5:22 a.m., indicated R6 was found lying on the floor beside her bed, and R6 had stated she was lying on her side in bed and attempted to roll toward the side of the bed and rolled out of bed. The progress note indicated that R6 did not have any injuries at the time of the assessment. During multiple observations on 6/23/26, other beds on the unit were observed and compared to R6's bed. R6's bed appeared to be the standard bed size. During an interview on 6/22/26 at 1:38 p.m., R6 stated she had fallen out of bed a couple of times when trying to reposition herself in bed, and felt her bed was too small. R6 stated she thought she was going to get a bigger bed but never did. During an observation and interview on 6/23/26 at 12:53 p.m., registered nurse (RN)-B stated R6 had a history of falls and R6 was supposed to have given a bigger bed. RN-B stated it appeared R6 had not received a larger bed because the one R6 had was a "normal-sized" bed. During an interview on 6/23/26 at 1:02 p.m., licensed practical nurse (LPN)-A, the nurse manager for the unit, stated as the fall intervention for R6's fall on 5/14/26, LPN-A ordered a larger bed and thought R6 had received it. LPN-A stated it appeared R6 had not received a larger bed and LPN-A needed to talk to the director of maintenance (DM) to determine what happened. During an interview on 6/23/26 at 1:07 p.m., the DM stated R6's bed was the standard-sized bed, and R6 had not been provided with a larger one. During a follow-up interview on 6/24/26 at 1:37 p.m., the DM stated there had been a miscommunication between maintenance and nursing. The DM stated nursing had indicated that a larger mattress was needed, but R6 already had the			F0689			

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F0689 SS = D	Continued from page 36 largest mattress size for her bed frame. The DM stated the ticket had then been “closed out” and a larger bed was not ordered. R44's admission Minimum Data Set (MDS), dated 5/13/26, indicated resident was cognitively intact and received supervision to moderate assistance with all activities of daily living (ADLs). R44's Face Sheet, printed 6/25/26, indicated R44 diagnoses included malignant neoplasm of unspecified kidney, dependence on renal dialysis, anxiety, and traumatic subdural hemorrhage without loss of consciousness. During an observation and interview on 6/22/26 at 3:07 p.m., R44 was in his room with his significant other, and two packs of cigarettes were observed on a corner table. R44 stated he smoked several times each day. No burn holes in R44's clothing were observed. During an observation on 6/24/26, at 11:46 a.m., R44 self-propelled in his wheelchair from his room to the designated outside smoking area, at the rear of the facility. R44 independently lit his cigarette, held it safely, extinguished his cigarette safely, and placed the cigarette butt in the smoking pole (a tall container where residents placed their cigarette butts). During an observation on 6/24/2026 at 12:04 p.m., R44 was seated in his room as he ate his noon meal. Two packs of cigarettes were on the corner table beside R44. During an observation on 6/24/26, at 3:58 p.m., R44 again wheeled himself in his wheelchair from his room to the designated outside smoking area. R44 managed the entire smoking process correctly and safely. R44’s Smoking Evaluation, dated 5/14/26, indicated R44 did not wish to smoke during his stay, and R44 did not utilize oxygen. The remainder of the assessment was blank. R44’s Smoking Evaluation, dated 5/24/26, indicated			F0689			

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F0689 SS = D	Continued from page 37 R44 did not wish to smoke during his stay, and the remainder of the assessment was blank. R44's Comprehensive Care Plan lacked information related to smoking. During an interview on 6/25/26 at 7:30 a.m., registered nurse (RN)-E stated R44 smoked independently at least four times a day. RN-E stated when R44 first admitted, he was not smoking and went outside "to get some fresh air." When staff noted R44 was smoking, staff approached R44 and he told staff, "I don't have that much more time to live, so I'm going to smoke." During an interview on 6/25/26 at 8:19 a.m., clinical manager (RN)-F stated he was not the clinical manager for R44's wing when R44 was admitted. and was not aware R44 lacked a comprehensive assessment of his smoking abilities. RN-F stated the facility's expectation was that any resident who smoked, whether known at the time of admission or observed afterwards, was assessed by the facility staff for resident safety. During an interview on 6/25/26 at 8:30 a.m., the director of nursing (DON) stated nursing staff were expected to assess and keep "eyes on" residents who wished to smoke to determine the resident's ability to smoke safely. If a resident was assessed as safe to smoke independently, they would not need supervision, unless there was a change in their status and needed to be reassessed. The facility's Managing Falls and Fall Risk policy, dated 6/2026, indicated that facility staff would attempt to identify appropriate interventions to reduce the risk of falls. The policy indicated that if a systematic evaluation of a resident's fall risk identifies several possible interventions, the staff may choose to prioritize interventions. The facility's Accident Prevention - Smoking Policy, revised 10/2022, indicated the facility shall establish and maintain safe resident smoking practices. Residents whom wish to smoke will be evaluated for "safe smoking" per community protocol. Any smoking-related privileges, restrictions, and concerns (for example, need for close monitoring) shall be noted on the care plan, and all personnel			F0689			

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F0689 SS = D	Continued from page 38 caring for the resident shall be alerted to these issues, per community protocol.			F0689			
F0690 SS = D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review, the facility failed to ensure appropriate provider orders were obtained to maintain an indwelling urinary catheter for 1 of 1 residents (R246) reviewed for catheter care. Findings include:			F0690			

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F0690 SS = D	Continued from page 39 R246's admission Minimum Data Set (MDS), dated 6/16/26 indicated R246 had moderate cognitive impairment, required assistance with activities of daily living (ADLs), and diagnoses included diabetes, atrial fibrillation, hypertension, dementia, and myelodysplastic syndrome (type of cancer in which the bone marrow does not make enough healthy blood cells). R246's Order Summary identified an order dated 6/4/26, for an indwelling (foley) caterer for comfort. However, the order failed to indicate the catheter size and balloon size needed for catheter replacement. R246's treatment administration record (TAR), dated 6/1/26 to 6/30/26 indicated an order for an indwelling (foley) catheter for comfort. However, the orders failed to include catheter size and balloon size needed for catheter replacement. R246's care plan, initiated 6/22/26, indicated R246 had an indwelling foley catheter. However, the care plan lacked the size of catheter and balloon size needed for catheter replacement. During interview on 0/25/26 at 10:56 a.m., registered nurse (RN)-I stated all orders for catheters were expected to include the size of the catheter and amount of normal saline needed to inflate the balloon. RN-I verified R246's orders did not indicate the catheter size and balloon size. During interview on 6/25/26 at 11:21 a.m., RN-H stated all catheter orders should have contained the diagnosis, catheter size and how much to fill the balloon. RN-H verified R246's orders lacked specifics regarding the size of the catheter and balloon size. During interview on 6/25/26 at 11:46 a.m., director of nursing (DON) stated indwelling urinary catheter orders were expected to include the diagnosis, size of the catheter and how much normal saline was to be used to fill the balloon. DON stated R246's orders looked as though no one had updated the order with the required information. DON stated it was important the correct catheter size and balloon volume were used to decrease discomfort.			F0690			

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F0690 SS = D	Continued from page 40			F0690			
	A facility policy was requested for catheter orders, but was not received.						
F0692 SS = D	Nutrition/Hydration Status Maintenance			F0692			
	CFR(s): 483.25(g)(1)-(3)						
	§483.25(g) Assisted nutrition and hydration.						
	(Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident-						
	§483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise;						
	§483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health;						
	§483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet.						
	This REQUIREMENT is NOT MET as evidenced by:						
	Based on interview and document review, the facility failed to ensure timely and effective interventions were implemented for significant, unplanned weight loss and failed to ensure consistency between physician orders and care plan directives related to weight monitoring for 1 of 1 residents (R256) reviewed for weight loss.						
	Findings include:						
	R256's annual Minimum Data Set (MDS) assessment, dated 5/25/26, indicated R256 had severe cognitive impairment, was dependent on staff for all activities of daily living (ADLs), including feeding, and had a diagnosis of weight loss. R256 received a mechanically altered diet and was not on a prescribed weight-loss regimen.						
	R256's physician order, dated 5/1/23, indicated an order for monthly weights. Additional orders included a house supplement shake 4 oz twice daily,						

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F0692 SS = D	Continued from page 41 initiated 1/9/24, for nutritional supplementation and ProStat Advanced Wound Care Liquid daily, initiated, 6/27/25 for wound healing. R256's weight records indicated R256 weighed 153.2 pounds (lbs) on 4/3/26 and 127 lbs on 6/3/26. These weights indicated a weight loss of 26.2 lbs (17.1%) over 2 months. R256's care plan, revised 3/1/23, identified R256 was at risk for altered nutritional/hydration status related to dysphagia, with altered textures, aphasia, hemiplegia, impaired mobility, and cardiac disease. Interventions included feeding assistance and weekly weights. However, R256's care plan directed weekly weights while R256's physician orders directed monthly weights. R256's nutrition progress note, dated 5/22/26, indicated R256's current weight was 127 lbs and identified a recent weight change within the last 30 days. The note indicated no notable change in oral intake over the 30-day lookback period and recommended continuation of the current plan of care. Despite ongoing weight loss trends, no new interventions or escalation of nutritional interventions were implemented at that time. During an interview on 6/24/26 at approximately 2:00 p.m., the registered dietitian (RD) stated residents were generally weighed monthly, but high-risk residents with weight loss were weighed weekly. The RD acknowledged the R256's weight loss trend and stated current interventions were not effective. The RD stated R256 could have received up to three nutritional shakes per day, and weekly weight monitoring should have been initiated to better evaluate trends. During an interview on 6/25/26 at 9:11 a.m., the Licensed Practical Nurse (LPN)-Unit Manager stated weights were typically obtained monthly per physician order. The LPN stated when discrepancies occurred between care plans and orders, staff followed physician orders, and care plans were expected to be updated accordingly. The LPN further stated the R256's weight loss had not been escalated as a concern requiring intervention change. During an interview on 6/25/26 at 11:20 a.m., the director of nursing (DON) stated the resident was monitored as a high-risk resident with weight loss. DON acknowledged R256 continued ongoing nutritional decline and needed for further evaluation of interventions.			F0692			

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F0692 SS = D	Continued from page 42			F0692			
F0695 SS = D	The facility's Weight Assessment and Intervention policy, dated 10/2025, indicated significant unplanned weight loss was greater than 7.5% weight loss in 3 months and care planning should include individualized identification of the cause of the weight loss, goals and benchmarks and interventions should consider resident choices, preferences, and abilities. 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 document review, the facility failed to ensure respiratory care and services were provided according to professional standards of practice and physician orders when the facility failed to ensure tracheostomy orders, included the specific type and size of tracheostomy tube, for 2 of 2 residents (R147 and R152) reviewed for tracheostomy care. In addition, the facility failed to obtain physician orders for oxygen therapy, including prescribed flow rate and administration parameters, for 1 of 3 residents (R152) reviewed for oxygen therapy, and the facility failed to ensure oxygen was administered according to physician orders for 1 of 3 residents (R14) reviewed for oxygen therapy. Findings included: R14 R14's quarterly Minimum Data Set (MDS), dated 4/22/26, identified R14 had intact cognition and required staff assistance with activities of daily living (ADLs). R14's diagnoses included respiratory failure, tracheostomy status (a surgically created opening in the neck to assist with breathing), and acute respiratory failure with hypoxia (low oxygen levels). R14's care plan, dated 5/6/26, identified R14 had a			F0695			

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F0695 SS = D	Continued from page 43 tracheostomy related to impaired breathing mechanics and used a Volera/Metaneb device for secretion management. The care plan directed staff to provide humidified oxygen as prescribed with a goal oxygen saturation greater than or equal to 92%, monitor respiratory status, suction as necessary, and maintain emergency tracheostomy equipment at bedside. R14's physician orders, dated 6/22/26, included an order, initiated 2/24/26, for oxygen at 5 liters per minute (LPM) per tracheostomy collar continuously for hypoxia. During observations on 6/22/26 through 6/25/26, R14's oxygen was set as follows, instead of 5 LPN as per physician orders: On 6/22/26 at 2:04 p.m., R14's oxygen was set at 3 LPM. Additionally, the oxygen tubing contained condensation and was not labeled or dated to identify when it was last changed. On 6/22/26 at 2:04 p.m., R14's oxygen was set at 3 LPM. On 6/23/26 at 1:16 p.m., R14's oxygen was set at 3 LPM. On 6/24/26 at 8:20 a.m., R14's oxygen was set at 3 LPM. On 6/25/26 at 10:53 a.m., R14's oxygen remained set at 3 LPM. R147 R147's quarterly MDS, dated 4/28/26, identified R147 had intact cognition and required staff assistance with ADLs. R147's diagnoses included chronic respiratory failure, respiratory failure, and tracheostomy status. The MDS identified R147 required suctioning and tracheostomy care. R147's care plan, dated 5/11/26, identified R147 had altered respiratory status and difficulty breathing related to tracheostomy status. The care plan directed staff to maintain a clear airway, suction as ordered or required, monitor for signs and symptoms of respiratory distress, and provide oxygen as ordered and needed. Review of R147's physician orders, dated 6/22/26, identified an order initiated 6/12/26, "Name of Trach _____ Size of Trach _____ every shift for Tracheostomy care." However, the type or size of			F0695			

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F0695 SS = D	Continued from page 44 tracheostomy tube used by R147 was not identified. R152 R152's Medicare 5-day MDS, dated 5/28/26, identified R152 had intact cognition and required staff assistance with ADLs. R152's diagnoses included acute respiratory failure with hypoxia, chronic obstructive pulmonary disease (COPD), respiratory failure, and tracheostomy status. The MDS identified R152 received oxygen therapy and required suctioning and tracheostomy care. R152's care plan, dated 5/25/26, identified R152 had a tracheostomy related to impaired breathing mechanics and had a history of adjusting oxygen flow settings despite redirection. The care plan directed staff to check the oxygen flow rate when entering the resident's room, administer humidified oxygen as prescribed, monitor respiratory status, suction as necessary, and maintain emergency tracheostomy equipment at bedside. R152's physician orders, dated 6/22/26, identified an order initiated 6/12/26, "Name of Trach _____ Size of Trach _____ every shift for Tracheostomy care," However, the type or size of tracheostomy tube used by R152 was not identified. Additionally, R152's electronic medical record (EMR) had not included a current physician order for oxygen therapy, prescribed liter flow, delivery method, frequency, or parameters. During observations from 6/22/26 through 6/25/26, R152 received oxygen without a physician order: On 6/22/26 at 3:14 p.m., oxygen was set at 5 LPM. On 6/23/26 at 1:19 p.m., oxygen was set at 4.5 LPM. On 6/24/26 at 8:27 a.m., oxygen was set at 4 LPM. On 6/25/26 at 7:39 a.m., oxygen was set at 6 LPM. During an interview on 6/25/26 at 10:53 a.m., registered nurse (RN)-A stated staff checked physician orders to verify oxygen liter flow and tracheostomy information. RN-A reviewed R14's orders and confirmed R14's oxygen was set at 3 LPM instead of the ordered 5 LPM. RN-A reviewed R152's record and confirmed there was no oxygen order and no order identified the specific type and size of tracheostomy tube. During an interview on 6/25/26 at 11:07 a.m., the registered nurse case manager (RNCM) confirmed			F0695			

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F0695 SS = D	Continued from page 45 R152 did not have an oxygen order or an order identifying the tracheostomy type and size. The RNCM stated oxygen orders should have identified the prescribed liter flow, and tracheostomy orders should have included the type and size. RNCM stated the information was important in vsdr T253'd tracheostomy required replacement during an emergency. During an interview on 6/25/26 at 1:35 p.m., the Director of Nursing (DON) stated she expected the tracheostomy type and size to be included in physician orders. The DON stated she expected oxygen orders to include oxygen use, liter flow, tubing changes, and oxygen saturation monitoring. The DON stated complete respiratory orders were important so staff knew how to appropriately care for residents. The facility's Oxygen Administration policy, dated 3/2026, directed staff to verify there was a physician order for oxygen administration and review the physician orders and care plan before providing oxygen. The policy directed staff to ensure the proper oxygen flow rate was administered and documentation included oxygen flow rate, route, frequency, duration of treatment, and resident response. The facility's Tracheostomy Care policy, dated 3/2026, directed staff to check physician orders prior to providing tracheostomy care. The policy directed staff to ensure emergency tracheostomy equipment was available at bedside and identified a replacement tracheostomy tube must be available at the bedside at all times.			F0695			
F0697 SS = D	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to ensure non-pharmacological pain interventions were offered, implemented, and documented when administering as-needed pain medication for 1 of 1			F0697			

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F0697 SS = D	Continued from page 46 resident (R142) reviewed for pain management. Findings include: R142's diagnoses list, dated 6/12/26, included malignant neoplasm of the prostate with secondary malignant neoplasms of the bone, lung, and lymph nodes, and neoplasm-related pain. R142's Pain Assessment Instrument (PAINAD), dated 6/14/26, documented R142 had no pain. R142's pain assessment, dated 6/16/26, indicated R142 was cognitively intact and had experienced frequent pain during the previous five days. R142's physician orders, dated 6/12/26, included the following as needed (PRN) medications for pain: hydromorphone 8 milligrams (mg) every 2 hours PRN for pain, ibuprofen 600mg every 8 hours PRN for pain, methocarbamol 500-1000mg every 6 hours PRN for muscle spasms, and baclofen 2.5mg two times daily PRN for muscle pain. R142's June 2026 Medication Administration Record (MAR), revealed R142 received PRN hydromorphone up to four times daily 6/12/26 through 6/24/26. Additionally, R142 received PRN ibuprofen one time, and methocarbamol 1000mg one time, between 6/12/26 and 6/24/26. R142's EMR revealed the facility failed to provide and document non-pharmacological pain interventions before or after administration of as-needed pain medication. R142's hospice care plan, initiated 6/15/26, addressed the resident's terminal prognosis related to metastatic prostate cancer. However, individualized, non-pharmacological pain interventions were not identified. During an observation on 6/24/26 at 8:10 a.m., R142's call light was activated. Nurse Manager/Licensed Practical Nurse (LPN)-C responded to the call light. During the encounter, R142 requested pain medication. However, LPN-C did not offer or implement non-pharmacological pain intervention while R142's request was addressed.			F0697			

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F0697 SS = D	Continued from page 47 During an observation on 6/24/26 at 8:15 a.m., LPN-D administered scheduled pain medication, and subsequently administered PRN hydromorphone after R142 requested additional pain medication. However, LPN-D failed to offer or implement any non-pharmacological pain interventions before the PRN narcotic was administered. During an observation and interview on 6/24/26 at 8:32 a.m., nursing assistant (NA)-F assisted R142 with morning cares. NA-F stated R142 frequently experienced significant pain. R142 stated, "I don't think just pills will get this pain away". R142 further stated massage had helped in the past but had not been offered since R142 admitted to the facility. During an interview on 6/24/26 at 10:47 a.m., R142 stated his pain remained “poorly controlled” despite the receipt of pain medication. R142 stated ongoing pain was discussed with the hospice nurse, but no changes had been made. During an observation and interview on 6/24/26 at 1:42 p.m., R142 was in bed and appeared lethargic. R142 stated he felt "out of it" and did not feel well. During an interview on 6/24/26 at 1:28 p.m., registered nurse (RN)-O stated non-pharmacological interventions were documented under behavior management, and staff were expected to document interventions attempted and their effectiveness in a progress note. During an interview on 6/25/26 at 9:11 a.m., LPN-C stated staff were expected to implement non-pharmacological pain interventions, document interventions attempted in progress notes, and document whether those interventions were effective. LPN-C stated staff were expected to communicate with the provider or hospice when scheduled pain medications had not adequately controlled a resident's pain. During an interview on 6/24/26 at 2:53 p.m., the hospice RN case manager stated facility staff had not communicated concerns that R142 continued to experience uncontrolled pain.			F0697			

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F0697 SS = D	Continued from page 48 During an interview on 6/25/26 at 11:20 a.m., the director of nursing (DON), stated the R142's care plan should have identified individualized non-pharmacological pain interventions were to be attempted. The DON stated nursing staff were expected to document in a nurse's note or progress note the non-pharmacological interventions offered and whether the interventions were effective in managing the resident's pain. The facility's Pain Assessment and Management policy, dated 5/2026, directed staff to monitor the frequency of as-needed (PRN) pain medication use and to notify the practitioner when PRN pain medications were being administered around the clock so routine scheduled pain medication could be considered. The policy further indicated pharmacological interventions alone do not typically address the cause of pain and may result in adverse effects. The policy indicated non-pharmacological interventions may be appropriate, either independently or in conjunction with pain medications, as part of pain management.			F0697			
F0726 SS = D	Competent Nursing Staff CFR(s): §483.35(a)(3)(4)(c) §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.71. §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs.			F0726			

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F0726 SS = D	Continued from page 49 §483.35(c) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review, the facility failed to ensure licensed nursing staff demonstrated competency by administering the incorrect dose of a controlled medication and inaccurately documenting controlled substance administration for 1 of 3 residents (R142) reviewed for medication administration. Findings include: R142's diagnoses list, dated 6/12/26, included malignant neoplasm of the prostate with secondary malignant neoplasms of the bone, lung, and lymph nodes, and neoplasm-related pain. R142's physician orders, dated 6/12/26, included an order for Methadone HCl 10 milligram (mg) tablets - 50 milligrams (mg) every morning, 20 mg daily (midday), and 40 mg at bedtime for pain. During observation on 6/24/26 at 8:15 a.m., Licensed Practical Nurse (LPN)-D entered R142's room to administer scheduled medications. During the medication pass, R142 requested as-needed pain medication and LPN-D why there were only two pain pills in his medication cup as he should have five pills. LPN-D told R142 that the medication cup contained his morning dose. Review of R142's methadone medication card revealed all three varying doses of methadone were packaged in the same medication card, with each bubble containing either two, four or five 10mg-tablets. LPN-D stated she removed methadone tablets from the medication card in the order they were packaged, rather than verifying the prescribed dose before administration. LPN-D acknowledged she had administered 20 mg (two 10mg-tablets) instead of the ordered 50 milligrams (five 10mg-tablets) for the scheduled 6/24/26 morning dose. Following R142's medication administration on			F0726			

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F0726 SS = D	Continued from page 50 6/24/26 at 8:15 a.m., LPN-D documented the controlled substance incorrectly in the narcotic accountability record when she recorded an incorrect remaining tablet count. After LPN-D acknowledged she had administered Methadone 20mg instead of 50mg as ordered for R142's morning medication administration, LPN-D corrected the documentation after the error was acknowledged.. During observation and interview on 6/24/26 at approximately 8:45 a.m., LPN-D returned to R142's room with three additional methadone 10mg-tablets, stated hospice had been contacted, and hospice instructed LPN-D to administer the remaining tablets to complete the prescribed morning dose. During an interview on 6/25/26 at 9:11 a.m., Nurse Manager LPN-C stated licensed nurses were expected to follow the five rights of medication administration, verify medication directions prior to administration, review medication parameters, and maintain accurate narcotic accountability records by documenting the correct quantities administered and remaining. LPN-C stated the nurse should have recognized that multiple methadone doses were packaged within the same medication card. During an interview on 6/25/26 at 11:20 a.m., the Director of Nursing (DON), stated licensed nurses were expected to follow the five rights of medication administration by ensuring the right resident, right medication, right dose, right route, and right time before medications were administered. The DON stated nurses were expected to accurately document controlled substance administration and follow up with nurse management if concerns with medication packaging were noted. The facility's Medication Administration policy, dated 10/2025, directed staff to administer medications safely, timely, and as prescribed. The policy required licensed staff to administer medications in accordance with physician orders, verify the right resident, right medication, right dose, right time, and right route before administration by checking the medication label three times, and accurately document medication administration following administration. The policy further directed staff to contact the resident's physician if a prescribed dosage was believed to be inappropriate or excessive and indicated newly authorized staff were not permitted to administer medications until they had been oriented to the facility's medication administration system.			F0726			

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F0756 SS = D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to ensure recommendations from the consulting pharmacist were acted upon timely to reduce the risk of adverse effects for 1 of 5 residents (R9) reviewed for unnecessary medication use.			F0756			

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F0756 SS = D	Continued from page 52 Findings include: R9's admission Minimum Data Set (MDS), dated 4/15/26, indicated R9 had severe cognitive impairment, required assistance with activities of daily living (ADLs), and diagnoses included edema, dementia, hypertension, insomnia and encephalopathy (broad term for any disease, damage, or malfunction that affects the brain). R9's Pharmacy Consultation Report, dated 5/19/26, indicated the facility needed to obtain a psychotropic consent for a new order of trazadone (a psychotropic medication) for insomnia. Additionally, the report indicated the facility needed to monitor R9's sleep while R9 received trazadone. However, R9's medical record lacked evidence that the facility obtained psychotropic consent for R9's trazodone. Additionally, R9's medical record lacked evidence sleep monitoring was completed as recommended. During an interview on 6/25/26 at 11:21 a.m., registered nurse (RN)-H stated nurses obtained consent for a psychotropic medication when a resident was admitted to the facility, or when a new psychotropic medication was ordered. RN-H stated she processed the pharmacy recommendations for the nursing department. RN-H verified R9's medical record lacked evidence of psychotropic consent for trazodone. Additionally, RN-H acknowledged sleep monitoring had not been initiated for R9. RN-H stated the sleep monitoring was important to monitor if R9 was sleeping too much or not sleeping enough. During an interview on 6/25/26 at 11:46 a.m., director of nursing (DON) stated the nurse managers were responsible for completing nursing department pharmacy recommendations. DON stated the nurse managers were expected to complete nursing pharmacy recommendations within a week. A policy for follow up and review of consulting pharmacist recommendations was requested, however, not received.			F0756			

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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 §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 document review, the facility failed to ensure adequate monitoring was completed for 1 of 5 residents (R255) reviewed for unnecessary medications. Findings include: R255's admission Minimum Data Set (MDS), dated 4/30/26, indicated R255 had severe cognitive impairment, required substantial assistance with activities of daily living (ADLs), and diagnoses included hypertension, chronic kidney disease, dementia, diabetes, and anxiety. R255's order summary report, printed 6/25/26, included an order dated 5/12/26 for metoprolol succinate extended release 50 milligrams (mg) by mouth one time daily, hold for systolic blood pressure (SBP) less than 100 or heart rate (HR) less than 60.			F0757			

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F0757 SS = D	Continued from page 54 R255's medication administration records (MAR) for May 2026 and June 2026, indicated R255's blood pressure was monitored. However, R255's MARs failed to indicate R255's heart rate was monitored and recorded as per provider order. During an interview on 6/25/26 at 10:56 a.m., registered nurse (RN)-I stated staff were expected to check a resident's blood pressure and/or heart rate if the orders had parameters to hold a medication. RN-I verified R255's orders indicated metoprolol was to be held if the SBP was less than 100 or HR less than 60. RN-I stated R255's MAR indicated staff needed to obtain R255's blood pressure prior to the administration of R255's metoprolol. RN-I acknowledged R255's MAR failed to prompt staff to obtain R255's heart rate prior. During an interview on 6/25/26 at 11:05 a.m., RN-J stated when a medication required a heart rate and blood pressure to be taken, the order should have triggered staff to check and record the reading. RN-J stated R255's order did not indicate the HR was to be recorded. During an interview on 6/25/26 at 11:46 a.m., director of nursing (DON) stated when an order was entered into the system supplementary documentation was expected to be added to the order to require both the heart rate and blood pressure to be recorded. DON reviewed R255's orders, stated the supplementary pulse (heart rate) was not selected to require the HR to be recorded, so the metoprolol could have been administered if R255's HR was less than 60. The facility's Physician Medication Orders policy, reviewed 10/2025, did not address medication parameters.			F0757			
F0770 SS = D	Laboratory Services CFR(s): 483.50(a)(1)(i) §483.50(a) Laboratory Services. §483.50(a)(1) The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services.			F0770			

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F0770 SS = D	Continued from page 55 (i) If the facility provides its own laboratory services, the services must meet the applicable requirements for laboratories specified in part 493 of this chapter. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to coordinate blood draws as ordered by the provider for 1 of 2 residents (R25) reviewed for dialysis. Findings include: R25's admission Minimum Data Set (MDS) assessment, completed on 5/12/26, indicated R25 was cognitively intact, was able to communicate wishes to others, understood others, and diagnoses included renal insufficiency with dependence on dialysis and anemia. R25's progress note on 6/8/26, at 1:56 p.m., indicated a call was received from the lab to alert facility R25 had a critical lab value of hemoglobin (hgb-the oxygen carrying cells in the blood) was low at 6.9 (normal hemoglobin level is 12 - 16). The note indicated that the provider was updated. The progress notes lacked indication of subsequent blood draws following the last blood draw on 6/15/26. During interview on 6/22/26 at 1:19 p.m., R25 stated he felt good and denied any symptoms of nausea or vomiting, although stated he was tired after dialysis. R25 stated he had his Hgb checked while at dialysis and his most recent lab value was at 8.2. R25 was unable to recall when that was completed. R25 stated the lab tech did come to draw blood on Monday, 6/22/26, however, R25 stated he had requested lab draws be done on his dialysis days as they were already accessing his site for dialysis. However, R25's narrative notes lacked any indication that the lab work had been attempted and declined by resident. Additionally, the documentation lacked indication that there had been follow up with dialysis facility to request labs while at dialysis, or subsequent follow up with the provider to inform them this had not been completed. R25's June 2026 Medication Administration Record (MAR)/Treatment Administration Record (TAR), identified the nurse on Sunday evening, 6/21/26, prepared a lab slip for weekly CBC (complete blood count-a test which reviews hemoglobin, white count and other measurements to assess status) to be drawn Monday, 6/22/26. However, R25's records,			F0770			

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NAME OF PROVIDER OR SUPPLIER NORTH RIDGE HEALTH AND REHAB				STREET ADDRESS, CITY, STATE, ZIP CODE 5430 BOONE AVENUE NORTH , NEW HOPE, Minnesota, 55428			
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F0770 SS = D	Continued from page 56 lacked evidence labs had been drawn. During observation and interview on 6/24/26 at 10:05 a.m., health unit coordinator (HUC)-B reviewed the lab book to see if blood had been drawn on 6/22/26 as ordered. HUC-B identified the lab draw had not been documented as having been done, nor was there documentation it had been declined, or of any subsequent follow up with the provider. HUC-B stated documentation was completed by the nurses. HUC-B stated a CBC had been drawn on 6/15/26 as ordered, however, there had been no subsequent follow up. HUC-B stated she was unaware if labs were able to be drawn during routine dialysis run. During interview on 6/24/26 at 1:57 p.m., the dialysis registered nurse (DRN)-A stated it was possible to draw lab work while at the dialysis facility, however, the request needed to be completed by nursing or lab, to allow coordination. DRN-A verified via email on 6/24/26 at 5:51 p.m., R25's hgb was last drawn at the dialysis facility on 6/18/26 and was at 8.2. During interview on 6/25/26 at 8:01 a.m., registered nurse/unit manager (RN/UM)-A stated R25 was admitted to the unit with orders for routine blood work. RN/UM-A stated she was unsure why the labs were not drawn on 6/22/26, and identified the documentation lacked rationale for missed draw or request for change in blood draw process at dialysis. During interview on 6/25/26 at 2:26 p.m., the director of nursing (DON) stated it was her expectation that if labs were not drawn as ordered, the nursing staff would investigate as to why it had not been completed as ordered and follow up with provider. DON stated refusal of lab draws, and subsequent follow up were to be documented to reflect this in the medical record. DON stated if it were the request to have labs done during the dialysis session, this was to be coordinated with the dialysis facility. The facility's Lab and Diagnostic Test Results-Clinical Guidelines policy, last reviewed 6/25, identified labs were ordered by the physician, and staff were to process test requisitions and arrange for tests per community and contracted lab protocol. The policy defined that a nurse was to review all results and alert the provider accordingly. The facility's Guidelines for Charting and Documentation policy, last reviewed 6/25, identified the purpose of charting was to document a complete			F0770			

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F0770 SS = D	Continued from page 57 account of the resident's care, treatment, and response to the care. The policy outlined refusal of treatments were to be documented and the information recorded was to include the date and time the treatment, the treatment refused, resident's response and reason for refusal, the date/time the provider was notified, and the provider response.			F0770			
F0790 SS = D	Routine/Emergency Dental Srvcs in SNFs CFR(s): 483.55(a)(1)-(5) §483.55 Dental services. The facility must assist residents in obtaining routine and 24-hour emergency dental care. §483.55(a) Skilled Nursing Facilities A facility- §483.55(a)(1) Must provide or obtain from an outside resource, in accordance with with §483.70(f) of this part, routine and emergency dental services to meet the needs of each resident; §483.55(a)(2) May charge a Medicare resident an additional amount for routine and emergency dental services; §483.55(a)(3) Must have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility; §483.55(a)(4) Must if necessary or if requested, assist the resident; (i) In making appointments; and (ii) By arranging for transportation to and from the dental services location; and §483.55(a)(5) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink			F0790			

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F0790 SS = D	Continued from page 58 adequately while awaiting dental services and the extenuating circumstances that led to the delay. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review, the facility failed to ensure oral health needs were met for 1 of 1 residents (R2) reviewed for denture fit and function resulting in the resident not consistently receiving or using dentures despite documented issues with improper fit and the resident's expressed desire to use them. Additionally, the facility failed to ensure routine dental service recommendations were followed to promote oral hygiene and reduce the risk of complications for 1 of 1 residents (R21) reviewed for dental services. Findings include: R2's quarterly Minimum Data Set (MDS) assessment, dated 4/6/26 indicated R2 was cognitively intact and required partial to moderate assistance with most activities of daily living (ADLs). R2's dental note, dated 10/1/24, documented R2's dentures did not fit properly and required adjustment, with the provider noting additional adjustments may be needed as the resident continued to adapt to new dentures. R2's MDS oral/dental assessment, dated 12/22/25, indicated the R2's dentures did not fit correctly and recommended evaluation for adjustment. R2's care plan, dated 2/22/23 and revised 8/8/25, identified oral/dental health problems and directed staff to provide mouth care as part of ADL assistance. However, the care plan lacked any specific interventions that addressed denture use, management, or follow-up. R2's electronic medical record (EMR) lacked documentation of dental follow-up or evaluation regarding dentures after December 2025. During an observation and interview on 6/22/26 at approximately 11:19 a.m., R2 was observed without dentures in place, and stated the dentures frequently fell out of his mouth and did not fit right. R2 stated staff stopped attempting to assist with denture use			F0790			

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F0790 SS = D	Continued from page 59 so he no longer consistently wore them. R2 stated he wanted to continue using dentures as he was also experiencing gum tenderness. During an interview on 6/24/26 at 10:33 a.m., Nursing Assistant (NA)-E stated R2 needed assistance of one staff for ADLs. NA-E confirmed staff provided oral care, but did not assist with placement or use of dentures, and did not think R2 wore dentures. During an interview on 6/24/26 at 10:53 a.m., the Health Unit Coordinator (HUC) stated the facility utilized both onsite and outside dental providers. HUC stated scheduling was variable and sometimes providers arrived without prior notice. The HUC was not aware of when R2 last received dental services or follow-up regarding dentures. During an interview on 6/24/26 at 1:28 p.m., the Registered Nurse (RN)-O, confirmed R2's treatment record did not indicate R2 currently used dentures, and RN-O was unaware of any denture use. During an interview on 6/25/26 at 9:11 a.m., the Licensed Practical Nurse/Unit Manager (LPN) stated R2 had dentures and LPN was unaware of concerns regarding improper fit. LPN acknowledged no dental follow-up had been completed after R2's 12/2025 dental assessment. R21's annual Minimum Data Set (MDS), dated 4/19/26, identified R21 with intact cognition, no behaviors or limitations in upper and lower extremities, required set up for oral hygiene, and diagnoses included diabetes, heart disease, kidney disease, and partial amputation of left foot. R21's electronic medical record (EMR), including R21's care plan, physician orders and progress notes, failed to identify the provision of denture adhesive. During observation and interview with R21 on 6/22/26 at 11:55 a.m., R21 stated he had both upper and lower dentures and, "they don't fit like they should, and they [facility] were supposed to get back to me about six weeks ago to put something on the bottom dentures but that has not happened" and "the bottom ones fit so bad that I worry I will lose them." No denture adhesive was in R21's room or			F0790			

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F0790 SS = D	Continued from page 60 bathroom. During interview with nursing assistant (NA)-D on 6/23/26 at 3:01 p.m., NA-D stated expectation of nursing assistants to review the resident's EMR prior to providing cares. "I look in computer for what residents need". NA-D stated denture adhesive was expected to be included if needed by the resident. During interview with R21 on 6/23/26 at 3:37 p.m., R21 stated facility failed to offer or provide denture adhesive to ensure his dentures stayed in his mouth. "I have asked several times and it has not been offered". R21's Dental Health Screening assessment, dated 5/8/25, identified "please provide denture adhesive for this resident". R21's Dental Health Screening assessment, dated 3/16/26, identified "He is concerned that his dentures are loose. He has asked for adhesive but has not received anything from the home." During interview with registered nurse (RN)-D on 6/24/26 at 1:19 p.m., RN-D verified R21 had upper and lower dentures. RN-D verified denture adhesive was not in R21's room, and his care plan did not indicate denture adhesive was needed. RN-D stated it "should be in there so we can make sure he gets what he needs". During interview on 6/25/26 at 11:02 a.m., the Director of Nursing (DON) acknowledged the facility did not have a reliable process to ensure residents were consistently offered dental services as required, and stated there was a lack of an effective system to ensure dental recommendations were followed, documented, and incorporated into the care plan. DON stated the systemic breakdown resulted in failure to ensure ongoing assessment and management of R2's oral health needs. Regarding R21, DON stated, "We are supposed to follow recommendations and document that in a progress note and update the care plan and kardex if changes or updates are needed. We do not have a good process now to ensure dental visits are offered as we should because people can miss out on basic routine dental care." The facility's Dentures, Cleaning and Storing policy, dated 10/2025, indicted damaged, broken, ill-fitting, or lost dentures should be documented in the EMR (electronic medical record) and reported to the licensed nurse or social services, as required by facility policy.			F0790			

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F0790 SS = D	Continued from page 61			F0790			
F0880 SS = D	The facility's Medication Orders and Treatment, Dental Services policy, effective 10/2025, indicated medication orders and treatment will be administered by nursing service personnel as soon as the order has been received. Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (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:			F0880			

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F0880 SS = D	Continued from page 62 (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to implement infection prevention and control practices by ensuring staff performed hand hygiene and changed gloves between contaminated and clean resident care tasks during incontinent care for 1 of 1 residents (R142) reviewed for incontinence care. Findings include: R142's admission Minimum Data Set (MDS) assessment was in progress following admission to the facility on 6/12/26. R142's diagnoses, dated 6/12/26, included malignant neoplasm of the prostate with secondary malignant neoplasms of the bone, lung, and lymph nodes, and neoplasm-related pain. R142's pain assessment, dated 6/16/26, indicated			F0880			

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F0880 SS = D	Continued from page 63 R142 was cognitively intact with a Brief Interview for Mental Status (BIMS) score of 14 and had experienced frequent pain during the previous five days. R142's care plan, dated 6/12/26, indicated the resident had a self-care deficit related to a diagnosis of cancer and required moderate assistance with most activities of daily living (ADLs). During observation on 6/24/26 at 8:32 a.m., Nursing Assistant (NA)-F provided incontinence care for R142. NA-F removed R142's soiled brief and cleansed the resident's perineal area using disposable wipes while wearing gloves. Without removing the contaminated gloves, NA-F applied a clean brief. While still wearing the contaminated gloves, NA-F repositioned R142, removed the soiled linens, placed clean sheets and pillowcases on the bed, and handled other clean linen and environmental surfaces. NA-F wore the same contaminated gloves throughout the care provided. During an interview on 6/25/26 at 8:44 a.m., the Infection Preventionist (IP) stated staff were expected to change gloves after completing a dirty task, such as providing perineal care or changing a soiled brief, before moving to a clean task, such as dressing a resident or handling clean linens. The IP further stated staff were expected to perform hand hygiene after removing contaminated gloves and before donning a new pair of gloves. The IP explained these practices were necessary to prevent contamination of clean surfaces, equipment, and resident care items. During an interview on 6/25/26 at 11:20 a.m., the Director of Nursing (DON), confirmed staff were expected to change gloves and perform hand hygiene between dirty and clean care tasks as described by the IP. The facility's Handwashing/Hand Hygiene policy, dated 10/2025, identified hand hygiene as the primary means of preventing the spread of infection and directed staff to perform hand hygiene before and after bathroom care and resident personal hygiene.			F0880			
F0732 SS = C	Posted Nurse Staffing Information CFR(s): §483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information.			F0732			

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F0732 SS = C	Continued from page 64 §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. (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			F0732			

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F0732 SS = C	Continued from page 65 State law, whichever is greater. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review, the facility failed to ensure the staff posting was updated each shift as required, resulting in outdated staffing information being consistently posted over multiple days. This had the ability to affect all 241 residents residing in the care facility. Findings include: From 6/22/26 through 6/25/26, the facility's nurse staffing post was observed to be outdated on multiple occasions. On 6/22/26 at 10:02 a.m., the posted nurse staffing information was dated Friday, 6/19/26. On 6/24/26 at 7:53 a.m., the posted nurse staffing information was dated 6/23/26. On 6/25/26 at 7:50 a.m., the posted nurse staffing information was dated 6/24/26. The posted nurse staffing information had not been updated daily or per shift as required. During an interview on 6/25/26 at 7:46 a.m., front desk staff (O)-1 stated staffing updates were typically maintained by the staffing office. During an interview on 6/25/26 at 7:50am, the staffing coordinator (SC) stated the scheduling staff were responsible for updating the posting on weekdays, and on weekends the house manager was expected to ensure the posting was updated. During an interview on 6/25/26 at 11:20 a.m., the Director of Nursing (DON) stated the expectation was that staff postings were updated each shift to reflect current staffing levels, and on weekends the house supervisor was responsible for ensuring the posted nursing staff information remained accurate and timely. The facility's Posting Direct Care Daily Staffing Numbers policy, dated 10/2025, indicated at the beginning of each shift, the number of Licensed Nurses (RNs, LPNs, and LVNs) and the number of unlicensed nursing personnel (CNAs) directly responsible for resident care will be posted in a prominent location (accessible to residents and visitors) and in a clear and readable format.			F0732			

Minnesota Department of Health

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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 6/22/26 through 6/25/26, 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. The following facility reported incidents were reviewed: NO licensing orders were issued.			20000			

Office of Primary Care and Health Systems Management

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 06/25/2026	
NAME OF PROVIDER OR SUPPLIER NORTH RIDGE HEALTH AND REHAB				STREET ADDRESS, CITY, STATE, ZIP CODE 5430 BOONE AVENUE NORTH , NEW HOPE, Minnesota, 55428			
(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
20000	Continued from page 1 H51831153 (iQIES Incident #2978781 with associated Complaint 2976996) H51833022C (iQIES Incident #3049974). The following complaints were reviewed: NO licensing orders were issued. H51831153 (iQIES Incident #2978781 with associated Complaint 2976996) H51831582C (iQIES Complaint #1008831); H51831594C (iQIES Complaint # 2693077); H51831593C (iQIES Complaint #2698232); H51831590C (iQIES Complaint #2701147); H51831587C (iQIES Complaint #2715252); H51831589C (iQIES Complaint #2715569); H51831581C (iQIES Complaint # 2715590); H51831591C (iQIES Complaint #2718107); H51831586C (iQIES Complaint #2722942); H51831585C (iQIES Complaint #2732806); H51831583C (iQIES Complaint #248538709 and 2785303); H51831660C iQIES Complaint #2995084); H51832859C (assigned iQIES Complaint #3038052); H51833012C (iQIES Complaint #3050588 and Incident #3050195). 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."			20000			

Minnesota Department of Health

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20000	Continued from page 2 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/infobulletins/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				
20300	Competency CFR(s): MN Rule 4658.0105 A nursing home must ensure that direct care staff are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through the comprehensive resident assessments and described in the comprehensive plan of care, and are able to perform their assigned duties. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review, the facility failed to ensure licensed nursing staff demonstrated competency by administering the incorrect dose of a controlled medication and inaccurately documenting controlled substance administration for 1 of 3 residents (R142) reviewed for medication administration. Findings include: R142's diagnoses list, dated 6/12/26, included malignant neoplasm of the prostate with secondary		20300				

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20300	Continued from page 3 malignant neoplasms of the bone, lung, and lymph nodes, and neoplasm-related pain. R142's physician orders, dated 6/12/26, included an order for Methadone HCl 10 milligram (mg) tablets - 50 milligrams (mg) every morning, 20 mg daily (midday), and 40 mg at bedtime for pain. During observation on 6/24/26 at 8:15 a.m., Licensed Practical Nurse (LPN)-D entered R142's room to administer scheduled medications. During the medication pass, R142 requested as-needed pain medication and LPN-D why there were only two pain pills in his medication cup as he should have five pills. LPN-D told R142 that the medication cup contained his morning dose. Review of R142's methadone medication card revealed all three varying doses of methadone were packaged in the same medication card, with each bubble containing either two, four or five 10mg-tablets. LPN-D stated she removed methadone tablets from the medication card in the order they were packaged, rather than verifying the prescribed dose before administration. LPN-D acknowledged she had administered 20 mg (two 10mg-tablets) instead of the ordered 50 milligrams (five 10mg-tablets) for the scheduled 6/24/26 morning dose. Following R142's medication administration on 6/24/26 at 8:15 a.m., LPN-D documented the controlled substance incorrectly in the narcotic accountability record when she recorded an incorrect remaining tablet count. After LPN-D acknowledged she had administered Methadone 20mg instead of 50mg as ordered for R142's morning medication administration, LPN-D corrected the documentation after the error was acknowledged.. During observation and interview on 6/24/26 at approximately 8:45 a.m., LPN-D returned to R142's room with three additional methadone 10mg-tablets, stated hospice had been contacted, and hospice instructed LPN-D to administer the remaining tablets to complete the prescribed morning dose. During an interview on 6/25/26 at 9:11 a.m., Nurse Manager LPN-C stated licensed nurses were expected to follow the five rights of medication administration, verify medication directions prior to administration, review medication parameters, and maintain accurate narcotic accountability records by documenting the correct quantities administered and remaining. LPN-C stated the nurse should have			20300			

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20300	Continued from page 4 recognized that multiple methadone doses were packaged within the same medication card. During an interview on 6/25/26 at 11:20 a.m., the Director of Nursing (DON), stated licensed nurses were expected to follow the five rights of medication administration by ensuring the right resident, right medication, right dose, right route, and right time before medications were administered. The DON stated nurses were expected to accurately document controlled substance administration and follow up with nurse management if concerns with medication packaging were noted. The facility's Medication Administration policy, dated 10/2025, directed staff to administer medications safely, timely, and as prescribed. The policy required licensed staff to administer medications in accordance with physician orders, verify the right resident, right medication, right dose, right time, and right route before administration by checking the medication label three times, and accurately document medication administration following administration. The policy further directed staff to contact the resident's physician if a prescribed dosage was believed to be inappropriate or excessive and indicated newly authorized staff were not permitted to administer medications until they had been oriented to the facility's medication administration system. SUGGESTED METHOD OF CORRECTION: The administrator or designee could develop and/or revise and implement policies and procedures related to nursing oversight and implement a training program for newly hired and/or existing nursing staff. The administrator or designee should ensure oversight is provided to ensure appropriate competency and orientation is provided upon hire, yearly, and as needed. The director of nursing or designee should re-educate staff on the policies and procedures and have a system for evaluating and monitoring consistent implementation of these policies. Audits should be brought to the facility's Quality Assurance Committee for review to determine compliance or the need for further monitoring. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.			20300			
20550	Comprehensive Resident Assessment; Review CFR(s): MN Rule 4658.0400 Subp. 4			20550			

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20550	Continued from page 5 Subp. 4. Review of assessments. A nursing home must examine each resident at least quarterly and must revise the resident's comprehensive assessment to ensure the continued accuracy of the assessment. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to ensure the Minimum Data Set (MDS) was accurately coded, with the potential for inaccurate federal reimbursement and resident care planning for 3 of 3 residents (R12, R15, R123) reviewed for MDS accuracy. Findings include: R12's readmission Minimum Data Set (MDS) assessment, dated 3/20/26 indicated R12 had not had any falls in the month prior to admission/re-admission, and indicated R12 had not had any fractures related to a fall in the 6 months prior to admission/re-admission. R12's quarterly MDS assessment, dated 6/22/26, indicated R12 had no falls in the previous 90 days. R12's care plan indicated R12 was at risk for falls related to cognition, unsteady gait and weakness. The care plan further indicated a fall with fractured hip on 3/9/26. During an interview on 6/25/26 at 11:17 a.m., licensed practical nurse manager (LPN)-A stated R12's readmission MDS assessment dated 3/20/26, and quarterly MDS assessments were inaccurate due to R12's fall with hip fracture on 3/9/26. During an interview on 6/25/26 at 1:52 p.m., Director of Nursing (DON) confirmed R12 had a fall with fracture on 3/9/26, the MDS assessments dated 3/20/26 and 6/22/26 were inaccurately coded. DON stated it was important for the MDS assessments to be accurate so residents received the care they needed and to prevent potential negative outcomes to residents. R15's significant change MDS, dated 4/18/26, indicated R15 took an anticoagulant and not an			20550			

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20550	Continued from page 6 antiplatelet. R15's Medication Administration Record (MAR), dated 4/1/26 to 4/30/26, indicated R15 had not received an anticoagulant during the look back period (LBP), but had received 81 milligrams (mg) of aspirin (an antiplatelet medication) daily during the LBP. During an interview on 6/25/26 at 8:44 a.m., MDS coordinator (MDSC)-A, a registered nurse (RN), reviewed R15's medical record and stated R15 had taken an antiplatelet medication, aspirin, and had not received an anticoagulant medication during the LBP. R123's annual MDS, dated 5/28/26, indicated R123 was taking an anticoagulant and not an antiplatelet. R123's May 2026 MAR, dated 5/1/26 to 5/31/26, indicated R123 had not received an anticoagulant during the look back period (LBP) but did receive 81 milligrams (mg) of aspirin (an antiplatelet medication) daily during the LBP. During an interview on 6/25/26 at 7:57 a.m., RN-G reviewed R123's medical record and stated R123 had not been taking an anticoagulant but did take aspirin. During an interview on 6/25/26 at 8:27 a.m., RN-D, a nurse manager, reviewed R123's medical record. RN-D verified R123 had not taken an anticoagulant since 2021 when it was discontinued. RN-D stated R123 was and had been taking aspirin and verified aspirin was not an anticoagulant. During an interview on 6/25/26 at 8:51 a.m., MDSC-A, reviewed R123's medical record and stated R123 had taken an antiplatelet medication (aspirin), and not an anticoagulant medication during the LBP. MDSC-A verified the MDS was coded incorrectly. During an interview on 6/25/26 at 10:35 a.m., DON stated it was important the MDS was accurate as it affected reimbursement and MDS assessment information directed the care plan and interventions.			20550			

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20550	Continued from page 7 The facility's MDS Assessment Coordinator policy, dated 3/2027, indicated that each individual who completed a portion of the MDS must certify the accuracy of the assessment. SUGGESTED METHOD OF CORRECTION: The administrator or designee could review applicable procedures and policies to ensure the timely and accurate capture of resident information pertaining to the Minimum Data Set (MDS); then educate staff and audit to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.		20550				
20830	Adequate and Proper Nursing Care; General CFR(s): MN Rule 4658.0520 Subp. 1 Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review, the facility failed to ensure fall interventions were implemented to prevent further falls and potential injury for 1 of 3 residents (R6) reviewed for falls. Additionally, the facility failed to comprehensively assess to prevent potential injury for 1 of 1 residents (R44) reviewed for smoking. Findings include: R6's annual Minimum Data Set (MDS), dated 6/8/26, indicated R6 was cognitively intact, had not rejected cares, was independent with activities of daily living (ADLs), and diagnoses included arthritis and depression. R6's progress note, dated 5/14/26 at 5:13 a.m., indicated that R6 slid from bed and was found on the floor with no injuries observed.		20830				

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20830	Continued from page 8 R6's fall risk management, dated 5/14/26, indicated R6 had fallen out of bed and was found on her bedside floor by staff. The report indicated R6 stated she was rolling in her bed when she had fallen. The report indicated R6 thought the bed was too small, causing her to fall off her bed, and R6 was given a new and bigger bed to reduce the risk of falling. R6's care plan, dated 5/18/26, indicated R6 was at risk for falls related to gait and balance problems and had fallen on 7/8/25, 1/25/26, 2/10/26, and 5/14/26. The care plan indicated that related to a fall on 5/14/26, R6 was "given a bigger bed". R6's progress note, dated 6/22/26 at 5:22 a.m., indicated R6 was found lying on the floor beside her bed, and R6 had stated she was lying on her side in bed and attempted to roll toward the side of the bed and rolled out of bed. The progress note indicated that R6 did not have any injuries at the time of the assessment. During multiple observations on 6/23/26, other beds on the unit were observed and compared to R6's bed. R6's bed appeared to be the standard bed size. During an interview on 6/22/26 at 1:38 p.m., R6 stated she had fallen out of bed a couple of times when trying to reposition herself in bed, and felt her bed was too small. R6 stated she thought she was going to get a bigger bed but never did. During an observation and interview on 6/23/26 at 12:53 p.m., registered nurse (RN)-B stated R6 had a history of falls and R6 was supposed to have given a bigger bed. RN-B stated it appeared R6 had gotten a larger bed because the one R6 had was a "normal-sized" bed. During an interview on 6/23/26 at 1:02 p.m., licensed practical nurse (LPN)-A, the nurse manager for the unit, stated as the fall intervention for R6's fall on 5/14/26, LPN-A ordered a larger bed and thought R6 had received it. LPN-A stated it appeared R6 had not received a larger bed and LPN-A needed to talk to the director of maintenance (DM) to determine what happened.			20830			

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20830	Continued from page 9 During an interview on 6/23/26 at 1:07 p.m., the DM stated R6's bed was the standard-sized bed, and R6 had not been provided with a larger one. During a follow-up interview on 6/24/26 at 1:37 p.m., the DM stated there had been a miscommunication between maintenance and nursing. The DM stated nursing had indicated that a larger mattress was needed, but R6 already had the largest mattress size for her bed frame. The DM stated the ticket had then been "closed out" and a larger bed was not ordered. R44's admission Minimum Data Set (MDS), dated 5/13/26, indicated resident was cognitively intact and received supervision to moderate assistance with all activities of daily living (ADLs). R44's Face Sheet, printed 6/25/26, indicated R44 diagnoses included malignant neoplasm of unspecified kidney, dependence on renal dialysis, anxiety, and traumatic subdural hemorrhage without loss of consciousness. During an observation and interview on 6/22/26 at 3:07 p.m., R44 was in his room with his significant other, and two packs of cigarettes were observed on a corner table. R44 stated he smoked several times each day. No burn holes in R44's clothing were observed. During an observation on 6/24/26, at 11:46 a.m., R44 self-propelled in his wheelchair from his room to the designated outside smoking area, at the rear of the facility. R44 independently lit his cigarette, held it safely, extinguished his cigarette safely, and placed the cigarette butt in the smoking pole (a tall container where residents placed their cigarette butts). During an observation on 6/24/2026 at 12:04 p.m., R44 was seated in his room as he ate his noon meal. Two packs of cigarettes were on the corner table beside R44. During an observation on 6/24/26, at 3:58 p.m., R44 again wheeled himself in his wheelchair from his room to the designated outside smoking area. R44 managed the entire smoking process correctly and			20830			

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20830	Continued from page 10 safely. R44's Smoking Evaluation, dated 5/14/26, indicated R44 did not wish to smoke during his stay, and R44 did not utilize oxygen. The remainder of the assessment was blank. R44's Smoking Evaluation, dated 5/24/26, indicated R44 did not wish to smoke during his stay, and the remainder of the assessment was blank. R44's Comprehensive Care Plan lacked information related to smoking. During an interview on 6/25/26 at 7:30 a.m., registered nurse (RN)-E stated R44 smoked independently at least four times a day. RN-E stated when R44 first admitted, he was not smoking and went outside "to get some fresh air." When staff noted R44 was smoking, staff approached R44 and he told staff, "I don't have that much more time to live, so I'm going to smoke." During an interview on 6/25/26 at 8:19 a.m., clinical manager (RN)-F stated he was not the clinical manager for R44's wing when R44 was admitted. and was not aware R44 lacked a comprehensive assessment of his smoking abilities. RN-F stated the facility's expectation was that any resident who smoked, whether known at the time of admission or observed afterwards, was assessed by the facility staff for resident safety. During an interview on 6/25/26 at 8:30 a.m., the director of nursing (DON) stated nursing staff were expected to assess and keep "eyes on" residents who wished to smoke to determine the resident's ability to smoke safely. If a resident was assessed as safe to smoke independently, they would not need supervision, unless there was a change in their status and needed to be reassessed. The facility's Managing Falls and Fall Risk policy, dated 6/2026, indicated that facility staff would attempt to identify appropriate interventions to reduce the risk of falls. The policy indicated that if a systematic evaluation of a resident's fall risk identifies several possible interventions, the staff may choose to prioritize interventions.			20830			

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20830	Continued from page 11 The facility's Accident Prevention - Smoking Policy, revised 10/2022, indicated the facility shall establish and maintain safe resident smoking practices. Residents whom wish to smoke will be evaluated for "safe smoking" per community protocol. Any smoking-related privileges, restrictions, and concerns (for example, need for close monitoring) shall be noted on the care plan, and all personnel caring for the resident shall be alerted to these issues, per community protocol. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON), or designee, could review and revise (as needed) applicable policies and procedures pertaining to fall interventions and smoking safety; then educate staff on the completion of these safety assessments/interventions; then audit to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.			20830			
20960	Dietary Service - Food Quality CFR(s): MN Rule 4658.0600 Subp. 1 Subpart 1. Food quality. Food must have taste, aroma, and appearance that encourages resident consumption of food. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, and interview, the facility failed to ensure food was served in a timely manner to preserve desired temperatures of food for 5 of 5 residents (R3, R28, R156, R197, R294) reviewed who expressed concerns for food temperatures and palatability. This had the potential to affect all residents who consumed food from the facility kitchen. Findings include: R3's quarterly Minimum Data Set (MDS) assessment, dated 3/16/26, identified R3 had intact cognition with an admission date of 11/13/24. During an interview on 6/24/26 at 10:23 a.m., R3 stated she ate in the main dining room on 2W, and she had brought up the concern of cold food to staff previously.			20960			

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20960	Continued from page 12 R28's quarterly MDS assessment, dated 5/31/26, identified R28 had intact cognition with an admission date of 10/24/25. During an interview on 6/24/26 at 10:23 a.m., R28 stated the food was always cold. It didn't make a difference if you ate in your room or in the dining room. R28 stated he ate in both places and had brought up the concern of cold food to staff previously. R156's quarterly MDS assessment, dated 5/25/26, identified R156 had intact cognition with an admission date of 2/18/26. During an interview on 6/24/26 at 10:23 a.m., R156 stated the food was served cold when it should be hot most of the time. R156 stated he ate in the dining room most of the time and had brought up the concern of cold food to staff previously. R197's quarterly MDS assessment, dated 6/4/26, identified R128 had intact cognition with an admission date of 11/25/25. During an interview on 6/24/26 at 10:23 a.m., R197 stated the French fries were "always cold." R197 stated he ate in the main dining room on 2W most of the time and had brought up the concern of cold food to staff previously. R294's quarterly MDS assessment, dated 4/1/26, identified R294 had intact cognition with an admission date of 1/17/26. During an interview on 6/22/26 at 1:02 p.m., R294 stated the food was served cold when it should have been hot. Furthermore, R294 stated the flavor "wasn't always great". During an observation and interview on 6/24/26 at 12:56 p.m., dining staff, including the dietary manager (DM), were observed serving food from the 3 west dining room. After all resident meals were plated, DM temped the food that remained in the food warmer. The following temperatures were obtained: turkey 164 degrees Fahrenheit (F), green beans 173.8 F and sweet potato 149.5 F. After the temperatures were obtained, the food remained on the warming table. The DM then followed the meal cart into the memory care unit, waited until the last tray was ready to be served, and obtained the following food temperatures from the last tray: turkey 103.5 F, green beans 96.5 F, and sweet potato 102.4 F. DM stated all the food should have been			20960			

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20960	Continued from page 13 above 140 degrees at the time it was served, regardless of if it was in the dining room or served in the resident room. DM stated food temperatures that were below 140 degrees were in the "danger zone" and increased the potential for food-born illnesses. SUGGESTED METHOD OF CORRECTION: The administrator, registered dietician, or designee could ensure proper temperature for meals served. The facility could update or create policies and procedures, and educate staff on proper temperature for meals served to residents. The administrator, registered dietician, or designee could perform audits for a designated amount of time as determined by the Quality Assurance Performance Improvement (QAPI) committee to ensure proper temperatures of meals served to residents. The facility could report those findings to QAPI for further recommendations and determine the need for further monitoring or compliance. TIME PERIOD FOR CORRECTION: 21 days			20960			
20965	Dietary Service -Nutritional Status CFR(s): MN Rule 4658.0600 Subp. 2 Subpart. 2. Nutritional status. The nursing home must ensure that a resident is offered a diet which supplies the caloric and nutrient needs as determined by the comprehensive resident assessment. Substitutes of similar nutritive value must be offered to residents who refuse food served. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to ensure timely and effective interventions were implemented for significant, unplanned weight loss and failed to ensure consistency between physician orders and care plan directives related to weight monitoring for 1 of 1 residents (R256) reviewed for weight loss. Findings include: R256's annual Minimum Data Set (MDS) assessment, dated 5/25/26, indicated R256 had severe cognitive impairment, was dependent on staff for all activities of daily living (ADLs), including feeding, and had a diagnosis of weight loss. R256 received a mechanically altered diet and was not on a prescribed weight-loss regimen.			20965			

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20965	Continued from page 14 R256's physician order, dated 5/1/23, indicated an order for monthly weights. Additional orders included a house supplement shake 4 oz twice daily, initiated 1/9/24, for nutritional supplementation and ProStat Advanced Wound Care Liquid daily, initiated, 6/27/25 for wound healing. R256's weight records indicated R256 weighed 153.2 pounds (lbs) on 4/3/26 and 127 lbs on 6/3/26. These weights indicated a weight loss of 26.2 lbs (17.1%) over 2 months. R256's care plan, revised 3/1/23, identified R256 was at risk for altered nutritional/hydration status related to dysphagia, with altered textures, aphasia, hemiplegia, impaired mobility, and cardiac disease. Interventions included feeding assistance and weekly weights. However, R256's care plan directed weekly weights while R256's physician orders directed monthly weights. R256's nutrition progress note, dated 5/22/26, indicated R256's current weight was 127 lbs and identified a recent weight change within the last 30 days. The note indicated no notable change in oral intake over the 30-day lookback period and recommended continuation of the current plan of care. Despite ongoing weight loss trends, no new interventions or escalation of nutritional interventions were implemented at that time. During an interview on 6/24/26 at approximately 2:00 p.m., the registered dietitian (RD) stated residents were generally weighed monthly, but high-risk residents with weight loss were weighed weekly. The RD acknowledged the R256's weight loss trend and stated current interventions were not effective. The RD stated R256 could have received up to three nutritional shakes per day, and weekly weight monitoring should have been initiated to better evaluate trends. During an interview on 6/25/26 at 9:11 a.m., the Licensed Practical Nurse (LPN)-Unit Manager stated weights were typically obtained monthly per physician order. The LPN stated when discrepancies occurred between care plans and orders, staff followed physician orders, and care plans were expected to be updated accordingly. The LPN further stated the R256's weight loss had not been escalated as a concern requiring intervention change. During an interview on 6/25/26 at 11:20 a.m., the director of nursing (DON) stated the resident was monitored as a high-risk resident with weight loss.			20965			

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20965	Continued from page 15 DON acknowledged R256 continued ongoing nutritional decline and needed for further evaluation of interventions. The facility's Weight Assessment and Intervention policy, dated 10/2025, indicated significant unplanned weight loss was greater than 7.5% weight loss in 3 months and care planning should include individualized identification of the cause of the weight loss, goals and benchmarks and interventions should consider resident choices, preferences, and abilities. SUGGESTED METHOD OF CORRECTION: The administrator, registered dietician, or designee should ensure dietary interventions are implemented in a timely manner. The facility should review and/or update or create policies and procedures and educate staff on specific requirements or interventions related to weight and nutrition. The administrator, registered dietician, or designee should perform audits for a measurable amount of time as determined by the Quality Assurance Performance Improvement (QAPI) committee to ensure food items given, offered, or consumed by residents are implemented as identified or ordered. The facility should report those findings to QAPI for further recommendations and determine the need for further monitoring or compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.			20965			
21340	Providing Routine & Emergency Oral Health Ser CFR(s): MN Rule 4658.0725 Subp. 4 Subp. 4. Dental records. For each dental visit, the clinical record must include the name of the dentist or dental hygienist, date of the service, specific dental services provided, medications administered, medical or dental consultations, and follow-up orders. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review, the facility failed to ensure oral health needs were met for 1 of 1 residents (R2) reviewed for denture fit and function resulting in the resident not consistently receiving or using dentures despite documented issues with improper fit and the resident's expressed desire to use them.			21340			

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21340	Continued from page 16 Additionally, the facility failed to ensure routine dental service recommendations were followed to promote oral hygiene and reduce the risk of complications for 1 of 1 residents (R21) reviewed for dental services. Findings include: R2's quarterly Minimum Data Set (MDS) assessment, dated 4/6/26 indicated R2 was cognitively intact and required partial to moderate assistance with most activities of daily living (ADLs). R2's dental note, dated 10/1/24, documented R2's dentures did not fit properly and required adjustment, with the provider noting additional adjustments may be needed as the resident continued to adapt to new dentures. R2's MDS oral/dental assessment, dated 12/22/25, indicated the R2's dentures did not fit correctly and recommended evaluation for adjustment. R2's care plan, dated 2/22/23 and revised 8/8/25, identified oral/dental health problems and directed staff to provide mouth care as part of ADL assistance. However, the care plan lacked any specific interventions that addressed denture use, management, or follow-up. R2's electronic medical record (EMR) lacked documentation of dental follow-up or evaluation regarding dentures after December 2025. During an observation and interview on 6/22/26 at approximately 11:19 a.m., R2 was observed without dentures in place, and stated the dentures frequently fell out of his mouth and did not fit right. R2 stated staff stopped attempting to assist with denture use so he no longer consistently wore them. R2 stated he wanted to continue using dentures as he was also experiencing gum tenderness. During an interview on 6/24/26 at 10:33 a.m., Nursing Assistant (NA)-E stated R2 needed assistance of one staff for ADLs. NA-E confirmed staff provided oral care, but did not assist with placement or use of dentures, and did not think R2 wore dentures.			21340			

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21340	Continued from page 17 During an interview on 6/24/26 at 10:53 a.m., the Health Unit Coordinator (HUC) stated the facility utilized both onsite and outside dental providers. HUC stated scheduling was variable and sometimes providers arrived without prior notice. The HUC was not aware of when R2 last received dental services or follow-up regarding dentures. During an interview on 6/24/26 at 1:28 p.m., the Registered Nurse (RN)-O, confirmed R2's treatment record did not indicate R2 currently used dentures, and RN-O was unaware of any denture use. During an interview on 6/25/26 at 9:11 a.m., the Licensed Practical Nurse/Unit Manager (LPN) stated R2 had dentures and LPN was unaware of concerns regarding improper fit. LPN acknowledged no dental follow-up had been completed after R2's 12/2025 dental assessment. R21's annual Minimum Data Set (MDS), dated 4/19/26, identified R21 with intact cognition, no behaviors or limitations in upper and lower extremities, required set up for oral hygiene, and diagnoses included diabetes, heart disease, kidney disease, and partial amputation of left foot. R21's electronic medical record (EMR), including R21's care plan, physician orders and progress notes, failed to identify the provision of denture adhesive. During observation and interview with R21 on 6/22/26 at 11:55 a.m., R21 stated he had both upper and lower dentures and, "they don't fit like they should, and they [facility] were supposed to get back to me about six weeks ago to put something on the bottom dentures but that has not happened" and "the bottom ones fit so bad that I worry I will lose them." No denture adhesive was in R21's room or bathroom. During interview with nursing assistant (NA)-D on 6/23/26 at 3:01 p.m., NA-D stated expectation of nursing assistants to review the resident's EMR prior to providing cares. "I look in computer for what residents need". NA-D stated denture adhesive was expected to be included if needed by the resident. During interview with R21 on 6/23/26 at 3:37 p.m., R21 stated facility failed to offer or provide denture adhesive to ensure his dentures stayed in his			21340			

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21340	Continued from page 18 mouth. "I have asked several times and it has not been offered". R21's Dental Health Screening assessment, dated 5/8/25, identified "please provide denture adhesive for this resident". R21's Dental Health Screening assessment, dated 3/16/26, identified "He is concerned that his dentures are loose. He has asked for adhesive but has not received anything from the home." During interview with registered nurse (RN)-D on 6/24/26 at 1:19 p.m., RN-D verified R21 had upper and lower dentures. RN-D verified denture adhesive was not in R21's room, and his care plan did not indicate denture adhesive was needed. RN-D stated it "should be in there so we can make sure he gets what he needs". During interview on 6/25/26 at 11:02 a.m., the Director of Nursing (DON) acknowledged the facility did not have a reliable process to ensure residents were consistently offered dental services as required, and stated there was a lack of an effective system to ensure dental recommendations were followed, documented, and incorporated into the care plan. DON stated the systemic breakdown resulted in failure to ensure ongoing assessment and management of R2's oral health needs. Regarding R21, DON stated, "We are supposed to follow recommendations and document that in a progress note and update the care plan and kardex if changes or updates are needed. We do not have a good process now to ensure dental visits are offered as we should because people can miss out on basic routine dental care." The facility's Dentures, Cleaning and Storing policy, dated 10/2025, indicted damaged, broken, ill-fitting, or lost dentures should be documented in the EMR (electronic medical record) and reported to the licensed nurse or social services, as required by facility policy. The facility's Medication Orders and Treatment, Dental Services policy, effective 10/2025, indicated medication orders and treatment will be administered by nursing service personnel as soon as the order has been received. SUGGESTED METHOD OF CORRECTION: The administrator or designee could develop/revise and implement policies and procedures related to dental recommendations and educate staff on these			21340			

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21340	Continued from page 19 requirements. The quality assessment and assurance committee could perform random audits to ensure compliance.			21340			
	TIME PERIOD FOR CORRECTION: Twenty One (21) days						
21426	Tuberculosis Prevention And Control CFR(s): MN St. Statute 144A.04 Subd. 3 (a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines. (b) Written compliance with this subdivision must be maintained by the nursing home. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to ensure tuberculosis (TB) screening was completed and documented according to Minnesota tuberculosis screening requirements and facility policy for 3 of 3 residents (R12, R152, and R255) reviewed for TB screening. Findings included: R12 was admitted to the facility on 12/18/25. R12's December 2025 medication administration record (MAR) identified the first step Mantoux tuberculosis test was completed. However, the January 2026 MAR lacked documentation the required second step Mantoux tuberculosis test was administered and completed. R152 was admitted to the facility on 4/9/26. R152's April 2026 MAR identified the first step Mantoux tuberculosis test was completed. The second step Mantoux tuberculosis test was administered on			21426			

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21426	Continued from page 20 4/23/26. However, the MAR lacked documentation the second step Mantoux test was read and the results were documented. R255 was admitted to the facility on 4/23/26. R255's April 2026 MAR lacked documentation the required first and second step Mantoux tuberculosis testing was completed. The MAR identified R255 refused Mantoux testing after two attempts. However, the electronic health record (EHR) lacked documentation staff continued attempts to complete the screening, notified the provider, or obtained an alternative TB screening method. During an interview on 6/25/26 at 8:44 a.m., the infection preventionist (IP) reviewed R12, R152, and R255's medical records and confirmed the required tuberculosis screening process was not completed. IP confirmed R12's second step Mantoux tuberculosis test was not administered, R152's second step Mantoux tuberculosis test was administered but not documented as read, and R255 refused Mantoux testing after two attempts with no further follow-up completed. IP stated staff were expected to complete the first Mantoux test upon admission, and the second step within the required timeframe. If testing was refused, staff were expected to continue to make attempts, notify the provider if refusal continued, and alternative screening options should have been pursued, such as a TB blood test or chest x-ray, to identify potential active tuberculosis and prevent transmission within the facility. During an interview on 6/25/26 at 1:40 p.m., the director of nursing (DON) stated residents who were able to complete the two-step Mantoux testing series were expected to have the testing completed. The DON stated if a resident refused testing, staff were expected to follow up with alternative screening options, including a TB blood test or chest x-ray. The DON stated completion of TB screening was important to ensure residents were screened for tuberculosis. The facility's Tuberculosis (TB) Screening Residents policy, revised 1/2025, identified the facility would screen all residents for tuberculosis infection and disease. The policy identified residents without documentation of a negative tuberculin skin test (TST), blood assay for Mycobacterium tuberculosis (BAMT), or chest x-ray (CXR) within the previous 12 months would receive a baseline two-step TST or one-step BAMT upon admission. The policy further identified if the first TST was negative, a follow-up TST would be administered one to three weeks after			21426			

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21426	Continued from page 21 the initial test was read. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could develop and/or revise, and implement policies and procedures related to resident TB screening. The DON or designee should ensure oversight to ensure completion and follow up of TB screening, and provide education/re-education as needed. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.			21426			
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 document review, the facility failed to assess resident for safety and the ability to self-administer medications for 1 of 1 resident (R21) reviewed for self-administration of medications (SAM). Findings include: R21's annual Minimum Data Set (MDS), dated 4/19/26, identified R21 was cognitively intact, and diagnoses included diabetes, heart disease, and kidney disease. R21's physician progress note, dated 1/20/26, identified R21 medication order for nystatin ointment 100000 unit/gram to groin and intergluteal cleft (the deep vertical groove between the buttocks) topically two times a day for fungal rash/dry skin, and with every brief change. R21's electronic medical record (EMR) identified physician orders for nystatin ointment was discontinued on 5/7/26. During an observation and interview on 6/23/26 at			21565			

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21565	Continued from page 22 3:37 p.m., R21 had a nearly empty tube of prescription nystatin ointment, with label attached listing R21's name, and instructions for use as indicated on the 1/20/26 medication order, and the label indicated dates of "Jan 20, 2026, to Feb 20, 2026". R21 stated nystatin remained on his rolling bedside table or top of nightstand since January of 2026. R21 stated he applied the ointment when he felt he needed it. R21 stated staff were aware he had it in his room. R21 stated facility staff had never talked to him about an assessment to determine safety and competence to keep the prescription ointment in his room. During an observation on 6/24/26 at 1:11 p.m., R21's rolling bedside table had a nearly empty tube of the prescription Nystatin ointment. During an interview on 6/24/26 at 11:21 a.m., RN-M stated nurses were to document an assessment in the resident EMR if a resident wished to keep prescription and over the counter (OTC) medications at bedside. When a resident was assessed as safe to self-administer their medications, a provider order for self-administration was obtained and the care plan was updated. RN-M stated complete and accurate medication orders were important due to potential risk of contraindications. During an interview on 6/24/26 at 11:28 a.m., RN-L stated nursing staff were expected to document an assessment in the resident EMR if a resident wished to keep prescription and/or over-the-counter medications at bedside. RN-L stated residents should not have prescription or OTC medications in their rooms unless an assessment was completed and documented in the EMR. RN-L stated, "we don't want [residents] medicating themselves and potentially harm[ing] them". During observation and interview on 6/24/26 at 1:12 p.m., RN-D confirmed the prescription nystatin ointment was in R21's room and verified it was prescribed to R21. RN-D stated the nystatin ointment "should not be here because we need to know all meds". RN-D verified a self-administration of medications assessment had not been completed for R21. RN-D stated the discontinued nystatin order meant the nystatin should have been removed from R21's room when it was discontinued. During an interview on 6/25/26 at 10:56 a.m.,			21565			

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21565	Continued from page 23 director of nursing (DON) stated nurses were expected to document a self-administration assessment for all prescribed and OTC medications left in a resident room. DON stated when a resident was assessed to be safe to self-administer a medication, a provider order for SAM was obtained by staff and documented in the EMR, and the care plan was updated. DON verified R21 was never assessed for safe self-administration of medication, and the order and care plan were never updated. The facility's Self-Administration of Drugs policy, dated 11/2016, indicated residents in our facility who wish to self-administer their medications may do so, if it is determined that they are capable of doing so and clinically appropriate. For self-administering residents, the nursing staff will determine who will be responsible (the resident or the nursing staff) for documenting that medications were taken. The nursing staff will rotate bedside stock and will remove expired, discontinued, or recalled medications. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review applicable policies and procedures to ensure residents' are assessed timely with self administration of all prescribed and over the counter medications; then provide staff education. The quality assurance committee could monitor for compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.		21565				
21615	MedicineCabinet & Preparation Area;ScheduleII CFR(s): MN Rule 4658.1340 Subp. 2 Subp. 2. Storage of Schedule II drugs. A nursing home must provide separately locked compartments, permanently affixed to the physical plant or medication cart for storage of controlled drugs listed in Minnesota Statutes, section 152.02, subdivision 3. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to ensure controlled substance reconciliation was completed in accordance with established policies and procedures		21615				

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21615	Continued from page 24 to reduce the risk of diversion and/or theft on 2 of 8 medication carts reviewed. This had the potential to affect 8 residents identified to have controlled substances in the reviewed carts. Findings include: During an observation and interview on 6/23/26 at 1:54 p.m., the 2W “far south” medication cart was reviewed with registered nurse (RN)-A. The mobile cart was locked with a physical key, along with a separately attached metal narcotic box, which was also locked. The narcotic box was opened and contained numerous controlled substances. RN-A explained that the narcotics and controlled substances were counted at each shift exchange, and these reconciliations were recorded on a Narcotic Shift to Shift Signature form. RN-A provided the flow sheets used to track the documented count(s). However, approximately half of the signature spaces were blank. RN-A confirmed the form had approximately half of the spaces filled and stated all the signature spots should have been completed. RN-A stated she did not know why spaces were blank. The facility's 2 West FS (far south) Narcotic Shift to Shift Signature Sheet, for June 2026, indicated there were 132 possible signature spaces, with 106 documented signatures for 6/1/26 through 6/26/26. During an observation and interview on 6/23/26 at 2:03 p.m., with RN-B and RN-C, the 2W “near south” mobile medication cart was observed locked with a physical key, along with a separately attached metal narcotic box, which was also locked. The narcotic box was opened and contained numerous controlled substances. RN-C explained the narcotics and controlled substances were counted at each shift exchange, and these reconciliations were recorded on a form to indicate the count had occurred. RN-C provided the flow sheets used to track the documented count(s). However, approximately half of the signature spaces were blank. The facility's 2 West NS (near south) Narcotic Shift to Shift Signature Sheet, June 2026, indicated there were 132 possible signature spaces for 6/1/26 to 6/22/26. However, there were 41 signatures total on the sheet for 6/1/26 through 6/22/26.			21615			

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21615	Continued from page 25 During an interview on 6/23/26 at 2:09 p.m., the nurse manager/ licensed practical nurse (LPN)-A stated staff were expected to sign the controlled medication reconciliation form to indicate that controlled medication reconciliation had occurred. LPN-A confirmed approximately half the signatures were missing on the 2W NS form. LPN-A stated that based on documentation, he was unable to confirm that medication reconciliation had occurred. During an interview on 6/24/26 at 10:17 a.m., the director of nursing (DON) stated nursing staff were expected to complete controlled medication reconciliation at each shift change, and the reconciliation should have been documented on the narcotic shift change forms. The facility's Controlled Substances policy, dated 10/2026, indicated the controlled substance records would be reconciled by a physical count of the remaining controlled substance supply at the change of each shift by the oncoming and outgoing licensed nurse/designee. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could develop, review, and/or revise policies and procedures to ensure narcotic medications were signed into the bound narcotic book using the index page to minimize the potential for diversion. The Director of Nursing or designee could educate all appropriate staff on the policies and procedures.The Director of Nursing or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.			21615			
21805	Patients & Residents of HC Fac.Bill of Rights CFR(s): MN St. Statute 144.651 Subd. 5 Subd. 5. Courteous treatment. Patients and residents have the right to be treated with courtesy and respect for their individuality by employees of or persons providing service in a health care facility. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review, the facility failed to provide a dignified dining			21805			

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21805	Continued from page 26 experience for 7 of 7 residents (R28, R124, R128, R197, R233, R244, R257) when meals were served on hard plastic trays in the dining room. Further, the facility failed to ensure resident's right to privacy and dignity for 1 of 1 residents (R2) when staff failed to knock and wait for permission before entering the resident's room. Findings include: R28's quarterly Minimum Data Set (MDS) assessment, dated 5/31/26, indicated R28 had intact cognition, and an admission date of 10/24/25. R124's quarterly MDS assessment, dated 4/13/26, indicated R124 had severely impaired cognition, no hallucinations or delusions, and an admission date of 11/21/18. R128's annual MDS assessment, dated 5/16/26, indicated R128 had short-term and long-term memory issues, severely impaired daily decision making, and an admission date of 11/13/20. R197's quarterly MDS assessment, dated 6/4/26, indicated R128 had intact cognition, and an admission date of 11/25/25. R233's quarterly MDS assessment, dated 4/28/26, indicated R233 had moderately impaired cognition and an admission date of 10/18/24. R244's quarterly MDS assessment, dated 5/1/26, indicated R244 had short term and long-term memory issues, severely impaired daily decision making, and an admission date of 4/5/19. R257's annual MDS assessment, dated 6/14/26, indicated R257 had moderately impaired cognition, no hallucinations or delusions, and an admission date of 8/26/22. During an observation of lunch service on 6/23/26 at 12:59 p.m., 5 residents (R124, R128, R233, R244, R257) were observed eating in the small dining room on the 2W unit, with two staff observed assisting residents at the tables. Positioned on the table in front of each resident was a meal on a hard plastic			21805			

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21805	Continued from page 27 serving tray. Each hard plastic tray had a food plate, silverware, and beverage containers on it. The warming lids from the plates were tipped upside down on the table in front of the residents. During an observation of lunch service on 6/24/26 at 11:46 a.m., the lunch meal service was observed on the 2nd floor west main dining room. The dining room had a steam serving table with food items. The staff placed the food items, beverages, and silverware onto a hard plastic serving tray. The meals were then delivered to each resident at their table. However, the hard plastic servicing trays were then left on the table with plated food, beverages and silverware on top of them. Staff did not ask or offer to remove the items from the serving trays and place them onto the table. R28 and R197 were observed eating from the hard plastic meal tray. R197 stated he did not like the hard plastic serving trays and would not eat from one at home. During an observation on 6/25/26 at 8:03 a.m., breakfast meal service was observed on 2nd floor west main dining room. The residents ate in the dining room and their breakfast meal was served on the hard plastic serving tray. The serving trays remained under each resident's dishes during the meal service. The staff that served the meals in the dining room did not ask residents if they wanted the serving tray removed while the residents ate. During an interview on 6/25/26 at 7:49 a.m., nursing assistant (NA)-A stated the nursing assistants helped serve residents in the dining room. NA-A stated the process was to bring the residents the serving tray of food, set the tray in front of the resident, and take the covers off the plates and beverages. NA-A stated staff had not been directed to take the food items off the hard plastic tray. NA-A stated there was no reason why the food was left on the hard plastic tray when served to residents. During an interview on 6/25/26 at 8:59 a.m., registered nurse unit manager (RN)-D stated nursing staff brought the trays to the residents in the dining room during mealtimes. RN-D acknowledged the meals were served to residents in the dining room on the hard plastic tray. RN-D stated he was not sure why the food was left on the hard plastic trays. During an interview on 6/25/26 at 10:37 a.m.,			21805			

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21805	Continued from page 28 director of nursing (DON) stated meals should have been served without the hard plastic trays. DON stated the food should have been taken off the trays when served to residents to create a more homelike environment. R2's quarterly Minimum Data Set (MDS) assessment, dated 4/6/26, indicated R2 was cognitively intact and and admitted to the facility on 2/21/23. During an observation and interview on 06/22/2026 at 11:27 a.m., staff entered R2's room without ensuring privacy was maintained. An unidentified nursing assistant (NA) knocked once on R2's door, and entered the room without waiting for a response, to inform R2 it was time for lunch. R2 stated staff "just walk right in", expressed fear of changing clothes due to lack of privacy, and reported he did not feel he had adequate privacy in his room. During an interview on 06/24/2026 at 10:33 a.m., NA-E stated that before staff entered a resident's room, staff were expected to knock and wait for a response. During an interview on 06/25/2026 at approximately 9:11 a.m., the nurse manager/ licensed practical nurse (LPN)-C, stated staff were expected to knock and wait for a response prior to entering the room to ensure resident privacy and dignity. During an interview on 06/25/2026 at 11:20 a.m., director of nursing (DON) stated staff were required to knock and wait for a response before entering resident rooms. DON stated this was the facility's expectation to maintain resident privacy. The facility's Dining Environment policy, dated 10/25, indicated the facility would create an appropriate dining environment. The facility's Resident Rights policy, dated 11/2025, indicated federal and state law guarantee residents' basic rights, including the right to privacy. SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON), or designee could develop and implement a plan of care by the interdisciplinary team to ensure residents experience			21805			

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21805	Continued from page 29 a dignified homelike dining experience along with ensuring residents dignity is being maintained at all times (knocking on doors and waiting for response prior to entering). The facility could update policies and procedures, educate staff on these changes, and audit to ensure resident(s) dignity are maintained. The results of these audits will be reviewed by the quality assurance committee to ensure compliance.		21805				
21810	TIME PERIOD FOR CORRECTION: Twenty-one (21) days. Patients & Residents of HC Fac.Bill of Rights CFR(s): MN St. Statute 144.651 Subd. 6 Subd. 6. Appropriate health care. Patients and residents shall have the right to appropriate medical and personal care based on individual needs. Appropriate care for residents means care designed to enable residents to achieve their highest level of physical and mental functioning. This right is limited where the service is not reimbursable by public or private resources. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and record review, the facility failed to accommodate resident needs by ensuring a call light was accessible for 2 of 2 residents (R221, R283) reviewed for call lights. Findings include: R221's admission Minimum Data Set (MDS), dated 5/18/26, identified R221 was cognitively intact, and diagnoses included diagnoses of neurogenic bladder, diabetes, and schizophrenia. Additionally, R221 had impairment on one side of upper and lower extremities, required a walker and wheelchair for mobility, and required substantial assistance for dressing and hygiene. During an observation and interview on 6/25/26 at 8:37 a.m., R221 was seated in a wheelchair in her room, facing her bed with the bedside table between her and her bed. R221's call light was wrapped around the upper bedrail of the bed and out of reach. R221 was unable to access her call light, and stated, "it is too far away". R221 attempted to move her wheelchair around the bed stand but was unable to move. Licensed practical nurse (LPN)-B and		21810				

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21810	Continued from page 30 nursing assistant (NA)-D entered R221's room and verified the call light was not within R221's reach. LPN-B stated the call light "should be in reach". NA-D stated the call light "should be [in reach]". R283's admission MDS, dated 4/13/26, identified R283 with impaired cognition, required assistance with hygiene, and diagnoses of cardiomyopathy, heart disease, kidney disease, diabetes, and depression. During an observation and interview on 6/22/26 at 11:02 a.m., R283 was observed in bed as he watched television (TV). However, R283's call light was wrapped around the wall call light unit and was out of R283's sight and reach. R283 stated if he needed assistance, he would "call out" and it "takes all day to get attention". During an interview on 6/22/26 at 11:06 a.m., nursing assistant (NA)-B verified R283's call light was wrapped around the wall unit and was out of R283's sight and reach. NA-B stated the call light should have been within R283's reach so R283 could "call for help if needs it". During an observation and interview on 6/23/26 at 5:08 p.m., R283 watched TV from his bed. R283's call light was wrapped around the wall and was out of R283's sight and reach. R283 stated, "I don't use it because I can't reach it". During an interview on 6/24/26 at 10:39 a.m., NA-C stated staff were expected to ensure call lights were within reach of every resident when in their rooms. NA-C stated residents could not request help unless the call light was within reach, and it was important for resident safety. During an interview on 6/24/26 at 11:23 a.m., registered nurse (RN)-L stated expectation of call lights to always be in reach of every resident when in their rooms. During an interview on 6/24/26 at 11:19 a.m., RN-M stated call lights should be "ideally within reach". RN-M stated call lights wrapped around the wall unit, and not in reach was not acceptable. RN-M stated the call lights were a "lifeline" for residents			21810			

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21810	Continued from page 31 to use if they needed assistance. During an interview on 6/25/26 at 10:59 a.m., DON stated expectation of call lights to be in reach of every resident “to have for help if needed”. The facility's Answering the Call Light policy, effective 10/2025, indicated when the resident is in bed or confined to a chair, be sure the call light is within easy reach of the resident. SUGGESTED METHODS OF CORRECTION: The director of nursing (DON) or designee could develop, review, and /or revise policies and procedures to ensure all residents have their call lights within reach. The DON or designee could educate all appropriate staff. The DON or designee could develop monitoring systems to ensure ongoing compliance and report those results to the quality assurance committee. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.			21810			
21925	Patients & Residents of HC Fac.Bill of Rights CFR(s): MN St. Statute 144.651 Subd. 29 Subd. 29. Transfers and discharges. Residents shall not be arbitrarily transferred or discharged. Residents must be notified, in writing, of the proposed discharge or transfer and its justification no later than 30 days before discharge from the facility and seven days before transfer to another room within the facility. This notice shall include the resident's right to contest the proposed action, with the address and telephone number of the area nursing home ombudsman pursuant to the Older Americans Act, section 307(a)(12). The resident, informed of this right, may choose to relocate before the notice period ends. The notice period may be shortened in situations outside the facility's control, such as a determination by utilization review, the accommodation of newly-admitted residents, a change in the resident's medical or treatment program, the resident's own or another resident's welfare, or nonpayment for stay unless prohibited by the public program or programs paying for the resident's care, as documented in the medical record. Facilities shall make a reasonable effort to accommodate new residents without disrupting room assignments.			21925			

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21925	Continued from page 32 This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to provide written information on the duration of the bed-hold and reserve bed payment at the time of transfer for 4 of 4 residents (R21, R147, R203, R260) reviewed for hospitalizations. Findings include: R21's annual Minimum Data Set (MDS), dated 4/19/26, identified R21 with intact cognition, and diagnoses included diabetes, heart disease, kidney disease, and partial amputation of left foot. R21's Clinical Assessment screen identified transferred to the hospital on 6/8/26. R21's electronic medical record (EMR) lacked evidence bed holds were offered, signed, and followed up on. During an interview on 6/22/26 at 11:46 a.m., R21 stated he had never been offered or signed a bed hold form when he transferred to the hospital, and stated, "No one from here reached out to me". R147's quarterly Minimum Data Set (MDS), dated 4/28/26, identified R147 had intact cognition and diagnoses included chronic respiratory failure, quadriplegia, and R147 required suctioning and tracheostomy care. R147's EMR identified R147 was transferred to the hospital on 3/15/26, and 4/3/26. However, review of R147's EMR lacked evidence the facility provided R147 and/or R147's resident representative with written information regarding the facility's bed hold policy at the time of the hospital transfers. During an interview on 6/25/26 at 7:50 a.m., the social services designee (SSD) stated social services completed bed holds when available, and nursing staff completed the process if social services were unavailable. The SSD stated when a bed hold was not obtained by nursing staff at the time of transfer, social services followed up with the resident's			21925			

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21925	Continued from page 33 representative. The SSD stated the director of nursing (DON) confirmed completion of bed holds. During an interview on 6/25/26 at 10:53 a.m., registered nurse (RN)-A stated staff determined if the resident was their own responsible party or if the resident's representative needed to be contacted regarding the bed hold. RN-A stated completion of the bed hold process was documented in the resident's progress notes. During an interview on 6/25/26 at 11:07 a.m., the registered nurse case manager (RNCM) stated when a resident was transferred to the hospital, nursing staff notified the resident's representative, discussed the bed hold, and documented the information in the progress notes. The RNCM stated social services were updated and a bed hold form was sent with the resident. The RNCM confirmed R147's EMR lacked evidence bed hold information was provided to R147 and/or R147's resident representative for the hospital transfers on 3/15/26 and 4/3/26. During an interview on 6/25/26 at 1:35 p.m., director of nursing (DON) stated for emergency transfers, social services followed up with the resident and/or resident representative regarding whether they wanted a bed hold and documented the information in the progress notes. The DON stated the process was important to determine if the resident or resident representative wanted to hold the resident's bed, identify the length of time the bed would be held, and ensured clear communication. R203's quarterly MDS, dated 6/2/26, identified R203 with moderate cognitive impairment, and diagnoses included hypertension, peripheral vascular disease, kidney disease, receiving hemodialysis, left below the knee amputation, and diabetes. R203's EMR identified transfers to the hospital on 4/27/26, 5/8/26, and 6/3/26. However, R203's EMR lacked evidence bed holds were offered, signed, and followed up on. During an interview on 6/23/26 at 5:21 p.m., RN-K stated nurses were expected to print out a face sheet, orders, and medication list to send with resident to hospital. In addition, the nurse was			21925			

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21925	Continued from page 34 expected to start a Transfer Form in the EMR. RN-K stated a signed bed hold form was to accompany the resident to the hospital, and a progress note written after the resident transferred to identify status of the bed hold, such as who was notified. During an interview on 6/23/26 at 5:21 p.m., RN-L stated expectation of nursing staff to print out a face sheet, orders, and medication list to accompany resident to hospital once orders to transfer were obtained. In addition, the nurse was expected to start a Transfer Form in the EMR. RN-L stated the bed hold form was a separate piece of paper “that needs to be signed [by the resident] and followed up if they cannot at the time”. RN-L stated expectation of a progress note following the transfer to indicate whether bed hold was signed or offered, and to be followed up by social services if it is not signed. During an interview on 6/24/26 at 11:10 a.m., RN-M stated expectation of nursing staff to print out a face sheet, orders, and medication list to accompany resident to hospital once orders are obtained, and the nurse was expected to start a Transfer Form in the EMR. RN-M stated the bed hold form was expected to be offered to and signed by the resident or guardian and accompany the resident to the hospital. RN-M stated expectation of the nurse to document in a progress note whether the bed hold was offered or signed, and if it was not then social services were to follow up. RN-M acknowledged the process was not followed for R21 and R203. During an interview on 6/24/26 at 11:44 a.m., SS-D reviewed EMR for R21 and R203 and stated he was unable to locate any signed bed hold forms. SS-D stated, “The process should be to have the patient or guardian sign the bed hold and [facility] scan it in the EMR. We should be following up if it was done or not in a progress note.” SS-D stated the facility failed to document if a written notice was offered and provided to R21 and R203, or their guardians on transfer, including notifying the Office of the State Long Term Care Ombudsman. During an interview on 6/25/26 at 8:41 a.m., R203 stated he had never been offered or signed a bed hold form when he was hospitalized. During an interview on 6/25/26 at 10:51 a.m., DON stated expectation of a signed bed hold to accompany resident at time of transfer. “It should be			21925			

Minnesota Department of Health

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21925	Continued from page 35 scanned in the EMR but [process] is not reliable.” DON verified the facility failed to document if a written notice was offered and provided to R21 or R203, or their guardians on transfer, including notifying the Office of the State Long Term Care Ombudsman. R260's admission MDS, dated 3/16/26, identified R260 was cognitively intact, was able to express needs and wishes, and was able to understand others, and diagnoses included surgical amputation, peripheral vascular disease (a disease with narrowing of the blood vessels which impacts blood circulation throughout the body), and malnutrition. R260's care plan, initiated 3/4/26, identified R260 was at risk for falls and was dependent on staff for cares. R260's progress note, dated 3/25/26 at 5:23 a.m., identified R260 was found on the floor at 5:00 a.m., and denied striking head. At that time, the provider and family were advised. The documentation indicated the provider would follow up with patient to assess. R260's progress note, dated 3/25/26 at 5:14 p.m., identified R260 was noted to have swelling to the left side of face and was confused, and waw not able to recognize family member/power of attorney (POA). Notification was sent to the provider triage nurse and resident was transferred to the hospital for evaluation. The progress note indicated the bed hold was signed by the POA. However, R260's EMR lacked evidence of the signed bed hold from 3/25/26. During interview on 6/25/26 at 11:52 a.m., registered nurse/unit manager (RN/UM)-A stated upon transfer to the hospital, a bed hold wase obtained from the responsible party. This is completed either in person, or via the telephone for verbal consent. Once signed, RN/UM-A stated the document was placed in the medical record. During interview on 6/25/2026, at 2:30 p.m., DON provided a handwritten note which identified “3/25/26 at 5:43 p.m. Bed hold per POA of			21925			

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21925	Continued from page 36 resident". DON acknowledged this documentation lacked indication as to information provided to the POA, including potential fees and right to appeal. The facility's Bed Hold policy, revised 04/2025, indicated community staff shall inform residents upon admission and prior to a transfer for hospitalization (unless for an emergency) or therapeutic leave of the bed-hold policy, and a copy of the resident's bed-hold or release record will be filed in the resident's medical record SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON), or designee could review and/or develop policy and procedures that written notification was provided to the resident and their representative before a transfer. The facility could educate staff on these policies and audit periodically. The results of these audits will be reviewed by the quality assessment committee to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty One (21) days			21925			