Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Submitted

May 18, 2026

Administrator
Park River Healthcare and Rehabilitation Center
9899 Avocet Street Northwest
Coon Rapids, MN 55433

RE: CCN: 426040600
Cycle Start Date: April 27, 2026

Dear Administrator:

On April 27, 2026, survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

Your facility was not in substantial compliance with the participation requirements and the conditions in your facility constituted both **substandard quality of care** and **immediate jeopardy** to resident health or safety. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted immediate jeopardy (Level J) whereby corrections were required. The Statement of Deficiencies (CMS-2567) is being electronically delivered.

REMOVAL OF IMMEDIATE JEOPARDY

On April 27, 2026, the situation of immediate jeopardy to potential health and safety cited at F689 and F880 was removed. However, continued non-compliance remains at the lower scope and severity of F.

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 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:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective June 2, 2026.

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

The CMS location will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective June 2, 2026, (42 CFR 488.417 (b)). They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective June 2, 2026, (42 CFR 488.417 (b)).

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.

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.

Therefore, your agency is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs or Competency Evaluation Programs for two years effective April 27, 2026. This prohibition is not subject to appeal. Under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

If you have not achieved substantial compliance by June 2, 2026, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, PARK RIVER HEALTHCARE AND REHABILITATION CENTER will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years

from June 2, 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.

SUBSTANDARD QUALITY OF CARE

Your facility's deficiencies with one or more of the following: §483.10, Residents Rights, §483.12, Freedom from Abuse, Neglect, and Exploitation, §483.15, Quality of Life and §483.25, Quality of Care, 483.40 Behavioral Health Services, §483.45 Pharmacy Services, §483.70 Administration, or §483.80 Infection control has been determined to constitute substandard quality of care as defined at §488.301. Sections 1819(g)(5)(C) and 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) require that the attending physician of each resident who was found to have received substandard quality of care, as well as the State board responsible for licensing the facility's administrator, be notified of the substandard quality of care. If you have not already provided the following information, you are required to provide to this agency within ten working days of your receipt of this letter the name and address of the attending physician of each resident found to have received substandard quality of care.

Please note that, in accordance with 42 CFR 488.325(g), your failure to provide this information timely will result in termination of participation in the Medicare and/or Medicaid program(s) or imposition of alternative remedies.

Federal law, as specified in the Act at Sections 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, PARK RIVER HEALTHCARE AND REHABILITATION CENTER LLC is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective April 27, 2026. This prohibition remains in effect for the specified period even though substantial compliance is attained. Under Public Law 105-15 (H. R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable plan of correction (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 "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, Licensing and Certification Program 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 October 27, 2026, (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

APPEAL RIGHTS DENIAL OF PAYMENT

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 Tamika Brown at (312) 353-1502. Information may also be emailed to tamika.brown@cms.hhs.gov.

APPEAL RIGHTS NURSE AIDE TRAINING PROHIBITION

Pursuant to the Federal regulations at 42 CFR Sections 498.3(b)(13)(2) and 498.3(b)(15), a finding of substandard quality of care that leads to the loss of approval by a Skilled Nursing Facility (SNF) of its NATCEP is an initial determination. In accordance with 42 CFR part 489 a provider dissatisfied with an initial determination is entitled to an appeal. If you disagree with the findings of substandard quality of care which resulted in the conduct of an extended survey and the subsequent loss of approval to conduct or be a site for a NATCEP, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Department Appeals Board. Procedures governing this process are set out in Federal regulations at 42 CFR Section 498.40, et. Seq.

A written request for a hearing must be filed no later than 60 days from the date of receipt of this letter. Such a request may be made to the Centers for Medicare and Medicaid Services (formerly Health Care Financing Administration) at 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

A request for a hearing should identify the specific issues and the 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. You do not need to submit records or other documents with your hearing request. The Departmental Appeals Board (DAB) will issue instructions regarding the proper submittal of documents for the hearing. The DAB will also set the location for the hearing, which is likely to be in Minnesota or in Chicago, Illinois. You may be represented by counsel at a hearing at your own expense.

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,

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

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May 18, 2026

Administrator
Park River Healthcare and Rehabilitation Center
9899 Avocet Street Northwest
Coon Rapids, MN 55433

Re: State Nursing Home Licensing Orders
Event ID: 1F3609-H1

Dear Administrator:

The above facility survey was completed on April 27, 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.

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Office: 651-201-4384
Email: holly.zahler@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245448	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARK RIVER HEALTHCARE AND REHABILITATION CENTER LLC	9899 AVOCET STREET NORTHWEST , COON RAPIDS, Minnesota, 55433

(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 4/20/26 to 4/27/26, 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		05/28/2026
F0000	INITIAL COMMENTS On 4/20/26 to 4/27/26, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was NOT in compliance with §42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed: H54481254C (iQIES #2798440) with deficiencies cited at F812. The survey resulted in an immediate jeopardy (IJ) to resident health and safety. An IJ at F698 began on 4/11/26 when the facility failed to immediately contact dialysis and instead removed and changed the CVC dressing without adequate training and sterile technique as required, and was identified on 4/24/26 at 4:10 p.m. The IJ was removed on 4/27/26 at 12:08 p.m., when the facility implemented corrective actions, including initiation of monitoring protocols for dialysis access sites, implementation of Enhanced Barrier Precautions (EBP), staff education on dialysis care and sterile technique, and establishment of a communication process with the dialysis center. The survey resulted in an immediate jeopardy (IJ) to resident health and safety. An IJ at F880 began on 4/15/26 when R38 developed respiratory illness	F0000		05/28/2026

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245448	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/27/2026

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F0000	Continued from page 1 symptoms and was not placed on transmission based precautions (TBP) and was identified on 4/24/26 after 4 other residents (R24, R43, R78, and R28) also developed respiratory symptoms, were not placed on TBP, were not assessed, monitored and were not tested for potential infectious agent in addition to the total lack of an ongoing and effective surveillance system. The administrator and director of nursing (DON) were notified of the IJ on 4/24/26 at 4:10 p.m. The IJ was removed on 4/27/26 at 12:08 p.m. when the facility implemented an acceptable removal plan, but noncompliance remained at a lower scope and severity with potential for more than minimal harm that is not immediate jeopardy (Level F). The above findings constituted Substandard Quality of Care and an extended survey was conducted on 4/27/26. 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		05/28/2026
F0698 SS = SQC-J	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to ensure residents receiving dialysis services were provided appropriate care and services, including failure to establish and implement an effective communication system with the dialysis center, failure to monitor and assess	F0698	1. How will corrective action be accomplished for those residents found to have been affected by the deficient practice? R16 was assessed for dialysis related complications including fluid status, vital signs, and access site condition on 4/26/2026. The resident was placed on EBP on 4/23/2026 due to the presence of a dialysis access site. Unauthorized CVC care practices were discontinued. 2. How will the facility identify other residents having the potential to be affected by the same deficient practice? Residents on dialysis were assessed through a head-to-toe comprehensive review for signs and	06/01/2026

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F0698 SS = SQC-J	Continued from page 2 vascular access sites, failure to implement Enhanced Barrier Precautions (EBP), failure to monitor fluid restrictions, assess vital signs per physician orders, and failure to ensure sterile technique and follow physician direction for central venous catheter (CVC) care, for 2 of 2 residents (R16, R12) reviewed for dialysis services. These failures resulted in Immediate Jeopardy (IJ) for R16, as the facility's practices placed the resident at likelihood for serious harm, including infection, sepsis, and complications related to uncontrolled bleeding. The Immediate Jeopardy began on 4/11/26 when the facility failed to immediately contact dialysis and instead removed and changed the CVC dressing without adequate training and sterile technique as required, and was identified on 4/24/26 at 4:10 p.m. The IJ was removed on 4/27/26 at 12:08 p.m., when the facility implemented corrective actions, including initiation of monitoring protocols for dialysis access sites, implementation of Enhanced Barrier Precautions (EBP), staff education on dialysis care and sterile technique, and establishment of a communication process with the dialysis center. Findings include: R16's admission Minimum Data Set (MDS) dated 3/26/26 identified R16 had intact cognition and was independent with activities of daily living (ADL)'s. Relevant diagnoses included end stage renal disease (ESRD; advanced kidney failure requiring dialysis), dependence on renal dialysis (requires dialysis treatments to perform kidney function), heart failure (a condition where the heart cannot pump blood effectively), atrial fibrillation (an irregular heart rhythm), hypertension (high blood pressure), anemia (a condition with a decreased number of red blood cells causing fatigue and weakness), hyperparathyroidism (overactivity of the parathyroid glands causing abnormal calcium and phosphorus levels), and long-term anticoagulant use (ongoing use of blood thinning medication to prevent blood clots). R16's care plan, dated 4/8/26, identified R16 required offsite hemodialysis on Tuesdays, Thursdays, and Saturdays related to ESRD and included interventions related to the AV fistula for staff to assess the site every day and as needed for signs of infection, tenderness, drainage, bruit and thrill. However, there was no monitoring in place on the Medication Administration Record (MAR) or Treatment Administration Record (TAR) and no physician order for this monitoring. The care plan dated 4/8/26 identified a fluid restriction of 1500	F0698	Continued from page 2 symptoms of fluid overload and infection on 4/26/2026. The following actions were completed- verification of all CVC care orders with dialysis provider/nephrologist, verification of EBP in place, completion of risk and benefit related to fluid restriction compliance. 3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur? A standardized dialysis care and monitoring process was implemented to include dialysis assessments completed pre and post treatment, daily monitoring of weights, intake and symptoms, required documentation of access site monitoring. A communication protocol was implemented to include notification of dialysis provider/nephrologist for changes of condition. Re-education was provided to licensed nurses, NARS, dietary, and other ancillary departments related to the overall expectations related to dialysis care per their scope of practice and as outlined in the abatement plan. 4. Monitoring to ensure compliance DON/ Designee will audit 5 resident dialysis visits per week for 4 weeks related to the dialysis clinical program, which includes communication with the dialysis site, EBP implementation, monitoring of dialysis port, weights and intakes tracking, etc. Results of the audit will be reviewed by the QAPI committee to ensure compliance and determine ongoing need for audits.	06/01/2026

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PARK RIVER HEALTHCARE AND REHABILITATION CENTER LLC	9899 AVOCET STREET NORTHWEST , COON RAPIDS, Minnesota, 55433

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F0698 SS = SQC-J	Continued from page 3 milliliters (ml) 1200 ml for dietary and 300 ml for nursing to provide. The care plan directed daily weights. Staff were directed by the care plan to review communication from dialysis for medications given, labs performed, et, after each session. R16's care plan failed to include R16's CVC site, lacked interventions for monitoring and care of the CVC, and failed to include implementation of Enhanced Barrier Precautions (EBP) related to the resident's dialysis access devices. R16's uploaded dialysis documents identified records titled "Dialysis (April Treatment Sheets)" that contained only three of thirteen dialysis treatment run sheets received from the dialysis center and lacked evidence of communication or clinical information provided by the facility to the dialysis center. R16's electronic medical record (EMR) from 3/20/26 through 4/23/26 failed to identify evidence of a consistent communication system between the facility and the dialysis center, including lack of documentation of dialysis treatment summaries, changes in condition, weights, vital signs, or post-treatment concerns. During interview on 4/20/26 at 4:07 p.m., R16 stated he did not recall any documents being sent with him to dialysis or returning with any documentation. During interview on 4/23/26 at 10:32 a.m., the dialysis facility administrator (FA) stated the facility should send communication with residents to dialysis, including changes in condition, vital signs, access concerns, weights, and other relevant clinical information for each run. The FA stated the facility did not consistently send documentation with R16 and the dialysis center was unaware of one of R16's emergency room (ER) visits and hospitalization until R16 failed to arrive for dialysis. During interview on 4/23/26 at 4:01 p.m., director of nursing (DON) stated the facility sent only a general appointment referral consisting of the resident's face sheet and medication list and confirmed the facility was working to improve communication with the dialysis center. R16's physician orders for April 2026, identified an order for Metoprolol Tartrate 50 MG (milligram), give 50 mg by mouth two times a day for ESRD, with parameters to hold the medication for systolic blood pressure (SBP) less than 90 or pulse less than 50, initiated on 3/20/26.	F0698		06/01/2026

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F0698 SS = SQC-J	Continued from page 4 Review of R16's medication administration records (MAR) from 3/20/26 through 4/22/26 identified Metoprolol Tartrate was administered as ordered; however, there was no documentation blood pressure or pulse were obtained prior to administration, as required by the physician's order. During interview on 4/22/26 at 2:09 p.m., trained medication aide (TMA)-A confirmed blood pressure and pulse were not obtained prior to administration despite the medication hold parameters. During interview on 4/23/26 at 10:08 a.m., licensed practical nurse (LPN)-C stated, to her knowledge, there were no residents with medication parameters requiring vital signs prior to administration and confirmed she had not obtained vital signs that morning related to medication administration. During interview on 4/23/26 at 3:35 p.m., assistant director of nursing (ADON) confirmed vital sign monitoring was not in place and was not completed prior to medication administration for R16. During interview on 4/27/26 at 1:17 p.m., LPN-G confirmed blood pressure and pulse should be obtained prior to administering medications with hold parameters and acknowledged this was not initiated for R16 until 4/23/26. During interview on 4/27/26 at 1:48 p.m., DON and consultant nurse (C-RN) confirmed staff were expected to follow physician orders, including obtaining vital signs prior to administration of medications with hold parameters. Review of the facility's Medication Administration policy, revised 7/25, required staff to obtain and document vital signs when indicated by physician order and hold medications if vital signs were outside prescribed parameters. Review of R16's physician orders printed 4/23/26 identified an active order initiated on 3/24/26 for a 1500 ml daily fluid restriction related to ESRD and chronic heart failure. During observation and interview on 4/20/26 at 4:07 p.m., staff delivered a full water pitcher to R16's room. A can of soda was also present at bedside. R16 stated, "I drink when I want." During observation on 4/22/26 at 4:22 p.m., a water pitcher approximately half full remained at R16's bedside.	F0698		06/01/2026

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F0698 SS = SQC-J	Continued from page 5 During interview on 4/22/26 at 2:23 p.m., nursing assistant (NA)-A stated they were not aware which residents were on fluid restrictions. During interview on 4/23/26 at 10:08 a.m., LPN-C confirmed R16 was on a fluid restriction and should not have water pitchers in the room. During interview on 4/23/26 at 3:35 p.m., ADON confirmed water pitchers were present in R16's room despite the fluid restriction order. During interview on 4/23/26 at 4:01 p.m., DON confirmed residents on fluid restrictions should not have water pitchers in their rooms. During observation on 4/21/26 at 11:28 a.m., R16's room lacked EBP signage and lacked readily available personal protective equipment (PPE) for staff use during care. Review of R16's EMR on 4/23/26 failed to identify evidence EBP was initiated for R16 despite the presence of dialysis access devices, including a CVC. Guidance from the Centers for Disease Control and Prevention (CDC) identified residents with dialysis access devices were at increased risk for transmission of multidrug-resistant organisms (MDROs) and required Enhanced Barrier Precautions. During interview on 4/22/26 at 2:23 p.m., NA-A stated staff identified residents on precautions by signage outside the room and the presence of a PPE cart. During interview on 4/23/26 at 10:08 a.m., LPN-C stated EBP should include signage, PPE outside the room, and a trash receptacle and confirmed R16 was not on EBP precautions. During interview on 4/23/26 at 2:55 p.m., registered nurse (RN)-A confirmed dialysis residents were not on precautions. During interview on 4/23/26 at 3:35 p.m., ADON stated residents with indwelling catheters should be on EBP precautions and confirmed R16 was not on EBP precautions when EBP should have been implemented. During interview on 4/23/26 at 4:01 p.m., DON stated residents with external access devices should be on EBP precautions; however, R16 was not on EBP precautions.	F0698		06/01/2026

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F0698 SS = SQC-J	Continued from page 6 The facility's Enhanced Barrier Precautions policy, undated, required implementation of EBP for residents with indwelling medical devices, including central lines and hemodialysis access. The policy required gown and glove use during high-contact care activities and required PPE to be readily available outside the resident's room. R16's progress notes identified repeated bleeding events related to the dialysis access site. Further review identified R16 was prescribed Coumadin (warfarin; a blood thinning medication), which increased the risk for significant bleeding complications. Progress note (pre-operative history and physical) dated 4/1/26 indicated R16 was scheduled for a left AV fistula revision with aneurysmorrhaphy (surgical repair and reconstruction of a weakened or enlarged area of the dialysis fistula) on 4/6/26. Progress note dated 4/11/26 at 12:37 a.m. indicated R16 called for assistance and was found bleeding from the port area. Documentation indicated the abdominal (ABD) pad had heavy blood saturation and bleeding was described as moderate. Area was re-dressed by the evening nurse and pressure was applied with gauze to reduce bleeding. The port area appeared bruised, and the left jugular area was distended and painful to touch. Emergency medical services (911) were contacted, and R16 was transferred to the ER for evaluation. Progress note dated 4/13/26 at 3:54 a.m. indicated R16 continued to experience bleeding from the port site, nurse performed a dressing change and notified provider of bleeding. The provider attributed the bleeding to warfarin use and instructed staff to apply pressure for 10 minutes and apply ice. Progress note (physician acute visit) dated 4/13/26 indicated the "shunt" on R16's left anterior chest continued leaking despite a dressing change. Documentation further indicated that R16 was bleeding from the wound site on the left anterior chest and required further hospital evaluation. The physician documented concern for ongoing bleeding, possible anemia, and possible infection related to the dialysis access site.	F0698		06/01/2026

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F0698 SS = SQC-J	Continued from page 7 R16's physician orders on 4/23/26 failed to identify physician orders for facility staff to perform CVC dressing changes or monitor the AV fistula site, including bruit and thrill assessments. R16's EMR on 4/23/26 failed to identify evidence of monitoring or documentation of the AV fistula site, including bruit and thrill assessments. Further review failed to identify evidence sterile supplies or aseptic technique were utilized during CVC dressing changes completed by facility staff. During interview on 4/23/26 at 10:03 a.m., LPN-A stated dialysis residents should be monitored for bruit and thrill, access site complications, fluid restrictions, diet and confirmed R16 had both a fistula and recently placed CVC. During interview on 4/23/26 at 10:08 a.m., LPN-C confirmed both R16 and R12 received dialysis and stated staff should monitor access sites for complications or signs of infection and document findings on the treatment record. During interview on 4/23/26 at 2:55 p.m., RN-A stated dialysis monitoring could include vital signs and access site monitoring. RN-A stated if a dialysis access site was bleeding, staff would control the bleeding and contact the on-call provider. RN-A confirmed neither dialysis resident was on precautions. During interview on 4/23/26 at 2:59 p.m., LPN-I stated staff obtained vital signs and assessed dialysis access sites upon residents' return from dialysis and documented findings in progress notes. LPN-I stated if a site was bleeding, staff would change the dressing, apply pressure, and contact the provider if bleeding did not stop. During interview on 4/23/26 at 3:35 p.m., ADON stated staff should assess dialysis access sites, monitor for signs of infection or bleeding, and notify the provider of concerns. ADON reviewed R16's EMR and confirmed there was no physician order for monitoring of the CVC or AV fistula. During interview on 4/23/26 at 4:01 p.m., DON stated staff should assess dialysis access sites, monitor for bleeding or infection, check for bruit and thrill, and ensure there was no bleeding upon return from dialysis. DON stated that dressing changes required a physician order and confirmed there was no physician order to monitor R16's access site. DON further confirmed orders for bruit and thrill monitoring were not initiated until 4/23/2026.	F0698		06/01/2026

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F0698 SS = SQC-J	Continued from page 8 During a telephone interview on 4/23/26 at 12:50 p.m., the FA stated R16's revised AV fistula should be monitored at least daily for bruit and thrill, and the temporary CVC should be monitored for bleeding, redness, dislodgement, and infection. FA stated nursing facility staff should never remove or replace the sterile CVC dressing and should only reinforce the dressing and apply pressure if bleeding occurred. FA stated removing and replacing the sterile dressing by nursing facility staff placed residents at risk for systemic infection. According to information provided by R16's dialysis company, a central venous catheter is only used temporarily while the AV fistula is ready to be used. R16's AV fistula was healing after surgery. Hemodialysis catheters have a higher risk of clotting and infection and provide for a slower rate. A CVC requires special handling and a registered nurse (RN) must be educated and trained in CVC care. A biopatch – a chlorhexidine (CHG) impregnated sponge which continually releases CHG is used which inhibits bacterial growth for up to 7 days. Staff outside of the dialysis unit should only reinforce the dressing, never change it with the exception of the emergency room. If there is bleeding from the site, a surgeon must be notified. A RN who changes the dressing must use sterile gloves, sterile draping and a face mask. CVC's are high risk for infection. If there are any concerns with R16's CVC or any dialysis concerns, the dialysis unit must be notified. They have emergency after hours numbers. During multiple nursing staff interviews on 4/23/26 between 3:00 p.m. and 3:30 p.m., LPN-D, LPN-E, LPN-F, and TMA-B stated residents were sent to dialysis with medication records, vital signs, and possibly weights in an envelope prepared by medical records staff. LPN-D, LPN-E, and LPN-F stated dialysis access monitoring should include assessment of CVC sites for redness, bleeding, loose dressings, and signs of infection and AV fistulas for redness, bleeding, pain, and bruit/thrill. LPN-D and LPN-E stated if a resident's CVC site was bleeding, staff would obtain supplies from the supply cart, replace the dressing, and contact the facility provider for direction. LPN-E stated staff obtained direction for dialysis care from the facility provider and did not identify contacting the dialysis center or nephrologist directly regarding dialysis access complications. R12 R12's quarterly MDS dated 4/10/26 identified R12	F0698		06/01/2026

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F0698 SS = SQC-J	Continued from page 9 received dialysis services and had diagnoses including renal failure (decreased kidney function requiring medical management or dialysis), hypertension (high blood pressure), peripheral vascular disease (poor circulation caused by narrowed blood vessels, usually in the legs), diabetes mellitus (a condition affecting blood sugar regulation), and dementia (decline in memory and thinking abilities affecting daily functioning). R12's care plan, with a print date of 4/22/26, identified R12 required hemodialysis related to ESRD and included interventions related to monitoring the fistula access site, bleeding, infection, fluid restriction, weights, and communication with the dialysis center. Review of R12's uploaded dialysis documents identified records titled "Dialysis (March Treatment Sheets)," "Dialysis (February Treatment Sheets)," and "Dialysis (November Treatment Sheets)." The documents contained only laboratory results received from the dialysis center and lacked evidence of communication or clinical information provided by the facility to the dialysis center. R12's EMR on 4/23/26 failed to identify evidence of a consistent communication system between the facility and the dialysis center, including lack of documentation of dialysis treatment summaries, changes in condition, weights, vital signs, or post-treatment concerns. During interview on 4/20/26 at 2:20 p.m., R12 stated the facility only sent a medication list to dialysis and she did not return with paperwork except for laboratory results. R12's physician orders printed 4/23/26 identified an active order for a 1500 ml daily fluid restriction related to dialysis and chronic kidney disease. During observation and interview on 4/20/26 at 2:12 p.m., R12 had a water pitcher and cup in the room and stated staff would provide them upon request despite the fluid restriction. During interview on 4/22/26 at 2:23 p.m., NA-A stated they were not aware which residents were on fluid restrictions. During interview on 4/23/26 at 10:08 a.m., LPN-C confirmed R12 was on fluid restrictions and should not have a water pitcher in the room. The facility's Dialysis policy, revised 7/25, required	F0698		06/01/2026

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F0698 SS = SQC-J	Continued from page 10 ongoing assessment and monitoring of dialysis residents, evaluation of access sites for complications, communication with the dialysis center regarding weights, medications, fluid restrictions, and changes in condition, and coordination of care related to dialysis services. The facility's removal plan was verified as implemented on 4/27/26 between 9:00 a.m. and 12:00 p.m. by interview of RN's, LPN's, and nursing assistants who all could clearly identify how to manage a dialysis patient and had received training. In addition, training of each staff member before they worked was verified through document review. Each resident on dialysis was reviewed to ensure communication to dialysis unit was in place, assessments were added to MAR/TAR and care plans. The IJ was removed at 12:08 p.m.	F0698		06/01/2026
F0880 SS = J	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	F0880	1. How will corrective action be accomplished for those residents found to have been affected by the deficient practice? R38 symptoms have subsided, and resident is at baseline. R24 has a chronic cough; care plan was updated; resident remains at baseline. R43 has a chronic cough, related to hx of smoking, care plan was updated, resident remains at baseline. R78 symptoms have subsided and resident is at baseline. R28 has a chronic cough, related to GERD, care plan was updated, resident remains at baseline. 2. How will the facility identify other residents having the potential to be affected by the same deficient practice? The facility completed a house wide audit and assessment of residents related to respiratory symptoms on 4/25/2026. No other residents were identified with an acute change in respiratory status.	06/01/2026

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F0880 SS = J	Continued from page 11 in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §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 establish and maintain an infection control program, failed to have a system for preventing, identifying, reporting, investigating, and controlling infections that occurred in the facility. The facility failed to identify a potential respiratory illness outbreak with 5 residents (R38, R24, R43, R78, and R28) showing signs of illness between 4/15/26 and 4/24/26, the facility failed to	F0880	Continued from page 11 The facility completed a house wide audit, and residents requiring EBP have been initiated. 3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur? The facility has implemented standing house orders that include diagnostic testing for common infections such as norovirus, COVID or influenza. The facility has implemented systems and trackers for residents who require isolation precautions, lab tracking in real time, line listing for symptomatic residents to prevent the spread of infections. The facility has provided re-education to licensed nurses and NARS, per their scope of practice, related to change of condition, appropriate nursing interventions such as implementing isolation precautions, tools for greater shift to shift report, and outbreak monitoring as outlined in the abatement plan on 4/24/2026. 4. Monitoring to ensure compliance DON/ Designee will audit 5 residents per week x4 weeks to ensure compliance with infection prevention program as outlined per community policy.	06/01/2026

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F0880 SS = J	Continued from page 12 assess, monitor, and document their symptoms, conduct any outbreak testing, or place on transmission-based precautions (TBP) to prevent the spread to others. In addition, the facility failed to identify the need for and implement enhanced barrier precautions (EBP) for 2 of 2 residents (R16 and R29) reviewed who required EBP. The facility's system failure had the potential affect all 85 residents who currently resided in the facility. The immediate jeopardy began on 4/15/26 when R38 developed respiratory illness symptoms and was not placed on TBP and was identified on 4/24/26 after 4 other residents (R24, R43, R78, and R28) also developed respiratory symptoms, were not placed on TBP, were not assessed, monitored and were not tested for potential infectious agent in addition to the total lack of an ongoing and effective surveillance system. The administrator and director of nursing (DON) were notified of the IJ on 4/24/26 at 4:10 p.m. The IJ was removed on 4/27/26 at 12:08 p.m. when the facility implemented an acceptable removal plan, but noncompliance remained at a lower scope and severity with potential for more than minimal harm that is not immediate jeopardy (Level F). Findings include: When interviewed on 4/22/26 at 10:00 a.m., the director of nursing (DON) stated she had been the infection preventionist since October 2025. The DON described the infection surveillance program as receiving a list of antibiotics at the end of the month and then entering them into a tracking log. Infections were not entered onto the log or tracked as they occurred in the facility, nor where they occurred in the building. No information about residents who had signs of illness such as cough or diarrhea were entered into the tracking form unless an antibiotic was initiated. She had not been able to implement a program where infection symptoms were tracked timely in order to identify if an outbreak was potentially occurring in the facility. However, staff did inform her when residents were showing signs of illness such as cough, diarrhea or other symptoms. When interviewed on 4/22/26 at 3:19 p.m., the DON stated the facility did not have a system for antibiotic time out where anyone who was started on an antibiotic would be evaluated for appropriateness of the antibiotic, any lab cultures would be reviewed to determine if current antibiotic was appropriate and resident condition would be evaluated to determine if condition was improving. The DON had access to	F0880		06/01/2026

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F0880 SS = J	Continued from page 13 any labs sent in but did not access them herself for evaluation. R38's annual Minimum Data Set (MDS) dated 2/15/26 identified moderate cognitive impairment, required assistance with most activities of daily living (ADL's) and diagnoses included vascular dementia, hypertension, asthma and dysphagia (difficulty swallowing). R38's provider note dated 4/15/26, identified she was seen for low back pain and a wet cough for 5 days as well as difficulty urinating and urinary frequency. The provider ordered a chest x-ray and urine sample. R38's physician orders dated 4/16/26 included R38 was to start an antibiotic, Doxycycline 100 mg (milligrams) twice a day for 7 days with a new diagnosis of pneumonia. A provider note identified R38 was using a nebulizer 3 times a day and was waiting on the urine specimen results. The chest x-ray results were abnormal. R38's progress note dated 4/16/26 identified a urine specimen was obtained at 7:00 a.m. and sent to the lab. R38's progress note dated 4/18/26 identified R38 was not feeling well, was refusing to eat and was nauseated, vital signs and oxygen saturations were within normal limits for R38 except had a rapid pulse at 104 (normal 60-100). It was noted the antibiotic ordered on 4/16/26 had not been started yet and would be initiated. R38's provider note dated 4/22/26 identified, "patient was seen today for a follow-up after being diagnosed with pneumonia and staff report she is not improving that much. Patient is lying in bed she does appear to be ill." "Will add Augmentin (antibiotic) for dual therapy for her pneumonia and see if it helps patient." The urine analysis and culture (UA/UC) results were requested. R38's medical record failed to include any illness monitoring. R38's vital signs were documented for 4/8/26, 4/15/26 and 4/22/26 as routine weekly vital signs. Even though R38's symptoms of a wet cough started approximately 4/8/26, there were no lung sounds, oxygen saturations, or routine vital signs and condition monitoring in the medical record except for once on 4/18/26. During observation on 4/24/26 at 10:05 a.m., R38 was in bed in her room. There was no signage	F0880		06/01/2026

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F0880 SS = J	Continued from page 14 outside of room or supplies located to indicate transmission-based precautions had been initiated for respiratory symptoms. When interviewed on 4/24/26 at 9:53 a.m., licensed practical nurse (LPN)-A stated when a resident shows signs of illness, the nurses will assess the resident including vital signs and lung sounds every shift and monitor for about 3 days and keep an eye on the resident. LPN-A did not know why monitoring had not been started for R38 despite her cough and start of antibiotics. When interviewed on 4/24/26 at 10:01 a.m., R38 stated she has had a cough for some time but is improving now. When interviewed on 4/24/26 at 11:30 a.m., the DON was unable to find any UA/UC results for R38 in the medical record. The DON stated residents who are showing signs of illness should have frequent vital signs, lung sounds and oxygen saturations and if stable for 3 days could go down to every shift. There was no system in place to ensure residents who exhibited signs of illness such as R38 illnesses were monitored in this way. She had hoped the nurses would implement and document this. The DON stated she would have expected a resident condition note to be put in the medical record every shift especially if staying in bed and not feeling well. Despite a wet cough for many days, R38 had not been placed on transmission-based precautions (TBP) and no testing had been ordered by the provider for influenza, RSV or COVID-19. R24's quarterly MDS dated 3/2/26 identified severe cognitive impairment, required assistance with most ADL's and diagnosis included dementia. R24's progress note dated 4/17/26 at 9:52 p.m. identified vital signs were stable and had received an albuterol nebulizer (used for respiratory symptoms) related to an audible wheeze and cough. Oxygen saturations were at 91% (normal 95-100%). The on-call provider was notified and orders were obtained for a chest x-ray and to administer the Albuterol nebulizer twice a day and every 4 hours as needed for cough. R24's progress note dated 4/18/26 at 1:14 p.m. identified a nebulizer treatment was effective for wheezing and cough. At 9:39 p.m. the chest x-ray results returned and were normal. R24's medical record between 4/18/26 and 4/24/26 failed to include illness monitoring every shift or any	F0880		06/01/2026

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F0880 SS = J	Continued from page 15 assessment of how she was progressing. The record included routine weekly vital signs on 4/21/26. No further lung sounds or oxygen saturations were documented. R24 had not been placed on TBP for cough. No testing for potential contagious illness had been ordered or obtained. When interviewed on 4/24/26 at 11:17 a.m. the DON stated R24 was noted to have a cough on 4/17/26. The DON reviewed R24's medical record and identified there was no illness monitoring in place related to the cough. She would have expected to see documentation of lung sounds, cough, assessment and vital signs routinely. R24 had not been placed on TBP and no testing had been ordered or conducted for potential respiratory illness outbreak. R43's quarterly MDS dated 3/5/26 identified moderate cognitive impairment and was independent with personal cares except bathing, diagnoses included dementia, and congestive heart failure. R43's care plan dated 3/5/26 identified shortness of breath related to emphysema and chronic obstructive pulmonary disease (COPD). R43's progress note dated 4/22/26 at 11:37 a.m. identified resident had a congested non productive cough, was afebrile and was given cough syrup. R43's progress notes dated 4/22/26 at 11:57 a.m. identified the provider was updated R43 was requesting cough syrup and new orders were obtained for Guiafed every 4 hours as needed for 3 days. R43's progress note dated 4/23/26 at 2:21 a.m. included, "Resident continues to have a congested cough. Cough syrup given. Has been up and about and told writer he was feeling better." R43's progress note dated 4/24/26 at 3:10 a.m. included, "Respiratory evaluation done on resident. The resident stated that he had some mucus with some blood earlier in the day and that this had occurred in the past. He reports congestion present for approximately the last 2 weeks. No shortness of breath but occasional cough present." VS were stable and had a history of mucus with smoking history and nurse practitioner saw him earlier in the week. During observation on 4/24/26 at 10:01 a.m., R43 was in his room on bed. R43 stated he had a "bad cold," and had been coughing and sneezing up	F0880		06/01/2026

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F0880 SS = J	Continued from page 16 blood off and on. R43 was coughing during interview. R43 was not on TBP for cough. When interviewed on 4/24/26 at 11:17 a.m., the DON stated R43 was noted to start coughing on 4/22/26. The DON reviewed the medical record and identified no follow up documentation had occurred about the cough; no illness monitoring had been documented. R43 had not been placed on TBP and no testing for potential respiratory outbreak had been ordered or conducted. R43 was placed on acute change charting for 72 hours due to congestion and occasional cough today after being questioned by surveyor. R78's quarterly MDS dated 4/13/26 identified moderate cognitive impairment, required assistance with ADL's and diagnosis included Alzheimer's disease. R78's progress note dated 4/10/26 at 10:28 p.m. identified, resident complained of cold symptoms, occasional cough and hoarse voice. R78 was provided with cough syrup. There was no monitoring placed to assess R78 for continued respiratory symptoms. However, R78's temperature was taken 3 times on 4/11/26 and 4/12/26 and was afebrile. No oxygen saturations were taken in this time frame. There were no further progress notes identifying cold symptoms until seen by provider on 4/23/26, "Patient was seen today by the request of staff and family as they were concerned about patient having a cough over the last couple days. Patient was seen in her room she was sitting up at edge of her bed she reports that her cough has improved significantly and she does not feel she needs any intervention at this time." There were no new orders. R78 had not been placed on TBP even though she had a cough for "several days" and had not been tested for potential contagious respiratory illness. On 4/23/26 at 9:51 a.m., licensed practical nurse (LPN)-D identified R78 had been coughing randomly, and staff were monitoring her status. When interviewed on 4/24/26 at 11:17 a.m., the DON stated R78 had been coughing this week and had seen provider with no new orders on 4/22/26. The DON stated staff should be monitoring for symptoms but noted no documentation had been initiated. R78 had not been placed on TBP and had not been tested for potential respiratory outbreak.	F0880		06/01/2026

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F0880 SS = J	Continued from page 17 R28's annual MDS dated 3/4/26 identified significant cognitive impairment, required assistance with most ADL's and diagnoses included Alzheimer's disease and congestive heart failure. During observation on 4/24/26 at 10:08 a.m. R28 was heard coughing. When interviewed R28 stated he had been coughing for quite a while, "I cough up some stuff." The cough was noted to be loose and productive and used tissue to capture the mucous brought up with the cough. R28's progress note dated 4/24/26 at 3:41 p.m., identified R28 had stated he had been coughing for 2 days with light mucus. R28 had not shortness of breath, lung sounds were clear and vital signs stable. R28 had not been placed on TBP and no testing for potential contagious illness had been ordered or completed. When interviewed on 4/24/26 at 11:17 a.m., the DON stated R28 has a frequent cough with medical diagnosis of such and unsure if would be anything contagious. R28 had not been placed on TBP and no respiratory illness testing had been completed. R28 had been placed on acute illness charting for 72 hours. During observation on 4/24/26 at 10:01 a.m. it was noted the 5 residents were observed with a cough (R24, R28, R38, R43, and R78), three of the five residents resided in the same hall, with two being next to one another, and the third being a few doors down on the opposite side of the hall. The DON provided infection "surveillance logs" on 4/23/26 at 5:22 p.m. The DON identified the logs are created off of an antibiotics prescribed list, residents and infections were not added to logs as the illnesses occurred, but rather at the end of each month. The logs also did not account for residents who may show signs of infection such as diarrhea or cough that did not require an antibiotic. When reviewed the logs failed to identify start date of symptoms, any testing performed, or dates of resolution of symptoms. The facility policy, Infection Prevention and Control Policy (IPCP) and Procedure, dated 2019, last reviewed 1/25, identified the IPCP to include the system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility. The intent of the IPCP was to establish facility wide systems for the prevention, identification,	F0880		06/01/2026

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F0880 SS = J	Continued from page 18 investigation, and control of infections with an ongoing system of surveillance to identify possible communicable diseases or infections before they can spread to other people. The role of surveillance was to include process and outcome surveillance, to include monitoring, data analysis, documentation, and reporting as required. Activities were to be conducted to identify practice, infection trends, and early identification of new infections and potential outbreak situations. The policy also identified standard and transmission-based policies were to be developed and precautions were to be followed to prevent the spread of infections, to include the selection of the precaution indicated, as well as to include the level of personal protective equipment (PPE) to be used. The policy further identified the type and duration of the isolation would be determined dependent on the infectious agent or organism involved. Although the policy identified transmission-based precautions, and isolation, the policy lacked identification, or definition of enhanced barrier precautions. The policy also identified an antibiotic stewardship program, which included protocols and a system to monitor antibiotic use, was to be included within the IPCP and procedure. The policy also identified the process was to include documentation of incidents identified under the facility's IPCP and the corrective action taken by the facility. R16’s admission MDS dated 3/26/26 identified cognitively intact, was independent with ADL’s, and diagnoses including on dialysis for end stage kidney disease and hyperparathyroidism (overactive parathyroid glands causing abnormal calcium and phosphorus levels) and long term anticoagulation use. R16’s care plan dated 4/8/26 identified R16 required offsite hemodialysis on Tuesdays, Thursdays, and Saturdays related to ESRD and included interventions related to the AV fistula for staff to assess the site every day and as needed for signs of infection, tenderness, drainage, bruit and thrill. R16’s medical record identified they also had a central venous catheter (CVC) which is a large bore tube placed into a large vein int he chest for urgent dialysis access. Typically, this is used only for a short period of time when the AV fistula is not accessible. This type of catheter/vascular access is	F0880		06/01/2026

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F0880 SS = J	Continued from page 19 at a very high risk of catheter related blood stream infections. 16's care plan did not identify this access site and did not direct any special infection control techniques. Guidance from the Centers for Disease Control and Prevention (CDC) identified residents with dialysis access devices were at increased risk for transmission of multidrug-resistant organisms (MDROs) and required Enhanced Barrier Precautions (EBP). During observation on 4/21/26 at 11:28 a.m. R16's room lacked any personal protective equipment (PPE) that would be used for EBP. When interviewed on 4/22/26, nursing assistant (NA)-A stated R16 was not on EBP. When interviewed on 4/23/26 at 10:08 a.m., licensed practical nurse (LPN)-C stated if residents are on EBP they put a sign on their door and place PPE outside the room. R16 was not on EBP. When interviewed on 4/23/6 at 2:55 p.m., registered nurse (RN)-A stated R16 was not on EBP. When interviewed on 4/23/26 at 3:35 p.m. the assistant director of nursing (ADON) stated residents with indwelling catheters required EBP and confirmed R16 was not on EBP, but should have been. When interviewed on 4/23/26 at 4:01 p.m. the DON stated residents with vascular access devices should be on EBP and verified R16 was not and should have been. R29's admission MDS dated 4/20/26 included severe cognitive impairment, was dependent upon staff for ADL's and had diagnoses including Alzheimer's disease and a sacral pressure ulcer stage 4 (down to bone). During observations on 4/20/26, 4/21/26, 4/22/26, 4/23/26 and 4/24/26, there was no signage outside of room, nor was there any PPE available for staff outside or inside R29's room. When interviewed on 4/22/26 at 8:39 a.m., LPN-A stated she had performed pressure ulcer care for R29 at 7:00 a.m. LPN-A stated R29 is not on any type of precautions. During observation on 4/23/26 at 9:17 a.m., the	F0880		06/01/2026

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F0880 SS = J	Continued from page 20 ADON entered R29's room for a dressing change. The ADON did not put on a gown, they washed their hands, put on gloves, removed the dressing over the pressure ulcer, doffed gloves and used hand sanitizer. The ADON replaced gloves and finished the dressing change. When interviewed on 4/23/26 at 9:36 a.m., the ADON stated R29 did not need to be on any type of precautions and just glove use during dressing change was adequate. Since the resident had been in the facility less than 90 days, the wound was not considered a chronic wound. Facility policy entitled: Enhanced Barrier Precautions (copyright 2025 The Compliance Store, LLC.) Initiation of Enhanced Barrier Precautions: a. Enhanced barrier precautions will be implemented for residents requiring EBP per CMS regulatory guidelines, including but not limited to residents with wounds, such as pressure ulcers, diabetic foot ulcers, unhealed surgical wounds, and venous stasis ulcers, and/or indwelling medical devices (e.g., central live, urinary catheters, feeding tubes, tracheostomy/ventilator tubes, hemodialysis catheters. PICC lines, midline catheters) and access ports. 4. Enhanced barrier precautions should be used for the duration of the affected residents' stay in the facility or until resolution of the wound or discontinuation of the indwelling medical device that placed them at higher risk." The Center for Disease Control's (CDC) Viral Respiratory Pathogens Toolkit for Nursing Homes dated 3/30/26, indicated when an infection is due to a respiratory virus, it is important to take rapid action to prevent the spread to others in the facility. Appropriate transmission-based precautions should be initiated for symptomatic residents based upon the suspected cause of infection. The CDC's Transmission Based Precautions dated 4/3/24, indicated droplet precautions should be used for patients known or suspected of being infected with pathogens transmitted by respiratory droplets that are generated by a patient who is coughing, sneezing, or talking. Droplet precautions include hand hygiene, face mask covering the nose and mouth, and eye protection. Additionally, the Frequently Asked Questions (FAQ's) about EBP, dated 6/28/24, identified EBP as an infection control	F0880		06/01/2026

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F0880 SS = J	Continued from page 21 measure designed to decrease transmission of multi-drug-resistant organisms (MDROs) in nursing homes. EBP involved gown and glove use during high-contact resident care activities for residents known to be colonized, or infected, with a MDRO, as well as those who were at increased risk of MDRO acquisition (e.g. residents with wounds or indwelling medical devices). On 4/27/26 at 11:00 a.m. it was verified via observation, interview and document review the facility had implemented their removal plan by 11:00 on 4/27/26. It was verified all residents had been screened for respiratory illness, all affected residents were assessed for illness symptoms and no other residents showed any respiratory symptoms. The facility had audited all residents for the need for EBP and implemented EBP where needed. A policy and procedure was implemented to ensure EBP was implemented as needed, symptom surveillance to be completed in real time with appropriate TBP as needed, a system was set up for follow up on lab results and antibiotic timeouts. A tracker was started for all labs, and antibiotic stewardship. A new daily clinical tool for monitoring residents with signs of illness and on antibiotics was started and a system to implement monitoring on the MAR/TAR was started. Staff were all trained on the new policies and procedures. These were verified through interviews of multiple RN's, LPN's, nurse aides and document review on 4/27/26 between 9:00 a.m. and 11:00 a.m.	F0880		06/01/2026
F0727 SS = F	RN 8 Hrs/7 days/Wk, Full Time DON CFR(s): §483.35(b)(1)-(3) §483.35(b) Registered Nurse §483.35(b)(1)Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. §483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. §483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents.	F0727	1. How will corrective action be accomplished for those residents found to have been affected by the deficient practice? The Director of Nursing has delegated the Infection Prevention duties to another qualified nurse at the facility. The DON is not a Charge Nurse in the community. She continues to work full time as the Director of Nursing. 2. How will the facility identify other residents having the potential to be affected by the same deficient practice? The community has an ADON, 2 MDS RN's and an RN nurse educator who are responsible for various portions of the community, and the schedules have been updated to reflect as such. The DON will not serve as a charge nurse.	06/01/2026

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F0727 SS = F	Continued from page 22 This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review the facility failed to ensure the director of nursing (DON) worked in the facility on a full-time basis. This deficient practice had the potential to affect all 85 current residents who resided in the facility. During an interview on 4/27/26 at 2:42 p.m., staffing coordinator (SC)-A stated day shift on Monday through Friday the director of nursing (DON) was the charge nurse, although typically one of the nurses on the transitional care unit (TCU) also served as the charge nurse. During an interview on 4/27/26 at 3:05 p.m., DON stated she worked 40 hours per week and at least four of those hours each week was spent on covering the role of the infection preventionist for the facility. A review of nursing staff schedules dated 4/20/26 through 4/27/26, failed to indicate the scheduled hours for the DON. A review of the facility assessment with a review date of 6/9/25, indicated staffing pattern included one DON full-time day shift. Facility Nursing Services- Registered Nurse (RN) policy dated 2025, indicated the facility would designate an RN to serve as DON on a full-time basis, the policy further defined full-time as worked 40 or more hours a week.	F0727	Continued from page 22 3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur? Administrator, DON, and Staffing Coordinator have been re-educated on the expectation of having full time DON who does not serve as a charge nurse, by the Regional Director of Clinical Services. 4. Monitoring to ensure compliance Administrator/ Designee will audit the daily schedule 3x per week for 4 weeks to ensure DON is full time as the DON. The results of the audits will be reviewed at the QAPI meeting for determination of ongoing audits.	06/01/2026
F0881 SS = F	Antibiotic Stewardship Program CFR(s): 483.80(a)(3) §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)(3) An antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use. This REQUIREMENT is NOT MET as evidenced by:	F0881	1. How will corrective action be accomplished for those residents found to have been affected by the deficient practice? There were no residents identified in this deficient practice. 2. How will the facility identify other residents having the potential to be affected by the same deficient practice? The community has implemented the ICAR tracking tool, is now tracking cultures and potential infectious processes in real time and	06/01/2026

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F0881 SS = F	Continued from page 23 Based on interview and document review, the facility failed to implement an ongoing antibiotic stewardship program for the facility which had the potential to affect all 85 residents the facility, as well as the potential to impact staff and visitors. Findings include: On 4/23/26, at10:27 a.m. the director of nursing (DON)/infection preventionist (IP) stated monthly, a report called antibiotic stewardship is pulled off the electronic medical record (EMR) which included includes all antibiotics ordered in the past month. IP stated the data compiled from that report was then placed into the surveillance log. IP stated she was not completing any investigation at that time. IP stated the results of testing is not consistently reviewed in “real time”. IP stated a time out should have been completed on every antibiotic was effective/working, however, stated she had not implemented an antibiotic time out program yet. IP stated she was good at consistently following up on cultures performed at the hospital, either in the emergency room (ER) or upon discharge/transfer from the hospital to the facility. IP stated she had access to the hospital EMR, however, did not do so to follow up on urine cultures. IP stated stated this was important in the event the resident had a resistant organism and they were on the wrong antibiotic, adding it was “Important to treat the right bug with the right med.” The facility policy, Infection Prevention and Control Policy and Procedure, reviewed 1/25, indicated an Infection Preventionist (IP) was to be designated for management of the program. The policy identified the IP was responsible for reviewing microbiology culture and sensitive reports on a regular basis to identify types, antibiotic resistant organisms, and transmission of organisms between residents. Additionally, the IP was to monitor antibiotic use to help determine if use was appropriate and assure that the appropriate personal protective equipment (PPE) was used when indicated. The facility policy identified the facility IPCP was to have an antibiotic stewardship program which included antibiotic use protocols and a system to monitor antibiotic use. An additional facility policy, titled Antibiotic Stewardship Program (ASP), revised 2/25, identified it was the policy of the facility to maintain an ASP with the mission of promoting the appropriate use of antibiotics to treat infections and reduce possible	F0881	Continued from page 23 completing McGeer's criteria as appropriate. 3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur? The designated Infection preventionist and DON were provided re-education on expectation related to antibiotic stewardships and tools in which tracking, trending and follow up should be documented by the Regional Director of Clinical Services. 4. Monitoring to ensure compliance The DON/designee will audit 3 residents per week for appropriate documentation and follow up related to the antibiotic stewardship program. The results of the audits will be reviewed at the QAPI meeting for determination of ongoing audits.	06/01/2026

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F0881 SS = F	Continued from page 24 adverse reactions associated with antibiotic use.	F0881		06/01/2026
F0882 SS = F	Infection Preventionist Qualifications/Role CFR(s): 483.80(b)(1)-(4) §483.80(b) Infection preventionist The facility must designate one or more individual(s) as the infection preventionist(s) (IP)(s) who are responsible for the facility's IPCP. The IP must: §483.80(b)(1) Have primary professional training in nursing, medical technology, microbiology, epidemiology, or other related field; §483.80(b)(2) Be qualified by education, training, experience or certification; §483.80(b)(3) Work at least part-time at the facility; and §483.80(b)(4) Have completed specialized training in infection prevention and control. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to ensure the criteria for Infection Preventionist was met with current certification and ongoing education, which had the potential to affect all 85 residents, visitors and staff. Findings include: On 4/23/26, at 10:20 a.m. (DON) identified she had completed the Infection Preventionist (IP) Specialized Training via an online training site, with a certificate issued 4/21/21 (date of expiration identified as 4/21/24). The online training site identified for renewal; the individual had to either test out at a score of 80% correct for a pass rate or have completed the course again to obtain recertification. DON stated she had a done “a "lot of learning", however, had not tracked it separately. A request was made for infection control training completed following the date of expiration of the certification, and this was provided. Upon review of the information for subsequent training in infection control, it was noted the sponsored online training provided included two	F0882	1. How will corrective action be accomplished for those residents found to have been affected by the deficient practice? An RN within the community has been designated as the Infection Preventionist for the community, has completed the CDC IP training course, and will attend QAPI. The DON has completed the required education to remediate the expired IP certification. 2. How will the facility identify other residents having the potential to be affected by the same deficient practice? All residents are at risk for alleged deficient practices. 3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur? The Administrator has been re-educated on the expectation to review IP qualifications on an annual basis by the Regional Director of Clinical Services. 4. Monitoring to ensure compliance NHA/designee will audit QAPI 1x per month to ensure participation and appropriate Infection Prevention qualifications.	06/01/2026

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F0882 SS = F	Continued from page 25 hours in 2024, two hours in 2025, and one hour in 2026. A review of facility online training modules completed after 4/21/24, included 2.35 of training hours. During an interview on 4/27/26, at 3:05 p.m. DON stated although she worked 40 hours per week at least four of those hours each week was spent on covering the role of the infection preventionist (IP) role for the facility. The facility policy, Infection Prevention and Control Policy and Procedure, reviewed 1/25, indicated an Infection Preventionist (IP) was to be designated for management of the program. The IP requirements were as follows; primary professional training in nursing, medical terminology, microbiology, epidemiology, or another related field; was qualified by education, training, experience, or certification; and worked part-time at the facility; had completed specialized training in an infection prevention and control; and be a member of the quality assessment and assurance committee and report to the committee on a regular basis. Additionally, the policy outlined that the IP was responsible for maintaining current knowledge in the field of infectious disease and epidemiology. The policy outlined the following ways in which the knowledge would be maintained: attend education programs provided by infection control organizations; collaboration with other infection control professionals; be well-informed on current practices, including infection control and epidemiology; had actively seek out learning opportunities to promote professional growth; accessed best practices for infection prevention and control; and maintained ongoing access to current federal, state, and local regulations on infection control requirements. The policy outlined the IP was responsible for having identified and communicated information about residents with potentially transmissible infectious agents and instructed staff on how they were to care for residents on contact precautions. Additionally, the policy identified the IP was responsible for reviewing microbiology culture and sensitive reports on a regular basis to identify types, antibiotic resistant organisms, and transmission of organisms between residents. Additionally, the IP was to monitor antibiotic use to help determine if use was appropriate and assure that the appropriate personal protective equipment (PPE) was used when indicated.	F0882		06/01/2026

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F0572 SS = E	Notice of Rights and Rules CFR(s): 483.10(g)(1)(16) §483.10(g) Information and Communication. §483.10(g)(1) The resident has the right to be informed of his or her rights and of all rules and regulations governing resident conduct and responsibilities during his or her stay in the facility. §483.10(g)(16) The facility must provide a notice of rights and services to the resident prior to or upon admission and during the resident's stay. (i) The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. (ii) The facility must also provide the resident with the State-developed notice of Medicaid rights and obligations, if any. (iii) Receipt of such information, and any amendments to it, must be acknowledged in writing; This REQUIREMENT is NOT MET as evidenced by: Based on observation and interview, the facility failed to ensure the most up to date Nursing Home Resident Bill of Rights (RBOR) was provided to each resident residing in the facility and displayed for residents, visitors and staff to review. This had the potential to affect 63 of 85 residents currently residing in the facility as well as all staff and visitors. Findings include: On 4/20/26 at 5:08 p.m., displayed by the transitional care unit (TCU) entrance was the RBOR, revised 2016. Displayed outside of dining room in long term care was RBOR, revised 2016. During observation on 4/21/26 at 11:27 a.m., on wall by long term care entrance was a hanging bin with folder that contained paper copies of the RBOR dated February 2016. On 4/21/26 at 1:48 p.m., reviewed facility admission packet, packet contained new RBOR dated 1/1/26.	F0572	1. How will corrective action be accomplished for those residents found to have been affected by the deficient practice? A new bill of rights poster was ordered upon notification and was placed in community on 4/27/2026. 2. How will the facility identify other residents having the potential to be affected by the same deficient practice? Residents were educated on the updated Bill of Rights. The admissions packet was updated with the current Bill of Rights. A copy of the bill of rights was sent via mail to responsible party's as needed. 3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur? The Administrator and Social Services department have been educated on the current nursing home Bill of Rights and the updates that were made to the Resident Bill of Rights, along with a schedule to discuss the bill or rights at each resident council, by the Regional Director of Clinical Services. 4. Monitoring to ensure compliance The administrator/ designee will audit x1 for 4 weeks that residents have access to the current Bill of Rights and that the appropriate Resident Bill of Rights is included in the admission packet. The results of the audits will be reviewed at the QAPI meeting for determination of ongoing audits.	06/01/2026

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F0572 SS = E	Continued from page 27 When interviewed on 4/21/26 at 4:59 p.m., social services (SS)-A stated they hadn't ordered a new RBOR poster in a long time. SS-A stated new pamphlets for the admission packets were ordered in January and March. Anyone who had admitted after then would have gotten the new RBOR in the packet. However, residents that were admitted prior to the purchase in January had not been informed there was an update to the RBOR. When interviewed on 4/21/26 at 5:26 p.m., administrator stated they were not aware there were changes to the RBOR. Administrator located an email received in January from Care Providers (non-profit association representing health care facilities) that identified there was an update to the RBOR. Administrator stated the update may have been missed due to transition to new ownership. Facility Resident Bill of Rights policy dated 10/22, indicated the facility would provide the residents with prompt notice of any changes in any State of Federal laws related to resident rights or facility rules during the residents stay in the facility.	F0572		06/01/2026
F0605 SS = E	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	1. How will corrective action be accomplished for those residents found to have been affected by the deficient practice? R11 is no longer on PRN Ativan. Related to R23's medication regimen, the consultant pharmacist reviewed the resident and determined no routine labs were necessary related to R23's psychotropic med use. R27 is no longer on PRN lorazepam. R27 had a GDR on his Remeron as of 5/27/2026. R29 now has behavior monitoring in place and is no longer on a PRN antipsychotic. 2. How will the facility identify other residents having the potential to be affected by the same deficient practice? All residents who have	06/01/2026

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F0605 SS = E	Continued from page 28 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. §483.45(e) Psychotropic Drugs. Based on a	F0605	Continued from page 28 been identified through pharmacy recommendatio ns and are appropriate for a GDR for psychotropic medications have been identified. A gradual dose reduction will be scheduled for these residents over the next 30 days. Psychotropic medications have been audited for appropriately documented GDRs, appropriate PRN stop dates, monitoring in place for behaviors, effectiveness, and adverse events, and follow up on labs if clinically indicated. 3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur? The IDT team, including nursing leadership and social services, have been re-educated on psychotropic medication documentation expectations for monitoring, stop dates, GDRs, and ongoing labs, if clinically appropriate, for residents on psychotropic medication by the Regional Director of Clinical Services. Licensed nurses have been educated on the expectation to document initial dose of the PRN and request orders for a 14 day stop date. 4. Monitoring to ensure compliance DON/designee will audit 10 residents per week x4 weeks to ensure all residents on psychotropic medications have appropriate documentation in place to ensure compliance with the psychotropic medication program.	06/01/2026

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F0605 SS = E	Continued from page 29 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 record review and interview, the facility failed to ensure residents were free from unnecessary psychotropic medications, including failure to ensure PRN psychotropic medications had appropriate stop dates, failure to attempt and document gradual dose reductions (GDRs), failure to obtain and monitor laboratory testing as indicated, and failure to monitor for adverse consequences, for 4 of 8 residents (R11, R23, R27, and R29) reviewed for unnecessary medications. Findings include: R27	F0605		06/01/2026

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F0605 SS = E	Continued from page 30 R27's significant change MDS dated 3/25/26, identified R27 had intact cognition and required assistance with ADL's. R27's diagnoses included depression (persistent sadness or loss of interest) and schizophrenia (a chronic mental disorder affecting thinking, perception, and behavior). The MDS also identified R27 was prescribed psychotropic medications. R27's physician's order summary, with a print date of 2/23/26, indicated R27 had an order for lorazepam (used to treat anxiety disorders) 0.5 mg, to be administered by mouth every 6 hours as needed (PRN) for anxiety, initiated on 02/23/2026. Further review of the EMR lacked evidence the PRN lorazepam order included a 14-day stop date or that the order was discontinued, renewed, or clinically re-evaluated after 14 days. R27's Psychoactive Medication Review assessment, completed on 3/22/26, indicated R27 was currently receiving a psychoactive medication. The assessment question, "Has a gradual dose reduction (GDR) been attempted in the past quarter?" was marked "N/A." The assessment indicated a medication reduction was contraindicated, noting the resident was on an optimal dose and clinically stable, with a referenced medical provider note dated 2/23/26. Further review of the electronic medical record (EMR) lacked evidence of documentation to support a GDR discussion or clinical rationale on 2/23/26. During interview on 4/23/2026 at 10:08 a.m., licensed practical nurse (LPN)-C stated R27 frequently requested lorazepam for shortness of breath (SOB) and confirmed the medication did not have an end date. The LPN further stated orthostatic blood pressures were only obtained if they appeared on the Treatment Administration Record (TAR) and confirmed there was no order for orthostatic blood pressure monitoring for R9. During interview on 4/27/26 at 1:17 p.m., LPN-G confirmed R27's PRN lorazepam order did not include an end date. During interview on 4/27/26 at 12:53 p.m.,	F0605		06/01/2026

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F0605 SS = E	Continued from page 31 consultant pharmacist (CP) stated PRN psychotropic medications should have a 14-day duration with a provider order, including documentation to support continued use beyond that timeframe. The CP stated gradual dose reductions (GDRs) should be completed in accordance with regulations, including attempts twice in the first year and annually thereafter, unless clinically contraindicated and documented by the provider. The CP further stated orthostatic blood pressures should be obtained to monitor for potential adverse effects of medications, particularly psychotropic medications. During interview on 4/27/26 at 1:48 p.m., the director of nursing (DON) and consultant nurse (C-RN) stated residents receiving psychotropic medications should be monitored for behaviors, side effects, effectiveness, and adverse effects. The DON and C-RN stated orthostatic blood pressures should be obtained for residents receiving antipsychotic medications to monitor for potential adverse effects. The DON and C-RN further stated gradual dose reductions (GDRs) should be completed and reviewed to ensure psychotropic medications are not unnecessary. They acknowledged there was no documented evidence GDRs had been completed for R27. The DON and C-RN also stated PRN psychotropic medications should have a 14-day stop date unless there is documented clinical justification for extended use, including ongoing provider monitoring and documentation supporting continued need. The DON and C-RN confirmed R27's PRN lorazepam order did not include a stop date. The facility's Psychotropic Medications policy (revised 4/24, 7/25) indicated psychotropic medications should only be used when necessary to treat a specific condition and must be supported by an appropriate diagnosis. The policy required identification and ongoing monitoring of target behaviors, including documentation of behaviors, non-pharmacological interventions, side effects, and effectiveness of the medication. Psychotropic medication use was to be reflected in the care plan and routinely reviewed to ensure the lowest effective dose. Additional monitoring included assessments for movement disorders and monthly orthostatic blood pressures, when applicable. The policy further required PRN psychotropic medications to have a 14-day stop date unless renewed by the provider with documented clinical rationale for continued use. All psychotropic medication use required provider orders specifying indications and documented informed consent.	F0605		06/01/2026

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F0605 SS = E	Continued from page 32 In review of R29's electronic medical Admission Record print date 4/24/26 ,were the following diagnoses: Alzheimer's disease with late onset, general anxiety disorder, dementia in other disease classified elsewhere, moderate without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety, personal history of malignant neoplasm of the breast (a disease where cells in the breast grow out of control, forming a tumor that can invade surrounding tissues or spread (metastasize) to other body parts), and encounter with palliative care. R29's admission comprehensive Minimum Data Set (MDS) dated 4/20/26, documented R29 was dependent on staff for all activities of daily living, was able to feed self after set up and was severely cognitively impaired. A review of R29's physician's orders (print date of 4/24/26) documented the following psychotropic medications: Haloperidol Oral Tablet 0.5 milligrams (mg) - give 0.5 mg by mouth three times a day for agitation / delirium / nausea related to dementia in other diseases classified elsewhere, moderate, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety. Haloperidol Oral Tablet 0.5 mg - give 0.5 mg by mouth every 1 hour as needed for agitation related to dementia in other diseases classified elsewhere, moderate, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety. Lorazepam Oral Concentrate 2 mg / milliliters (ml), give 0.25 ml by mouth every 6 hours as needed for agitation. In review of R29's recent PARK - Psychoactive Medication Review (dated 3/5/26) indicated only that R29 was receiving lorazepam 0.5 mg [every] 6 [hours] [as needed] for agitation. The assessment did not document the regularly scheduled haloperidol three times a day, nor the "as needed" haloperidol dosing, which R29 was prescribed. A review of R29's electronic medication administration records for March 2026 and April	F0605		06/01/2026

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F0605 SS = E	Continued from page 33 2026, R29 received Lorazepam Oral Concentrate 2 mg / milliliters (ml), give 0.25 ml by mouth every 6 hours as needed for agitation on the following dates: March 26, 2026 at 12:30 a.m. March 27, 2026 at 1:44 a.m. April 2, 2026 at 7:35 p.m. April 3, 2026 at 5:19 p.m. April 12, 2026 at 11:06 p.m. April 13, 2026 at 3:52 a.m. In review of R29's electronic medical record, documented a progress not from the consulting pharmacist (PharmD), communicating with the facility which documented the following: " Medication regimen reviewed. See communication to nursing regarding one nonsignificant irregularity and provider regarding one nonsignificant irregularity." A review of the communication form sent to the facility to address (dated 4/14/26), the PharmD requested the facility to follow up on the following recommendations: "1. This resident has an order for [as needed] lorazepam and [as needed] haloperidol. Just a friendly reminder the [as needed] lorazepam requires a 14day stop date per nursing home regulations. 2. To monitor her responses to these, recommend adding target behavior and side effects monitoring to the [treatment record - TAR]." During an interview on 4/24/26 at 9:23 a.m., the director of nursing (DON) stated she had not yet gone through all the PharmD recommendations from this month. DON stated the floor staff should have documented the 14 day documentation when the first dose was given and updated R29's primary physician. In a telephone interview on 4/27/26 at 12:54 p.m., the consulting pharmacist (PharmD) - stated that PRN psychotropic medications should be stopped and reviewed after 14 days of the first dose. The MD /NP needs to document rational for continued use, and a new order for the medication and instruction	F0605		06/01/2026

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F0605 SS = E	Continued from page 34 for a 14 stop date once it is again initially given. Per the CMS guidelines. During clarifying interview on 4/27/26 at 2:01 p.m., DON and the consulting registered nurse (C-RN) Kelly Corporate, C-RN stated it would be the expectation of the facility when a resident's PRN (as needed) psychotropic medication is initially given, the nurse giving the dose should document a 14 day stop date. When the 14 day stop date occurs, the facility should contact the primary / nurse practitioner and have the medication and effectiveness reviewed and rationale for a continued order of the medication. C-RN further stated it would be the expectation of the facility that all pharmacy recommendations be handled within 7-10 days, "while we wouldn't wait to have our medications reviewed." R23's quarterly Minimum Data Set (MDS) dated 1/23/26, indicated R23 had severe cognitive impairment and was moderate to maximum assistance with activities of daily living (ADLs). The MDS also indicated R23 took an antipsychotic medication. R23's diagnoses included bipolar disorder, anxiety, major depression dementia, neurocognitive disorder with lewy bodies (a progressive, irreversible brain disorder caused by abnormal protein deposits that disrupt brain function), bradycardia, muscle weakness and osteoporosis. R23's care plan revised 2/2/26, indicated R23 used psychotropic medications Aripiprazole and Olanzapine related to behavior management, disease process bipolar disorder with delusions/hallucinations, and included an intervention to monitor/document for side effects and effectiveness. R23's physician orders printed 4/24/26, indicated R23 had orders for aripiprazole (antipsychotic medication) 10 milligrams (MG) by mouth daily for paranoid delusion/hallucinations, olanzapine (antipsychotic medication) 5 mg twice daily for bipolar disorder, and venlafaxine (used to treat depression and anxiety) 37.5 mg twice daily for bipolar disorder. R23's electronic medical record (EMR) was reviewed, located labs completed on 6/25/25 for cholesterol	F0605		06/01/2026

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F0605 SS = E	Continued from page 35 levels and on 9/3/24 with potassium and hemoglobin levels, however R23's EMR lacked evidence of other monitoring labs while prescribed antipsychotic medications. Consultant Pharmacist's Medication Regimen Reviews for the months of October 2024 to March 2026 were reviewed, each indicated medication was reviewed for irregularities and no significant irregularities were noted. Recommendations lacked direction to monitor labs. When interviewed on 4/27/26, at 1:54 p.m. assistant director of nursing (ADON) stated would have to look into labs for R23, ADON was unable to locate labs other than cholesterol levels, potassium and hemoglobin. When interviewed on 4/27/26, at 3:05 p.m. director of nursing (DON) stated would expect labs to monitor complete blood count (CBC) and liver function tests (LFTs) for residents that took antipsychotic medication at least yearly and if there had been a change in medications. DON reviewed R23's EMR, was unable to locate a CBC and/or LFTS. Facility Psychotropic Medications policy sated 7/25, was provided, however, policy failed to address monitoring of labs while on psychotropic medications. R11's comprehensive/annual Minimum Data Set assessment dated 2/28/26, identified R11 was admitted to the facility on 2/3/25, with diagnoses which included vascular dementia, aphasia (difficulty with speaking), hemiplegia/hemiparesis (loss of mobility on one side of the body), depression and anxiety, and personality change due to physiological condition. Although R11 was identified as having cognitive impairments, it is noted R11 was able to understand others and make self understood. R11 was identified as having received personal assistance with all aspects of cares. R11's physician orders indicated on 4/1/26, orders were received for Lorazepam (an antianxiety medication) 0.5 mg (a unit of measurement) was ordered by mouth as needed for anxiety prior to dental work. The prescription lacked an end date and extended beyond the 14-day period allowed for PRN (as needed) psychotropic (mood altering)	F0605		06/01/2026

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F0605 SS = E	Continued from page 36 medication. The provider note of 4/1/26, identified R11 became anxious and resistant during dental procedures and initiated the order for Lorazepam, however, did not specify an end date for this prescription. R11's care plan, revised on 3/25/26, identified R11 had oral/dental problems related to poor nutrition and poor oral hygiene. Care plan identified further dental work was indicated and restoration was not recommended. R11 had historically refused dental exam/care and dentist recommended sedation. On 4/22/26 at 3:19 p.m., Assistant Director or Nursing (ADON) stated typically psychotropic medications had a duration of 14 days unless otherwise specified. ADON stated this one was for the dental work, so it is very time specific (only when dental work was to be provided). ADON stated with seizures and dental work, there can be a longer duration (beyond the 14 days), however, acknowledged a date for follow up review was not identified, which would have been the "preferred way".	F0605		06/01/2026
F0812 SS = E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.	F0812	1. How will corrective action be accomplished for those residents found to have been affected by the deficient practice? Dry food that expired was thrown out upon finding by the CDM. 2. How will the facility identify other residents having the potential to be affected by the same deficient practice? Food in dry food storage area was audited to ensure food was not being stored past its expiration date and stored in a secure fashion by an LNHA. 3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur? Food service manager and CDM were re-educated to ensure food being stored does not expire by an LNHA.	06/01/2026

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F0812 SS = E	Continued from page 37 This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review, the facility failed to ensure food inventory purchased and stored were rotated and utilized before the expiration dates. This had the potential to affect 82 out of 85 residents, and any visitors / staff who obtained meals from the facilities food services. Findings include - During full kitchen tour on 4/21/26 at 2:10 p.m., the dry storage room (the area of the kitchen where food items are stored which do not require refrigeration) of the kitchen was reviewed. On the top shelf of one of the storage racks the following items were noted: - a clear 5-gallon clear plastic food storage container which contained approximately 2 pounds of white rice. The container was covered with a loosely fitting piece of aluminum foil, with the date of "4/9" marked in green marker.- 2 1-gallon containers of salad dressing (similar to "Miracle Whip") with the expiration date of March 2026- 3 1-gallon containers of prepared yellow mustard with the expiration date of November 2025 In an interview on 4/21/26 at 2:10 p.m., the kitchen manger (KM) and the clinical certified dietary manager (CDM) verified these findings. The CMS stated the rice container should have had a matching lid which would have sealed the container. The CDM further stated the gallons of salad dressing and prepared mustard should have been rotated and used before the expiration dates. CDM further stated the department had begun a marking system for a "received date", which none of the none of the 5 condiment containers were marked with. KM confirmed. In a further interview on 4/21/26 at 2:27 p.m., a cook (Cook)-A stated when food items are needed from the dry storage, they do not always look at the expiration date, but they do check to see the containers are sealed and are not dented / leaking. In review of the facility policy, entitled: Date Marking for Food Safety (undated) documented the following: "Policy:The facility adheres to a date marking system to ensure the safety of ready-to-eat, time/temperature control for food safety. Policy Explanation and compliance Guidelines for Staffing: 1. Refrigerated, ready-to-eat, time/temperature control for safety food (i.e.: perishable food) shall be held at a temperature of [41 degrees Fahrenheit] or less.2. Dry storage shall be marked to indicate the date in which food would expire and thus discarded prior to serving.3. The individual opening or preparing food shall be responsible for date marking the food at the time the food is opened or prepared. Prepared food shall be discarded 72 hours post opening.4. The Head Cook, or designee, shall be responsible for	F0812	Continued from page 37 All dietary employees were re-educated on the expectation that they check the expiration date prior to utilizing the product and storing opened items in a secure fashion by the Food Service Manager. 4. Monitoring to ensure compliance Administrator/ Designee will audit x 10 items in dry food storage x 4 weeks to ensure food is not stored past the expiration date. Admin/designee will audit dry food storage 1x per week X4 weeks to ensure open foods are stored securely. The results of the audits will be reviewed at the QAPI meeting for determination of ongoing audits.	06/01/2026

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F0812 SS = E	Continued from page 38 checking the refrigerator daily for food items that are expiring, and shall discard accordingly. References:Food and Drug Administration, U.S. Department of Health and Human Services. Food Code (2022)F. Section 3-501.17 Ready-to-Eat, Time/Temperature Control for Safety Food, Date Marking."	F0812		06/01/2026
F0550 SS = D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal 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.	F0550	1. How will corrective action be accomplished for those residents found to have been affected by the deficient practice? Upon notification, R11's incontinence products were stored in an appropriate manner by the ADON. Residents' personal items were removed from the foot of the bed and stored in the closet by the ADON. 2. How will the facility identify other residents having the potential to be affected by the same deficient practice? Residents that have been identified as using incontinence products have been audited to ensure incontinence products are stored appropriately by an LNHA on 5/27/2026. All resident rooms have been audited to ensure personal items are stored in a dignified manner by an LNHA on 5/27/2026. 3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur? Licensed nurses and NARs were re-educated on appropriate storage of incontinence products and maintaining appropriate room order. 4. Monitoring to ensure compliance DON/designee will audit 5 resident rooms per week x 4 weeks to ensure incontinence products are properly stored, and personal items are stored in a manner that promotes dignity. The results of the audits will be reviewed at the QAPI meeting for determination of ongoing audits to ensure	06/01/2026

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F0550 SS = D	Continued from page 39 This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to implement interventions to maintain dignity for 1 of 2 residents (R11) reviewed for dignity. Findings include: R11's comprehensive/annual Minimum Data Set assessment was completed on 2/28/26 and identified R11 was admitted to the facility on 2/3/25 with multiple medical diagnoses which included vascular dementia, aphasia (difficulty with speaking), hemiplegia/hemiparesis (loss of mobility on one side of the body), depression and anxiety, and personality change due to physiological condition. Although R11 was identified as having cognitive impairments, it is noted R11 was able to understand others and make self understood. R11 was identified as having received personal assistance with all aspects of cares. On 4/22/26 at 8:39 a.m., R11 was observed in his room, in bed, under covers, with lights out. R11's eyes were closed and respirations were easy. R11 resided on one side of a double room. On the unoccupied bed, nearest the door, and easily visible from the hallway was a large washable incontinence pad, and two incontinence briefs. On 4/23/2026 at 10:20 a.m., the unoccupied bed had four incontinence briefs, small, unused garbage bags, large washable incontinence pad, and shorts turned inside out at the foot of the bed, easily visible from the door. On 4/23/26 at 12:50 p.m., licensed practical nurse (LPN)-D provided care to R11. The bed was stripped and linens were placed on the opposite side of the room, nearest the door. LPN-D stated R11's bed was being repaired and that linens were on the other bed. The unoccupied bed had three incontinence briefs, small, unused garbage bags, large washable incontinence pad, and shorts turned inside out at the foot of the bed. R11 wore shorts previously on the bed. LPN-D stated R11's personal items should not be stored on the foot of the bed. R11 had "lots of room to put away items." LPN-D stated this was important for R11's dignity. R11 stated he preferred his clothes not be left on the unoccupied bed. On 4/27/26 2:06 p.m., the assistant director of nursing (ADON) stated personal care items (incontinence products) were to be stored out of the	F0550	Continued from page 39 compliance.	06/01/2026

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F0550 SS = D	Continued from page 40 site of others and not on the foot of an unoccupied bed where it could be easily visualized by others. ADON stated those supplies were generally kept in the closet for “formality” and to promote a nice appearance. The facility policy, Resident Rights, dated 10/22 indicated that all residents were provided with information both orally, and in writing of his rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facilities. The policy also identified all direct and indirect care staff members, including contractors and volunteers, were educated on the rights of residents and the responsibility of the facility to properly care for its residents. Although the policy identified provision of information to residents, and provision of education to staff and others, it lacked definition as to the definition of what resident rights were and how they were to be implemented.	F0550		06/01/2026
F0554 SS = D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and record review, the facility failed to ensure residents were permitted to make choices regarding self-administration of medications and that physician orders and care processes reflected the residents’ current abilities or choices, for 3 of 3 residents (R27, R48 and R43) reviewed for self-administration of medications. Findings include: R27's significant change Minimum Data Set (MDS), dated 3/25/26, identified R27 had intact cognition and required assistance with activities of daily living (ADLs). R27's diagnoses included chronic respiratory failure with hypoxia (long-term inability of the lungs to maintain adequate oxygen levels), schizophrenia (a chronic mental disorder affecting thinking, perception, and behavior), chronic obstructive pulmonary disease [COPD] (a chronic lung disease that obstructs airflow and makes breathing difficult), dysphagia (difficulty swallowing), parkinsonism (a condition causing movement symptoms similar to Parkinson’s disease, such as	F0554	1. How will corrective action be accomplished for those residents found to have been affected by the deficient practice? R27 was re-assessed and is appropriate to self-administer medications on the assessment. Care plan and orders were updated to reflect. R48 was re-assessed and is appropriate to self-administer medications on the assessment. Care plan and orders were updated to reflect. R43 was re-assessed and is appropriate to self-administer medications on the assessment. Care plan and orders were updated to reflect. 2. How will the facility identify other residents having the potential to be affected by the same deficient practice? Residents with orders for nebulizers have been audited and assessed related to ability to complete treatment without supervision. Care plans, assessment, and orders have been updated as appropriate. Residents with an order for “okay to leave at bedside” have been audited and reassessed related to the ability to self-administer medication. Care	06/01/2026

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F0554 SS = D	Continued from page 41 tremors and stiffness), and dependence on supplemental oxygen (requires additional oxygen to maintain adequate breathing). The MDS also indicated R27 was receiving oxygen therapy. During observation on 04/20/2026 at 1:48 p.m., R27 was sitting in a recliner in his room with a nebulizer treatment running and the mask in place. The resident appeared to be sleeping, with his head slumped forward and the bottom of the mask positioned away from his chin. No nursing staff were present in the room at the time of observation. There was no evidence of a current self-administration of medication (SAM) assessment supporting the resident independently managing the treatment. During record review of R27's electronic medical record (EMR) on 4/22/26, the most current self-administration assessment (PARK–Self-Administration of Medication Quarterly Review – V3, dated 3/19/26) indicated the question, "Does resident self-administer medication?" was marked "No," with the directive, "If resident does not self-administer medication, DO NOT PROCEED." The remaining sections of the assessment were left blank, indicating the resident was not currently self-administering medications. Review of R27's EMR banner on his profile page, print date of 4/27/26, did not indicate R27 was approved or assessed to self-administer nebulizer treatments. Review of R27's physician orders on 4/22/26 identified an active order indicating it was "okay to self-administer (SAM) nebulizer once set up by staff, every shift," dated 12/10/2025. Despite this order permitting self-administration, there was no evidence the order had been clarified, discontinued, or revised to reflect R27's current preference or competency. R48's annual MDS, dated 2/13/26, identified R48 had intact cognition and required assistance with ADLs. R48's diagnoses included Alzheimer's disease (a progressive brain disorder affecting memory and thinking), anxiety disorder (excessive worry or fear), depression (persistent sadness or loss of interest), and chronic obstructive pulmonary disease [COPD] (a chronic lung disease that obstructs airflow and makes breathing difficult).	F0554	Continued from page 41 plan, assessments, and orders have been updated as appropriate. 3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur? Licensed nursing staff have been re-educated on the assessment of self-administration of medications and required documentation. Clinical management has been re-educated related to eMAR, physician orders, care plan and assessment all needing to match prior to resident self-administering medications by the Regional Director of Clinical Services. 4. Monitoring to ensure compliance DON/designee will audit 3 residents who self-administer medication per week x 4 weeks to ensure documentation reflects residents' abilities. The results of the audits will be reviewed at the QAPI meeting for determination of ongoing audits.	06/01/2026

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F0554 SS = D	Continued from page 42 During observation and interview on 4/22/26 at 8:54 a.m., trained medication aide (TMA)-B sanitized hands and entered R48's room with medications. An inhaler was observed on R48's bed within reach. TMA-B stated a physician order was required for medications to be left at bedside. R48 stated she used the inhaler as needed. The inhaler was identified as Levalbuterol Tartrate (a bronchodilator used to treat or prevent bronchospasm in individuals with asthma or COPD) 45 mcg (micrograms)/act (actuation). During record review of R48's EMR, the most current self-administration assessment (PARK–Self-Administration of Medication Annual Review – V3, dated 1/24/26) indicated the question, "Does resident self-administer medication?" was marked "No," with the directive, "If resident does not self-administer medication, DO NOT PROCEED." The remaining sections of the assessment were left blank, indicating the resident was not currently self-administering medications. Review of R48's EMR banner on her profile page, print date of 4/27/26, did not indicate R48 was approved or assessed to self-administer inhaler medication and/or to have it left at bedside. Review of R48's physician orders on 4/22/26 identified an active order for Levalbuterol Tartrate Inhalation Aerosol 45 mcg/act (Levalbuterol Tartrate), with instructions for 2 puffs inhaled orally every 4 hours as needed for shortness of breath (SOB) or wheezing, and indicating "ok to leave at bedside," dated 04/18/2024. Despite this order permitting bedside access and potential self-administration, there was no evidence the physician order had been clarified, discontinued, or revised to reflect R48's current preference or competency. During interview on 4/22/26 at 8:52 a.m., TMA-A stated staff identified whether a resident could self-administer medications by reviewing the EMR banner, which indicated if the resident was able to do so. During interview on 4/22/26 at 9:08 a.m., TMA-B stated there were no residents in the facility who self-administered nebulizer treatments, as residents could remove the device or it may not be positioned	F0554		06/01/2026

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F0554 SS = D	Continued from page 43 correctly, resulting in ineffective treatment. TMA-B further stated there were no residents who self-administered medications; however, if a medication was permitted to be kept at bedside, this would be indicated in the EMR banner. During interview on 04/22/2026 at 2:09 p.m., TMA-A stated she set up nebulizer treatments and, if she believed the resident was able to tolerate it, she left the room while the treatment was in progress. During interview on 4/23/26 at 10:03 a.m., licensed practical nurse (LPN)-A stated staff completed a self-administration assessment to determine if a resident was able to self-administer medications and, if appropriate, the physician was contacted to obtain an order. LPN-A stated residents were reassessed at least quarterly as part of the MDS assessment process. During interview on 4/23/26 at 10:08 a.m., LPN-C stated residents were assessed to ensure they were able to safely self-administer medications. LPN-C stated staff set up R27's nebulizer treatment, initiated the treatment, set a timer, and returned to turn it off, and did not remain with the resident during the treatment. During interview on 4/27/26 at 1:48 p.m., director of nursing (DON) and consultant nurse (C-RN) stated the process for self-administration of medications required a physician order and a nursing assessment to determine if the resident wished to and was able to safely self-administer medications. They stated the assessment was completed at least quarterly and should identify the specific medications approved for self-administration. They further stated the resident must demonstrate understanding and the ability to safely administer medications. The DON confirmed R27's and R48's most recent self-administration assessments were not accurate. The facility's Self-Administration of Drugs policy, dated 2/22, stated residents had the right to self-administer medications, and the facility was responsible for ensuring it was safe to do so. The policy required residents to be assessed on admission, quarterly, annually, with significant changes, and as needed to determine their desire and ability to self-administer. If a resident chose to	F0554		06/01/2026

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F0554 SS = D	Continued from page 44 self-administer, a safety assessment was to be completed, a medication-specific physician order obtained, and the self-administration plan was to be included in the resident's care plan. Findings include - On 4/22/2026 at 8:39 a.m., licensed practical nurse (LPN)-A, was talking with R43. R43 came to the medication cart requesting cough syrup, while resident was complaining of a productive cough, showing LPN-A his tissue full of phlegm. LPN-A reviewed his orders in the electronic medication administration record (eMAR) and provided R43 cough syrup them took his temperature. LPN-A asked R43 if he would (Albuterol Sulfate HFA Inhalation Aerosol Solution 108 90 micrograms actual per puff). R43 stated "you don't have it here, I have it in my room." LPNA- responded, "are you sure? You can't have it in your room unless they Oked it." LPN-A again reviewed R43's eMAR and the stated, "it looks like you can have it at bedside." R43 then headed back to his room. R43's electronic medical record's Admission Record documented the following diagnoses: senile degeneration of the brain, low back pain, chronic pain syndrome, chronic obstructive pulmonary disease (COPD - a progressive, treatable, but incurable lung disease, primarily caused by smoking, that makes breathing difficult), centrilobular emphysema (the most common form of smoking-related COPD) and Alzheimer's disease late onset. R43's most recent quarterly minimum data set (MDS), dated 3/6/26, documented R43 was independent with most activities of daily living and was moderately cognitively impaired. During an observation and interview with R43 on 4/22/26 at 10:07 a.m., R43 stated he was feeling better after the cough syrup from LPN-A and taking the inhaler when he returned to his room. When asked what type of inhaler R43 kept at bedside, resident pulled open his bedside stand drawer. Inside the drawer, R43 had the following medication: Albuterol Sulfate HFA Inhalation Aerosol Solution 108 [90 micrograms actual per puff] 2 puff inhale orally every 4 hours as needed for [shortness of breath].	F0554		06/01/2026

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F0554 SS = D	Continued from page 45 Bengay Ultra Strength External Cream 4-10-30% (Camphor-Menthol-Methyl Salicylate) apply to shoulder, back , neck topically two times a day for low back pain Cortisone 10 Anti-itch Cream In review of R43's electronic medical record, most current self administration assessment (PARK-Self-Administration of Medication Quarterly Review - V 3, dated 2/22/26), the first questions: "Does resident Self Administer medication?", it was marked 'No", followed by the direction "If resident does not Self-Administer medication, DO NOT PROCEED." The remaining sections of the assessment were unanswered. In review of R43's previous PARK-Self-Administration of Medication Quarterly Review - V 3 (dated 11/23/25), had indicated resident was able to self administer all three medications observed in R43's bedside stand. In further review of R43's electronic medical record, during the assessment period of resident's PARK-BIMS (Brief Interview for Mental Status 3.0 V1 (dated 11/26/25), R43's BIMS score was 13 - Cognitively Intact. The most current PARK-BIMS (Brief Interview for Mental Status 3.0 V1 (dated 2/22/26), Resident's BIMS score was assessed at 8 - Moderately Cognitively Impaired. A review of R43's eMAR (print dated 4/24/26) documented R43's Albuterol Sulfate HFA and Bengay Ultra Strength External Cream were documented R43 was able to keep the two medications at bedside. However, R43's Cortisone 10 Anti-itch Cream was not listed on resident's eMAR. In review of R43's physician's orders (print date of 4/24/26), the medication orders for the medications R43 kept in his bedside stand were documented as follows: 1. "Albuterol Sulfate HFA Inhalation Aerosol Solution 108 [90 micrograms actual per puff] 2 puff inhale orally every 4 hours as needed for [shortness of breath] replated to Chronic Obstructive Pulmonary Disease, unspecified (J44.9) May keep at Bedside" 2. "Bengay Ultra Strength External Cream 4-10-30%	F0554		06/01/2026

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F0554 SS = D	Continued from page 46 (Camphor-Menthol-Methyl Salicylate) apply to shoulder, back , neck topically two times a day related to Low Back Pain, unspecified (M54.50) unspervised self-administration Ok to have at bedside and to self [administer]." 3. "Cortisone 10 Anti-itch Cream - okay to have at bedside and the resident self administer as needed for itching twice daily as needed." During interview on 4/22/26 at 2:40 p.m., the director or nursing (DON) stated, even with the last quarterly self administration assessment from 2/22/26, indicated R43 didn't self administer medications, the 11/23/25, was still valid while R43 had physician's orders he could. DON stated the facility staff knew R43 well enough, and knew if they were to remove the medications from his room, R43 would ask for them back. During a clarifying interview on 4/27/26 at 2:01 p.m., with the DON and consulting registered nurse (CRN), CRN stated the facility last self administration assessment was the most current, therefore, invalidating the assessment from 11/23/25. CRN further, with s significant change in R43's BIMS scoring between 11/23/25 score of 13 (cognitively intact) and the most recent BIMS, assessed 2/22/26 of 8 (moderately cognitively impaired). R43 should have been reassessed for self administration of medications.	F0554		06/01/2026
F0628 SS = D	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	F0628	1. How will corrective action be accomplished for those residents found to have been affected by the deficient practice? R27 remains in the community. Resident representative was contacted, and policy and rights were reviewed. No negative impact to the resident. 2. How will the facility identify other residents having the potential to be affected by the same deficient practice? All residents admitted overnight to the hospital in the last 30 days have been audited and have had a bed-hold communicated to them.	06/01/2026

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F0628 SS = D	Continued from page 47 contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to	F0628	Continued from page 47 All current hospitalizations have received a bed hold notice. 3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur? Education has been provided to licensed nurses about the bed hold policy and procedure and appropriate documentation. Education has been provided to social services about the bed hold policy and procedure and appropriate documentation. 4. Monitoring to ensure compliance SSD/designee will audit 5 residents per week x 4 weeks to ensure appropriate documentation about bed hold notice. The results of the audits will be reviewed at the QAPI meeting for determination of ongoing audits.	06/01/2026

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F0628 SS = D	Continued from page 48 allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to	F0628		06/01/2026

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F0628 SS = D	Continued from page 49 effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. §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:	F0628		06/01/2026

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F0628 SS = D	Continued from page 50 (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 record review, the facility failed to ensure required information was provided to the resident or resident representative regarding bed-hold rights at the time of transfer to the hospital, including failure to discuss and document bed-hold options for a private pay resident, for 1 of 2 residents (R27) reviewed for transfer and discharge. Findings include: R27's significant change Minimum Data Set (MDS) dated 3/25/26, identified R27 had intact cognition and required assistance with activities of daily living (ADL)'s. R27's diagnoses included chronic respiratory failure with hypoxia (long-term inability of the lungs to maintain adequate oxygen levels in the blood) and COPD (chronic obstructive pulmonary disease; a lung disease that makes it hard to breathe). The MDS also indicated R27 received oxygen therapy. R27 was identified as private pay. During review of electronic medical record (EMR), it was identified: • R27 was transferred to the ED on 12/15/25 for wheezing, chest tightness, and shortness of breath and was subsequently hospitalized. R27 returned to the facility on 12/24/25. • R27 was transferred to the ED on 1/1/26 for two days of increasing cough, shortness of breath, and dyspnea on exertion (abnormal, uncomfortable breathlessness during physical activity that improves with rest, often indicating underlying heart or lung dysfunction) and was subsequently hospitalized. R27 returned to the facility on 1/6/26.	F0628		06/01/2026

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F0628 SS = D	Continued from page 51 • R27 was transferred to the ED on 2/9/26 for acute on chronic hypoxic respiratory failure (a sudden worsening of long-term low blood oxygen levels) and was subsequently hospitalized. R27 returned to the facility on 2/23/26. R27's EMR lacked documented evidence the facility provided written notification or verbal explanation of bed-hold rights at the time of transfer, and there was no evidence the option to hold the bed was discussed with R27 or the resident representative. Review of R27's clinical record, including transfer documentation and progress notes, lacked evidence the facility informed R27 of the right to reserve the bed during hospitalization, including applicable costs associated with bed hold for a private pay resident. During interview on 4/22/26 at 3:25 p.m., social worker (SW)-A and SW-B stated bed hold discussions were expected to be documented in the progress notes. SW-A and SW-B indicated they were unable to locate documentation of a bed hold discussion for R27 and stated a previous social services designee may not have documented the conversation. SW-A and SW-B further stated they were unable to locate documentation of a bed hold discussion for all three hospitalizations. SW-A stated she initially thought R27 was on MA; however, upon review, confirmed the record identified R27 as "private pay." SW-A referred to a completed MA application and stated it had been completed on 2/20/26. SW-A and SW-B stated the facility provided the bed hold policy upon admission and indicated it was important for residents to understand potential financial responsibility for holding a bed, particularly if the resident was private pay. The facility's Bed Hold Notice Upon Transfer policy revised 7/25, indicated the facility would provide written notice to the resident and/or resident representative at the time of transfer (or within 24 hours for emergency transfers) that included the duration of the bed-hold period, any reserve bed payment requirements, and the resident's right to return to the next available bed, as well as conditions for return to the facility.	F0628		06/01/2026
F0656 SS = D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement	F0656	1. How will corrective action be accomplished for those residents found to have been affected by the deficient practice? R2 Has enhanced barrier precautions implemented and is reflected in the orders and in the care plan.	06/01/2026

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F0656 SS = D	Continued from page 52 a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and record review, the facility failed to develop and implement comprehensive, person-centered care plans to include Enhanced Barrier Precautions (EBP) for residents who met criteria for 2 of 4 residents (R2,	F0656	Continued from page 52 R9 Has discharged. 2. How will the facility identify other residents having the potential to be affected by the same deficient practice? Residents have been audited, and those appropriate for EBP have had their care plans updated. 3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur? The clinical leadership team has been re-educated on the expectation that EBP for residents is to be reflected in their care plan by the Regional Director of Clinical Services. 4. Monitoring to ensure compliance The DON/designee will audit 5 residents per week x4 weeks for EBP being reflected on the care plan and in the orders. The results of the audits will be reviewed at the QAPI meeting for determination of ongoing audits.	06/01/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245448	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/27/2026

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F0656 SS = D	Continued from page 53 R9) reviewed for infection control and care planning. Findings include: R2's quarterly Minimum Data Set (MDS) dated 3/6/26, identified R2 had severe cognitive impairment and required assistance with activities of daily living (ADL)'s. R2's diagnoses included pressure ulcer of right ankle, stage 4 (a severe wound with full-thickness tissue loss exposing muscle, bone, or supporting structures), malnutrition (lack of proper nutrition due to inadequate intake or absorption), and dysphagia (difficulty swallowing). Review of R2's electronic medical record (EMR) identified the presence of a stage 4 pressure ulcer, which met criteria for EBP per current infection control guidance. R2's Order Summary Report printed 4/23/26, did not contain a physician order for EBP. R2's care plan printed 4/27/26, identified a pressure ulcer to the right ankle, stage IV (a severe wound with full-thickness tissue loss exposing muscle, bone, or supporting structures), with initial interventions initiated on 03/12/2026. The care plan included general pressure ulcer management interventions such as monitoring skin condition, evaluating ulcer characteristics, maintaining skin integrity, monitoring nutritional status, and providing wound care per treatment orders. Review of the care plan identified EBP related to the wound was not initiated until 04/23/2026. These dates indicated a delay of over one month from the identification of the stage IV pressure ulcer on 03/12/2026 to the implementation of critical infection prevention interventions, resulting in a care plan that was not comprehensive and failed to reflect timely, person-centered interventions to address the resident's risk for infection transmission. During observation on 4/20/26 at 11:42 a.m., no signage was posted outside of R2's room to indicate EBP, and EBP precautions were not in place. A PPE cart was located in the hallway between two residents' rooms, without clear designation for use specific to R2. R9's quarterly MDS dated 1/16/26, identified R9 had moderate cognition and required assistance with ADL's. R9's diagnoses included urinary retention (inability to completely empty the bladder) and benign prostatic hyperplasia with lower urinary tract symptoms (enlarged prostate causing urinary symptoms such as difficulty urinating). The MDS	F0656		06/01/2026

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F0656 SS = D	Continued from page 54 also indicated R9 had a suprapubic catheter (a catheter surgically inserted through the abdomen into the bladder to drain urine). Review of R9's EMR identified the presence of a suprapubic catheter, which met criteria for EBP per current infection control guidance. R9's Order Summary Report printed 4/23/26, did not contain a physician order for EBP. Care plan identified R9 had a suprapubic catheter related to diagnoses including atonic bladder (loss of bladder muscle function), benign prostatic hyperplasia [BPH], and urinary retention (inability to empty the bladder), with interventions initiated on 12/03/2025. The care plan included interventions to monitor intake and output, assess for pain and discomfort, monitor for signs and symptoms of urinary tract infection (UTI), and ensure proper positioning of the catheter bag below the level of the bladder. Review of the care plan identified the intervention for EBP related to the suprapubic catheter was not initiated until 04/23/2026, with revision on 04/24/2026. These dates indicated a delay of over four months from the initiation of the suprapubic catheter care plan on 12/03/2025 to the implementation of EBP, despite the presence of an indwelling catheter which met criteria for EBP. During interview on 4/22/26 at 2:23 p.m., nursing assistant (NA)-A stated staff would know a resident was on precautions by a sign posted outside the resident's room and the presence of a cart containing gowns and gloves. During interview on 04/23/2026 at 10:08 a.m., licensed practical nurse (LPN)-C stated a resident on precautions would have a bin outside the door containing PPE, and signage would be posted to alert staff the resident was on precautions. LPN-C confirmed R2 was not on EBP prior to the morning of 04/23/2026 and stated R9 was on precautions; however, EBP was not included in the care plan and there was no corresponding physician order. During interview on 4/23/26 at 3:35 p.m., assistant director of nursing (ADON) stated staff would know a resident was on precautions by the presence of a PPE cart outside the room and signage posted on the door. The ADON acknowledged precautions should be included in the care plan and that a physician order should be obtained and reflected in the medical record to ensure all staff were aware. During interview on 4/23/26 at 4:01 p.m., director of	F0656		06/01/2026

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F0656 SS = D	Continued from page 55 nursing (DON) stated EBP would be indicated by signage posted outside the resident's door and the presence of a PPE bin. The DON confirmed there was no physician order for EBP but acknowledged EBP should be included in the care plan and that the care plan should reflect the resident's care needs and guide staff in the provision of care. The facility policy titled Care Plan Policy and Procedure (revised 2/25, 7/25) indicated the facility was responsible to develop a baseline care plan within 48 hours of admission and a comprehensive, individualized care plan by day 21. The policy required care plans to include specific problems, goals, and interventions, and to be updated to reflect changes in the resident's condition. The policy further indicated care plans should be reviewed regularly, including significant changes, and should guide the care provided to the resident.	F0656		06/01/2026
F0657 SS = D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the	F0657	1. How will corrective action be accomplished for those residents found to have been affected by the deficient practice? R11 has been reassessed by therapy, and the residents' plan of care has been updated based on residents' current level of functioning and clinical needs. 2. How will the facility identify other residents having the potential to be affected by the same deficient practice? Residents with a splint have been reviewed to ensure the care plan; and cares are aligned with residents' preferences and clinically indicated plan of care. Residents on a range of motion program have been reviewed to ensure the care plan; and cares are aligned with residents' preferences and clinically indicated plan of care. 3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur? NARS has been re-educated to complete restorative programing and documenting in the medical record.	06/01/2026

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F0657 SS = D	Continued from page 56 comprehensive and quarterly review assessments. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review, the facility failed to maintain an updated care plan for 1 of 2 residents (R11) reviewed for range of motion. Findings include: R11’s comprehensive/annual Minimum Data Set assessment dated 2/28/26, identified R11 was admitted to the facility on 2/3/25, with diagnoses which included vascular dementia, aphasia (difficulty with speaking), hemiplegia/hemiparesis (loss of mobility on one side of the body), depression and anxiety, and personality change due to physiological condition. Although R11 was identified as having cognitive impairments, it is noted R11 was able to understand others and make self-understood. R11 was identified as having received personal assistance with all aspects of cares. R11's care plan, last revised on 6/5/25, identified R11 had an alteration in neurological status related to a stroke and history of temporal lobectomy (procedure that removes the front part of the temporal lobe of the brain to treat drug-resistant epilepsy) for seizures. R11's care plan identified the goal was for R11 to function at the fullest potential possible as outlined by the interdisciplinary team through the review date which was last revised on 2/28/26. The care plan interventions included provision of range of motion (ROM) /PROM (passive range of motion-exercises to maintain movement with either active or passive participation or actively in which the resident does not assist with) with am/pm (morning and afternoon/evening) care(s) daily to be completed by nursing/CNA (certified nursing assistant). The care plan lacked identification of the use of any splint to right hand. The resident care assignment sheet, dated 4/21/26, lacked directions to staff to provide assistance with range of motion, either active or passive, and lacked indication of a splint to right hand. The resident task tab lacked directions to the nursing assistants to perform range of motion exercises with am/pm cares. The resident task tab on the electronic medication record (EMR) identified Restorative Nursing Range of Motion, with directions to staff to indicate the number of minutes performed. On 4/21/26 at 2:41 p.m. R11 was observed in his	F0657	Continued from page 56 The Clinical Leadership team has been re-educated by the Regional Director of Clinical Services related to care plans for splints and passive range of motion programs. 4. Monitoring to ensure compliance DON/designee will audit 3 residents with a splint per week for X4 weeks. The results of the audits will be reviewed at the QAPI meeting for determination of ongoing audits. DON/designee will audit 3 residents with a passive range of motion programs per week for X4. The results of the audits will be reviewed at the QAPI meeting for determination of ongoing audits.	06/01/2026

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F0657 SS = D	Continued from page 57 room, resting on the bed with a splint noted on his right hand. R11 replied “No” when asked if staff provided assistance with exercises to his right side when performing his morning and evening cares. On 4/22/26 at 10:06 a.m. the restorative nursing aide (RNA)-A stated she assisted R11 with PROM three to five times a week. On 4/22/26 at 3:00 p.m., nursing assistant (NA)-H stated she was unaware of any directions for staff to complete twice daily ROM with cares, and indicated it was not on the care list, or task section for documentation. On 4/22/26 at 3:19 p.m. the assistant director of nursing (ADON) stated at one time, R11 had directions on the nursing assistant care list for ROM twice daily (14 times/week), however, that has now been changed to Restorative Nursing. ADON was unsure when that changed and would follow up on this. On 4/23/26 at 4:30 p.m. ADON provided the following documentation: A document, titled Restorative Nursing Program, dated 2/19/25 identified R11 was to receive right upper extremity PROM daily from shoulder to digits and was to have right palm protector on during AM and off with PM cares. Additionally, R11 was to receive lower extremities (plural) knee to chest, hip ABD (abduction)/ADD (adduction), and ankles. This would be a frequency of seven times a week, versus the previously identified frequency of 14 times a week. The document, Restorative Nursing Plan, with notes dated 4/15/25, 7/21/25, 10/27/25 directed staff to continue with PROM to maintain current ROM for activities of ADL’s (activities of daily living-dressing, grooming, bathing). On 4/27/26 1:57 p.m. ADON stated he was unsure why the frequency of ROM decreased from twice daily to three to five times a week. ADON acknowledged the care plan identified twice daily ROM and did not reflect R11 received Restorative Nursing three to five times a week. ADON acknowledged the care plan should reflect the care provided to the resident. The facility policy, Care Plan Policy and Procedure, revised 2/25, identified the care plan was to ensure the resident has the appropriate care required to maintain or attain the resident’s highest level of practicable function. The policy identified changes in the resident status would be identified in the care plan.	F0657		06/01/2026

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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 provide assistance with personal cares, for 2 of 2 residents (R23 and R98) reviewed for assistance with activities of daily living (ADLs-including placement of hearing aids, set up for eating, and personal grooming including shaving) for dependent residents. Findings include: R98's Nursing Assessment/Initial Care Plan, initiated on 4/8/26, indicated R98 was admitted with encephalopathy (any disorder or disease that affects brain function. It can lead to altered mental status, memory loss, personality changes, and in severe cases, coma) and was alert and oriented times one to two (person and/or person and place), demonstrated forgetfulness, and was unable to use call light to summon staff. The nursing assessment/initial care plan identified R98 required assistance with mobility, transfers, personal dressing, grooming, and bathing. R98's care plan, initiated on 4/14/26, identified R98's additional medical diagnoses included: depression, anxiety, corary artery disease (narrowing of the coronary arteries), hypertension (high blood pressure), dementia (altered thought processes) and abnormality of gait (walking). The Nursing Assistant Care List, dated 4/22/26, identified R98 required assistance of one with grooming, which included own teeth, and glasses. The grooming column did not specify shaving, or preference for facial hair. The care list also identified R98 received total assistance of one to complete dressing and received assistance of one with mobility. On 4/20/26 at 12:37 p.m. R98 was observed to have ¼ to 1/3 inch of facial hair present under his nose, cheeks, chin, and under chin. R98's family member (FM)-A stated she had brought a shaver to the facility, informed staff she had brought in the shaver, and requested routine shaving be completed, however, stated staff has not shaved R98 since his	F0677	1. How will corrective action be accomplished for those residents found to have been affected by the deficient practice? R23's plan of care has been updated to reflect the use of hearing aides. R23's preferences for seating the in the dining has been updated to reflect residents' preferences. R98 was discharged from the community. 2. How will the facility identify other residents having the potential to be affected by the same deficient practice? Residents on the transitional care unit have been audited to ensure preferences for grooming including shaving are reflected on the care plan and communicated per community protocol. Residents who have hearing aides have been audited to ensure the plan of care specifies and instructs staff to donning and doffing expectations. Residents have been identified and those with individualized seating preferences while in the dining room have been carried out as appropriate. 3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur? The community will add assessment questions that will capture grooming preferences, including shaving upon admission. Re-education has been provided to the clinical leadership team related to the process of hearing aides and updating the plan of care for implementation by the Regional Director of Clinical Services. Education has been provided to the clinical leadership team related to seating preferences in the	06/01/2026

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F0677 SS = D	Continued from page 59 admission (4/8/26). On 4/21/26 at 11:38 a.m. R98 was observed seated in room with FM-A and remains unshaved. On 4/22/26 at 9:00 a.m. licensed practical nurse (LPN)-J reviewed the resident care list which was noted to be on the nurse's station on the desk. Staff were directed to provide assistance of one for R98 with dressing and to use a gait belt with two assist. The assignment sheet identified staff were to assist R98 with personal grooming and identified R98 has his own teeth and glasses. The sheet lacked direction as to facial hair preference and directions for shaving. LPN-J stated R98 always had a bit of a "rough appearance" with facial hair unshaved, and she was unaware he wished to be shaved. LPN-J stated residents were only shaved upon request. LPN-J stated residents who resided in long term care unit were interviewed as to facial hair preference, and expressed desire for shaving, however, this was not completed on the transitional care unit (TCU) unit. LPN-J stated the information regarding cares to be provided was entered on the nursing assistant care sheets by the director of administrative services (DAS). On 4/22/26 at 9:10 a.m. nursing assistant (NA)-N stated she had not provided morning assistance on that day, however, had assisted on previous occasions. NA-M stated she had helped with personal grooming, however, not shaved recently, as FM-A was going to bring in an alternate shaver as initial shaver pinched R98's face. NA-N was unaware a new shaver had been brought in, however, did find one when drawer was checked. NA-A acknowledged R98 needed a shave. On 4/22/26 at 10:25 a.m., NA-M stated she was unaware of any concerns regarding R98's appearance with facial hair, however, stated she would only shave R98 if she were directed to do so on the care list, and would not perform cares which were not on the list unless this was cleared with the nurse. On 4/23/26 at 8:47 a.m. DAS stated that she created the worksheet, using the information provided to her by the nurses from the initial care plan. DAS stated any changes to the care list is provided by the director of nursing (DON), assistant directed of nursing (ADON), the nurse who completed the Minimum Data Set (MDS) assessment, and the activities director (AD)-A. DAS stated AD-A completed an interview upon admission for those who resided on the long-term to identify personal	F0677	Continued from page 59 dining room by the Regional Director of Clinical Services. Education has been provided to the Licensed Nurses and NARS related to grooming expectations including shaving with cares, appropriate donning/doffing of hearing aides, and appropriate individualized seating arrangements in the dining room. 4. Monitoring to ensure compliance The community will audit 5 residents per week X4 weeks on the TCU to ensure grooming preferences are identified, and the plan of care reflects as such. The results of the audits will be reviewed at the QAPI meeting for determination of ongoing audits. The community will audit 5 residents per week x4 weeks to ensure hearing aides are communicated appropriately via the community protocol. The community will audit 3 residents per week x4 weeks to ensure appropriate individualized seating arrangements while in the dining room.	06/01/2026

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F0677 SS = D	Continued from page 60 preferences for grooming (facial hair, shaving, and makeup). This interview was completed only for those on the long-term care unit. DAS stated if there were preferences for those on TCU, they would have to be identified individually. DAS stated it was important to be aware of the preference for the preference for facial hair, as individuals may prefer to be clean shaven, or have a beard. DAS stated those residents with dementia may not be able to express this, and interviews with family members/responsible parties were to be completed. . On 4/23/2026, at 11:09 a.m. activities director (AD)-A stated this was started previously when concerns were identified on the long-term care unit regarding preferences for personal grooming, however, this had not been implemented for TCU. AD-A stated grooming considerations are important for dignity, whether an individual wished to be clean shaven, or preferred facial hair. If the resident was unable to express this, the family member was consulted. On 4/27/26 at 2:13 p.m. ADON stated upon admission an assessment was completed to determine what assistance was required with provision of personal needs for residents. If able to respond, the resident was consulted, however, if unable the responsible party was asked. ADON acknowledged personal grooming and facial hair preference was not part of the assessment. ADON stated the expectation for morning cares was to include all aspects of grooming, including shaving. ADON stated this was asked upon admission by activities, and added to the care list. ADON stated it was important to be aware if the resident preferred to be clean shaven or have facial hair. ADON was unaware this was asked only of those residents on the long-term care unit. On 4/27/26 at 4:23 p.m. this was verified by the consultant registered nurse (C-RN) the preference interview was only completed for those residents who resided in the long-term care unit. An undated template of questions to be asked for “Morning and Night Routine-V2” included “What is your morning routine after you wake up? “, as well as the “Personal Hygiene Routine: 6. The resident prefers (Specify: being shaved (FREQ-frequency); having make-up applied (FREQ); hands washed; hair style).” A policy was requested for completion of this document was requested, however, was not available. The facility policy, titled Activities of Daily Living	F0677		06/01/2026

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F0677 SS = D	Continued from page 61 (ADLs), revised 7/25, indicated the facility will, based on resident's comprehensive assessment and consistent with needs and choices, ensure a resident's ability in ADLs do not deteriorate unless deterioration is unavoidable. The policy goes on to state that care and services were to be provided for the following ADLs, which included dressing, grooming and oral care. The policy lacked personal preferences and choices for shaving and facial hair, however, the policy identified the facility was to maintain individual objectives of the care plan and periodic review and evaluation. R23's quarterly Minimum Data Set (MDS) dated 1/23/26, indicated R23 had severe cognitive impairment and was moderate to maximum assistance with activities of daily living (ADLs). The MDS also indicated R23 took an antipsychotic medication. R23's diagnoses included bipolar disorder, anxiety, major depression dementia, osteoarthritis, neurocognitive disorder with lewy bodies (a progressive, irreversible brain disorder caused by abnormal protein deposits that disrupt brain function), bradycardia, muscle weakness and osteoporosis. R23's care plan revised 2/2/26, indicated R23 had a ADL self-care performance deficit related to cognitive concerns, bipolar disorder. Interventions included R23 used a wheelchair and required assistance to all destinations, R23 was able to propel wheelchair very short distances, when eating in the dining room R23 preferred to sit alone facing the window. During observation on 4/21/26, at 11:59 AM in dining room at over bed table facing the window, R23 asked surveyor if they were the hearing aid people, R23 stated he could not find the hearing aids. During observation on 4/21/26, at 12:27 p.m. R23 was in the dining room at an overbed table, while R23 attempted to eat the overbed table rolled away from him, R23 then had to move wheelchair forward to enable him to continue eating. R23 had difficulty propelling wheelchair forward, when R23 attempted to move the wheels would rock the wheels back and forth. At 12:31 p.m. R23 has difficulty propelling wheelchair forward to the overbed table, a staff member walked past R23, staff member did not provide assistance.	F0677		06/01/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245448	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F0677 SS = D	Continued from page 62 On 4/21/26, at 12:36 p.m. R23 was attempting to propel the wheelchair past surveyor, R23 stated “you can have that table, I’m done with that thing.” On 4/21/26, at 4:46 p.m. R23 was in the dining room, no hearing aides observed in ears. During observation on 4/21/26, at 5:44 p.m. R23 was at overbed table in dining room, when R23 attempted to eat the overbed table rolled away, R23 had to repeatedly propel wheelchair forward to continue with meal. When observed on 4/22/26, at12:00 p.m. and at 2:16 p.m. R23 was not wearing hearing aids. When interviewed on 4/22/26, at 4:35 p.m. nursing assistant (NA)-B stated R23 preferred to sit alone and look out the window at meals, NA-B stated had not observed the table move while R23 attempted to eat. NA-B stated R23 did not have hearing aids. During observation on 4/23/26, at 9:18 a.m. R23 was at overbed table, overbed table repeatedly rolled away while R23 attempted to eat. R23 was not wearing hearing aids, R23 asked surveyor if they had them On 4/23/26, at 9:32 a.m. reviewed R23’s electronic medical record (EMR) noted hearing aid delivery in scanned documents, hearing aids were delivered on 4/20/26, delivery slip indicated provider had educated a staff member on the care of the hearing aids slip had been signed by a licensed practical nurse (LPN). When interviewed on 4/23/26, at 10:06 a.m. NA-D stated if a resident had hearing aids it was noted on the care sheets, NA-D reviewed care sheet, stated there was no hearing aids for R23 indicated. NA-D stated R23 had meals at the overbed table and stated was aware the table rolled away from R23, he just had to roll back up to it when it did roll. NA-D acknowledged the table next to him could be raised and lowered for the level R23 required and did not have the ability to roll away.	F0677		06/01/2026

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F0677 SS = D	Continued from page 63 When interviewed on 4/23/26, at 11:12 a.m. assistant director of nursing (ADON) stated when the ancillary service the facility used delivered new glasses or hearing aids staff signed for the item. ADON was not aware R23 received hearing aids. ADON reviewed scanned documents, noted hearing aids were delivered on 4/20/26. ADON returned at 12:15 p.m. stated hearing aids were located charging at the nurses desk. When interviewed on 4/27/26, at 3:05 p.m. director of nursing (DON) stated the expectation when new hearing devices were delivered was to place an order in the EMR to apply every morning, remove them every evening and charge them for R23 as he would need assistance. DON stated R23 preferred to sit alone and look out the window, DON was not sure why R23 was sitting at an overbed table rather than a regular table, DON stated most of the tables were able to be raised or lowered to meet the height needed., DON stated the overbed table that rolled away while eating was a safety concern. Policies regarding hearing aids and dining tables was requested, however none was provided.	F0677		06/01/2026
F0684 SS = D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and record review, the facility failed to ensure services were provided in accordance with professional standards of practice and physician orders, including failure to apply compression stockings as ordered and failure to ensure accurate documentation of care provided, for 2 of 2 residents (R27 and R46) reviewed for quality of care. Additionally, the facility failed to ensure proper positioning in her wheelchair for 1 of 1 residents (R23) observed leaning over in their	F0684	1. How will corrective action be accomplished for those residents found to have been affected by the deficient practice? R27- has been re-assessed for edema and most appropriate interventions have been implemented. R46- Edema has been resolved and the order for compression stockings has been discontinued. R23- Has been assessed by therapy for wheelchair positioning with appropriate interventions implemented. 2. How will the facility identify other residents having the potential to be affected by the same deficient practice? Residents who have an order for compression stockings have been audited for appropriateness.	06/01/2026

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F0684 SS = D	Continued from page 64 wheelchair. Findings include: R27 R27's significant change Minimum Data Set (MDS) dated 3/25/26, identified R27 had intact cognition and required assistance with activities of daily living (ADL)'s. R27's diagnoses included peripheral vascular disease (PVD; poor circulation due to narrowed blood vessels), localized edema (swelling caused by fluid buildup in tissues), and dependence on supplemental oxygen (requires additional oxygen to maintain adequate oxygen levels). The MDS also indicated R27 was receiving oxygen therapy. R27's Order Summary report, with a print date of 4/23/26, indicated physician's orders for compression stockings to be applied in the morning for edema, with an order start date of 12/14/2025, and to be removed at bedtime for edema, with an order start date of 12/13/2025. During observation on 4/20/26 at 12:35 p.m., R27 exhibited bilateral pitting edema in the lower extremities. R27 was wearing yellow gripper socks, which were indented above the ankles. No compression stockings were in place; only yellow gripper socks were observed. During observation on 4/21/26 at 11:16 a.m., R27 was sitting in a recliner with feet on the floor. Bilateral lower extremity edema was observed. No compression stockings were in place; only yellow gripper socks were observed. During observation on 4/21/26 at 3:12 p.m., R27 was sitting in a recliner in the room with legs crossed. No compression stockings were in place; only yellow gripper socks were observed. During observation on 4/21/26 at 4:45 p.m., R27 remained sitting in the recliner with feet on the floor. No compression stockings were in place; only yellow gripper socks were observed. During observation on 04/22/2026 at 8:43 a.m., R27 was sitting in a recliner with eyes closed and legs crossed. No compression stockings were in place; only yellow gripper socks were observed. During observation on 04/23/2026 at 7:27 a.m., R27 was sitting in a recliner in his room with his eyes closed. No compression stockings were in place; only yellow gripper socks were observed.	F0684	Continued from page 64 Residents not on therapy caseload have been reviewed by therapy for appropriate wheelchair positioning. Orders for therapy eval and treat have been made as appropriate. 3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur? Education has been provided to licensed nurses and NARS related to the application of compression stockings and appropriate documentation in the TAR. Education has been provided to licensed nurses and NARS related to wheelchair positioning and how to communicate when a resident is not seated properly. The Clinical leadership team has been educated by the Regional Director of Clinical Services to initiate a therapy referral should a resident not be positioned correctly in their wheelchair. 4. Monitoring to ensure compliance DON/designee will audit 5 residents per week for X4 weeks for implementation of compression stockings per the plan of care. The results of the audits will be reviewed at the QAPI meeting for determination of ongoing audits. DON/designee will audit 5 residents per week for appropriate wheelchair positioning. The results of the audits will be reviewed at the QAPI meeting for determination of ongoing audits.	06/01/2026

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F0684 SS = D	Continued from page 65 Review of R27's Treatment Administration Record (TAR) for 4/20/26 to 4/23/26 indicated compression stockings were documented as applied as ordered. R46 R46's quarterly MDS dated 2/6/26, identified R46 had severe cognitive impairment and required assistance with ADL's. R46's diagnoses included peripheral vascular disease (PVD; poor circulation due to narrowed blood vessels) and hemiparesis (weakness on one side of the body). The MDS identified R46 did not have any behaviors exhibited. R46's Order Summary Report, print date of 4/23/26, indicated a physician's order, dated 11/3/2025, for knee-high TED stockings to be applied in the morning and removed at bedtime. The order specified use every day and evening shift, with ace wraps permitted as an alternative. The order was related to cellulitis of the left lower limb (a bacterial skin infection causing redness, swelling, and pain), blister (nonthermal), left foot, subsequent encounter (a healing skin lesion from a prior blister), and localized edema (swelling caused by fluid buildup in tissues). During observation on 04/20/2026 at 2:06 p.m., R46 exhibited bilateral lower extremity swelling. No compression stockings were in place; the resident was wearing fuzzy white socks. During observation on 04/21/2026 at 3:13 p.m., R46 was seated in the living room area and was observed fidgeting with clothing and attempting to swing legs off the left side of a Broda chair. R46 was wearing white socks, and bilateral lower extremity edema was noted. No compression stockings were in place; only white socks were observed. During observation on 04/21/2026 at 3:16 p.m., the administrator approached R46 and adjusted the strap of the Hoyer sling over the right arm of the wheelchair. During observation on 04/22/2026 at 2:05 p.m., R46 was seated in a Broda chair in the living room area, fidgeting with pant legs and leaning forward. R46 was wearing white socks. No compression stockings were in place; only white socks were observed. Review of R46's TAR for 4/20/26 through 4/23/26 indicated knee-high TED stockings were documented as applied as ordered. An exception	F0684		06/01/2026

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F0684 SS = D	Continued from page 66 was noted on 4/22/26, when a code of “9” was documented on the day shift; however, the TAR indicated the stockings were removed on the evening shift that same date, reflecting inconsistent documentation. During interview on 4/22/26 at 2:23 p.m., nursing assistant (NA)-A stated both R27 and R46 had compression stockings that should be worn daily and documented in PCC. NA-A stated staff were responsible for applying compression stockings per order and to report if unable to do so. NA-A confirmed neither R27 nor R46 were wearing compression stockings at that time. During interview on 4/27/26 at 1:17 p.m., licensed practical nurse (LPN)-G stated R46’s compression stockings were discontinued that morning as they could not be located. LPN-G stated night shift staff typically applied them in the morning before the resident got out of bed. LPN-G acknowledged R27 did not have compression stockings on. During interview on 4/27/26 at 1:48 p.m., the director of nursing (DON) and consultant nurse (C-RN) stated compression stockings should be applied according to the physician’s order, typically on in the morning and off at night, and documented accurately on the TAR. The DON stated residents have the right to refuse; however, the order should be followed unless refusal is documented. The facility’s Compression & Intervention Management policy (revised 7/25) stated compression devices are used to manage edema, improve circulation, and prevent complications when ordered by a provider. The policy indicated staff are responsible to apply compression devices (e.g., compression stockings, ace wraps, Tubi grips) according to provider orders and instructions, with specific application roles based on staff training. The policy further required the use of compression devices to be documented in the treatment record. R23’s quarterly Minimum Data Set (MDS) dated 1/23/26, indicated R23 had severe cognitive impairment and was moderate to maximum assistance with activities of daily living (ADLs). The MDS also indicated R23 took an antipsychotic medication. R23’s diagnoses included bipolar disorder, anxiety, major depression dementia, osteoarthritis, neurocognitive disorder with lewy bodies (a progressive, irreversible brain disorder caused by abnormal protein deposits that disrupt brain function), bradycardia, muscle weakness and osteoporosis.	F0684		06/01/2026

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F0684 SS = D	Continued from page 67 R23's care plan revised 2/2/26, indicated R23 had a mobility deficit related to cognitive concerns, bipolar disorder, pain, osteoarthritis and osteoporosis. Interventions included R23 used a wheelchair for mobility, required assistance to all destinations, R23 was able to propel wheelchair very short distances, R23 required assistance of two staff and mechanical lift for transfers. During observation on 4/20/26, at 12:07 p.m. R23 was sitting in wheelchair in dining room, R23 was leaned over toward right side, right side was rested on the arm rest, right arm hung over side of armrest. On 4/20/26, at 4:32 p.m. R23 was observed in hallway, R23 was leaning to right side, right side was resting on armrest of the wheelchair On 4/21/26, at 11:41 a.m. R23 was observed in the dining room participating in an activity. R23 was positioned leaned over to the right, right side rested against arm rest of wheelchair, right arm hung over arm rest with hand towards the floor. During observation on 4/21/26, at 5:44 p.m. R23 was in dining room, positioned leaning to right side with right side rested on arm rest, arm hung over the arm rest with hand hung towards the floor. On 4/22/26, at 3:09 p.m. R23 was observed in wheelchair in room, R23 was positioned leaned to the right side with arm hung over the arm rest, hand hung down towards the floor. When interviewed on 4/22/26, at 4:35 p.m. nursing assistant (NA)-B stated R23 tilted to the side a lot, when R23 was straightened would lean over again, NA-B stated they thought R23 preferred to lean and was comfortable. On 4/23/26, at 9:18 a.m. R23 was observed in the dining room, R23 was leaning to right side, right side rested on arm rest of wheelchair with arm hung down, hand was towards the floor. When interviewed on 4/23/26, at 10:06 a.m. NA-D	F0684		06/01/2026

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F0684 SS = D	Continued from page 68 stated R23 was repositioned to sitting upright several times throughout the day but continued to return to leaning to the one side. On 4/27/26, at 10:49 a.m. R23 was observed by the nurses station, R23 was seated in wheelchair positioned with right side leaning against the right arm rest of the wheelchair, right arm was hung over the armrest with hand hung towards the floor. When interviewed on 4/27/26, at 1:22 p.m. certified occupational therapy assistant (COTA)-A stated during morning meeting with management team someone might bring up a person that may benefit therapy then they would screen the resident to determine if they might benefit from therapy for positioning. COTA-A stated R23 hadn't been seen since they had been working in the facility. When interviewed on 4/27/26, at 3:05 p.m. director of nursing (DON) stated the expectation if a resident leaned was to obtain an order for therapy to evaluate and treat for wheelchair positioning. DON stated she believed they had attempted positioning with R23 and had been seen by therapy. However, DON was unable to locate documentation regarding therapy and/or positioning devices. Facility Wheelchair Positioning policy revised 7/2025, indicated all residents who required use of a wheelchair would be provided with a suitable wheelchair that met their needs, the policy further indicated orders for occupation therapy (OT) would be requested for positioning and safety when appropriate.	F0684		06/01/2026
F0688 SS = D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to	F0688	1. How will corrective action be accomplished for those residents found to have been affected by the deficient practice? R11 has been reassessed by therapy, and the residents' plan of care has been updated based on residents' current level of functioning and clinical needs. 2. How will the facility identify other residents having the potential to be affected by the same deficient practice?	06/01/2026

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F0688 SS = D	Continued from page 69 increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to consistently provide assistance to complete range of motion (ROM) as outlined in plan of care for 1 of 2 residents (R11) reviewed for range of motion. Findings include: R11's comprehensive/annual Minimum Data Set assessment completed 2/28/26, identified R11 was admitted to the facility on 2/3/25 with multiple medical diagnoses which included vascular dementia, aphasia (difficulty with speaking), hemiplegia/hemiparesis (loss of mobility on one side of the body), depression and anxiety, and personality change due to physiological condition. Although R11 was identified as having cognitive impairments, it is noted R11 was able to understand others and make self-understood. R11 was identified as having received personal assistance with all aspects of care. R11's care plan last revised on 6/5/25, identified R11 had an alteration in neurological status related to a stroke and history of temporal lobectomy (procedure that removes the front part of the temporal lobe of the brain to treat drug-resistant epilepsy) for seizures. R11's care plan identified the goal was for R11 to function at their fullest potential possible as outlined by the interdisciplinary team through the review date, last revised on 2/28/26. The care plan interventions included provision of range of motion (ROM) /PROM (passive range of motion-exercises to maintain movement with either active or passive participation or actively in which the resident does not assist with) with am/pm (morning and afternoon/evening) care(s) daily to be completed by nursing/CNA (certified nursing assistant). The care plan lacked identification of the use of any splint to right hand. The resident care assignment sheet dated 4/21/26, lacked directions for staff to aid with range of motion, either active or passive, and lacked	F0688	Continued from page 69 Residents with a splint have been reviewed to ensure the care plan; and cares are aligned with residents' preferences and clinically indicated plan of care. Residents on a range of motion program have been reviewed to ensure the care plan; and cares are aligned with residents' preferences and clinically indicated plan of care. 3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur? NARS has been re-educated to complete restorative programing and documenting in the medical record. The Clinical Leadership team has been re-educated by the Regional Director of Clinical Services related to care plans for splints and passive range of motion programs. 4. Monitoring to ensure compliance DON/designee will audit 3 residents with a splint per week for X4 weeks. The results of the audits will be reviewed at the QAPI meeting for determination of ongoing audits. DON/designee will audit 3 residents with a passive range of motion programs per week for X4. The results of the audits will be reviewed at the QAPI meeting for determination of ongoing audits. DON/designee will audit 5 residents per week x4 weeks to ensure the assigned restorative program has been implemented appropriately.	06/01/2026

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F0688 SS = D	Continued from page 70 indication of a splint to right hand. The resident task tab lacked directions to the nursing assistants to perform range of motion exercises with am/pm cares. The resident task tab on the electronic medication record (EMR) identified Restorative Nursing Range of Motion, with directions to staff to indicate the number of minutes performed. A review of the documentation completed under the task tab in the electronic medical record (EMR) identified ROM was only completed on seven occasions in the previous 30 days. On 4/21/26 at 2:41 p.m., R11 was observed in his room, resting on the bed with a splint noted on his right hand. R11 stated staff did not provide assistance with exercises to his right-side during morning and evening cares. On 4/22/26 at 10:06 a.m., the restorative nursing aide (RNA)-A stated she assisted R11 with PROM three to five times a week. RNA-A stated there had been a problem with the EMR tasks tab and it did not accurately reflect the frequency. Further documentation provided identified R11 received assistance with PROM at the following frequency on the past weeks: Week of 3/2/26: R11 was offered therapy on four occasions, and refused on one occasion. Week of 3/9/26: R11 was offered therapy on three occasions, and accepted PROM on two. Week of 3/16/26: R11 was offered therapy on four occasions and accepted on three occasions. Week of 3/23/26: R11 was offered therapy and accepted on 3/23/26. RNA-A was not in facility the remainder of the week (identified as “vacation”). Week of 3/30/26: R11 was offered therapy on four occasions and refused on two occasions. R11 was offered therapy on 15 of 31 days in March. An additional document, titled Documentation Survey Report v2 identified for 4/1/26-4/6/26, therapy was not provided. R11 did not receive therapy on 4/7/26-4/10/26 (rationale not identified), and again 4/14/26-4/17/26 to total eight days of eighteen days documented. On 4/22/26 at 3:00 p.m., nursing assistant (NA)-H stated she was unaware of any directions for staff to	F0688		06/01/2026

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARK RIVER HEALTHCARE AND REHABILITATION CENTER LLC	9899 AVOCET STREET NORTHWEST , COON RAPIDS, Minnesota, 55433

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F0688 SS = D	Continued from page 71 complete twice daily ROM with cares, and indicated it was not on the care list, or task section for documentation. On 4/22/26 at 3:19 p.m., the assistant director of nursing (ADON) stated ROM for resident may be done by either nursing staff or restorative nursing. ADON stated R11 required more coaxing and encouragement and therefore received assistance from Restorative Nursing. ADON stated at one time, R11 had directions on the nursing assistant care list for ROM twice daily (14 times/week), however, that had been changed to Restorative Nursing. ADON was unsure when that changed and would follow up on this. On 4/23/26 at 4:30 p.m., ADON provided the following documentation: A document, titled Restorative Nursing Program, dated 2/19/25 identified R11 was to receive right upper extremity PROM daily from shoulder to digits. Additionally, R11 was to receive lower extremities (plural) knee to chest, hip ABD (abduction)/ADD (adduction), and ankles. The document also reflected R11 was to have right palm protector on during AM and off with PM cares. This would be a frequency of seven times a week, versus the previously identified frequency of 14 times a week. The document, Restorative Nursing Plan, with notes dated 4/15/25, 7/21/25, 10/27/25 directed staff to continue with PROM to maintain current ROM for activities of ADL's (activities of daily living-dressing, grooming, bathing). ADON acknowledge the recommendations were for daily, however, Restorative Nursing was only in facility five days a week. On 4/27/26 1:57 p.m., ADON stated he was unsure why the frequency of ROM decreased from twice daily to three to five times a week. They were unsure where the initial direction for twice daily directions came from. ADON stated Restorative Nursing was present in the facility Monday through Friday. ADON stated he was unsure how Restorative Nursing was covered when RNA-A was away from the facility/on vacation. ADON acknowledged the discrepancy between the care plan, the care list, and the task tab within the EMR. ADON acknowledged the care plan should reflect the care provided to the residents. The facility policy, Restorative Nursing, last revised 7/25 identified the restorative nursing program referred to interventions which promoted resident's ability to adapt and adjust to living as independently as possible. The policy identified nursing personnel were responsible for care which would not require a qualified therapist, which included assisting	F0688		06/01/2026

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F0688 SS = D	Continued from page 72 residents with range of motion exercises, performing passive range of motion for residents who lacked active range of motion.	F0688		06/01/2026
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 record review and interview, the facility	F0756	1. How will corrective action be accomplished for those residents found to have been affected by the deficient practice? R9 has been discharged from the community. R65's pharmacist recommendations from 1/19/26 have been addressed. 2. How will the facility identify other residents having the potential to be affected by the same deficient practice? The community has audited unit moves from TCU to LTC in the past 60 days to ensure that residents who have changed units have had a pharmacist review of medications and appropriate follow up. The community has audited residents' most recent pharmacy recommendations and has been addressed by the resident's provider. 3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur? The clinical leadership team has provided education, by the Regional Director of Clinical Services on expectations related to follow up of pharmacist medication reviews. 4. Monitoring to ensure compliance DON/designee will audit 5 pharmacy recommendations per week x4 weeks to ensure timely and appropriate follow up has occurred. Results of the audits will be reviewed at the QAPI meeting for determination of ongoing audits.	06/01/2026

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F0756 SS = D	Continued from page 73 failed to ensure the recommendations from the monthly medication regimen review (MRR) conducted by the consultant pharmacist were reviewed and acted upon in a timely manner, in accordance with professional standards of practice, for 2 of 6 residents reviewed for unnecessary medications (R9 and R65). Findings include: R65's quarterly Minimum Data Set (MDS) assessment, completed on 2/23/26, identified R65 was admitted to the facility on 11/21/25 had impaired cognition, and required assistance with activities of daily living (ADL's-eating, dressing, grooming, bathing, and mobility). R65's medical diagnoses included: Alzheimer's disease and non-Alzheimer's dementia, anxiety, depression, hypertension (high blood pressure), orthostatic hypotension (a drop in blood pressure which occurred with a change in position and adult failure to thrive. A review of the consulting pharmacist reports was completed from the time of R65's admission date of 11/21/25. It was noted the consulting pharmacist's reviews were in place for the following dates: 11/24/25), 1/19/26, 2/17/26, 3/15/26 and 4/15/26. A consultant pharmacist review was not present for the month of December 2025. On 4/23/26, at 7:32 a.m. the director of nursing (DON) stated she had spoken with the Consultant Pharmacist (PharmD)-B and it was noted the review was missed in the month of December as R65 had moved from the transitional care unit to the long-term care unit. DON stated medical record reviews were expected to be reviewed by the Consultant Pharmacist monthly. On 4/27/26, at 12:59 p.m. it was noted by PharmD-A that R65 had changed units in December of 2025 and a record review was not completed that month. The facility's Pharmacy Recommendations policy, revised 7/25, required a review of resident medication regime is done monthly by the pharmacy consultant with recommendations addressed to the physicians and nursing. (Please add this to the front of Lanisha's policy information) Findings include: R9's quarterly Minimum Data Set (MDS) dated	F0756		06/01/2026

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F0756 SS = D	Continued from page 74 1/16/26, identified R9 had moderate cognitive impairment and required assistance with activities of daily living (ADL)'s. R9's diagnoses included Alzheimer's disease with late onset (a progressive brain disorder affecting memory and thinking), non-Alzheimer's dementia (decline in memory and thinking not caused by Alzheimer's disease), anxiety disorder (excessive worry or fear), and COPD (chronic obstructive pulmonary disease; a lung disease that makes it hard to breathe). Review of the consultant pharmacist's monthly medication regimen review (MRR), dated 1/19/26, identified recommendations related to R9's medication regimen, indicating, "resident is receiving citalopram and olanzapine. Please make sure we have patient specific target behavior monitoring, side effect monitoring, and orthostatic blood pressure monitoring in place." Review of the consultant pharmacist's MRR, dated 2/16/26, identified recommendations related to R9's medication regimen, indicating, "the resident has an order for trazodone, citalopram, and olanzapine and to monitor his response to these, recommend adding appropriate target behavior, orthostatic blood pressure, and side effect monitoring to the TAR." Review of R9's electronic medical record (EMR) and physician order records lacked evidence the facility reviewed, acknowledged, or acted upon the consultant pharmacist's recommendations in a timely manner. There was no documented evidence the recommendations were communicated to the physician, implemented, or that a rationale was provided for not implementing the recommendations. During interview on 04/27/2026 at 12:53 p.m., consultant pharmacist (CP) stated monthly medication regimen reviews were conducted to identify irregularities and ensure safe and appropriate medication use. The CP stated MRR recommendations were typically expected to be addressed within the following month, unless the provider had not yet seen the resident, in which case it could extend up to two months. The CP stated recommendations should be addressed as soon as possible. The CP further stated if recommendations were not addressed by the following month, a pending report would be issued, which included the same recommendations for follow-up and resolution. During interview on 4/27/26 at 1:48 p.m., director of nursing (DON) and consultant nurse (C-RN) stated the expectation was for MRR recommendations to be	F0756		06/01/2026

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F0756 SS = D	Continued from page 75 addressed within 30 days. The DON and C-RN further stated R9's MRR would have been considered a nursing MRR, which should have been addressed immediately or within a few days. The DON and C-RN confirmed the recommendations for R9 were missed and not followed up in a timely manner. The facility's Pharmacy Recommendations policy, revised 7/25, required that monthly medication regimen review (MRR) recommendations made by the consultant pharmacist be communicated to nursing and physicians, documented in the medical record, and addressed timely. The policy indicated physicians were to respond by either implementing recommendations with orders or documenting rationale for disagreement. Unresolved recommendations were to be tracked, re-reviewed the following month, and followed up by nursing, with ongoing non-response escalated to the medical director for further action.	F0756		06/01/2026
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:	F0757	1. How will corrective action be accomplished for those residents found to have been affected by the deficient practice? R16's metoprolol orders were clarified to include appropriate parameters. 2. How will the facility identify other residents having the potential to be affected by the same deficient practice? Residents who have an order for metoprolol were audited to ensure appropriate parameters are in place as clinically indicated. 3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur? Licensed nurses were educated on following physician orders as written for medication administration including taking vital signs prior to administration when necessary. HUCs, Licensed nurses and clinical leaders were educated, on expectations for implementing physician orders on the eMAR as written.	06/01/2026

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F0757 SS = D	Continued from page 76 Based on observation, interview, and record review, the facility failed to ensure medications were administered in accordance with professional standards of practice, including failure to follow physician orders to monitor blood pressure and pulse parameters prior to administration of a beta-blocker medication, for 1 of 1 resident (R16) reviewed for unnecessary medications. Findings include: R16's admission Minimum Data Set (MDS) dated 3/26/26, identified R16 had intact cognition and was independent with activities of daily living (ADL)'s. R16's diagnoses included hypertension (high blood pressure), atrial fibrillation (an irregular heart rhythm), coronary artery disease (narrowing or blockage of the heart's blood vessels), heart failure (a condition where the heart cannot pump blood effectively), and end stage renal disease (advanced kidney failure requiring dialysis). Review of R16's physician orders printed 4/22/26, identified an order for Metoprolol Tartrate 50 MG (milligram), give 50 mg by mouth two times a day for ESRD, with parameters to hold the medication for systolic blood pressure (SBP) less than 90 or pulse less than 50, initiated on 3/20/2026. R16's medication administration records (MAR) from 3/20/26 to 4/22/26, identified Metoprolol Tartrate was administered as ordered; however, there was no documentation to indicate R16's blood pressure or pulse were obtained prior to administration, as required by the physician's order. During interview on 4/22/26 at 2:09 p.m., trained medication aide (TMA)-A reviewed R16's medication record, confirmed Metoprolol had parameters to hold for SBP (systolic blood pressure) less than 90 or pulse less than 50, and stated they were not obtaining blood pressure or pulse prior to administration. During interview on 4/23/26 at 10:08 a.m., licensed practical nurse (LPN)-C stated there were no residents, to her knowledge, who currently had medication parameters requiring vital signs prior to administration. LPN-C further stated she did not obtain any vital signs that morning related to medication administration. During interview on 4/23/26 at 3:35 p.m., assistant director of nursing (ADON) stated Metoprolol had parameters on the order to hold the medication	F0757	Continued from page 76 4. Monitoring to ensure compliance DON/designee will audit 5 residents per week x4 weeks to ensure residents with parameters receive medications as ordered. The results of the audits will be reviewed at the QAPI meeting for determination of ongoing audits.	06/01/2026

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F0757 SS = D	Continued from page 77 based on vital signs and confirmed vital sign monitoring was not in place and was not being completed prior to medication administration for R16. During interview on 4/27/26 at 1:17 p.m., LPN-G confirmed blood pressure and pulse should be obtained prior to administering medications with parameters and acknowledged this was not initiated for R16 until 4/23/26. During interview on 4/27/26 at 1:48 PM, director of nursing (DON) and consultant nurse (C-RN) stated staff were expected to follow physician orders, including obtaining vital signs prior to administration of medications withhold parameters. The DON stated when medications have parameters for holding, vital signs must be obtained prior to administration and the medication should be held if the resident is outside of those parameters, as this is a provider order. Review of the facility's Medication Administration policy, revised 7/25, identified medications were to be administered by licensed or authorized staff in accordance with physician orders and professional standards of practice. The policy required staff to obtain and document vital signs when indicated by the order and to hold medications if vital signs were outside prescribed parameters. The policy further required adherence to the six rights of medication administration and accurate documentation on the medication administration record (MAR), including recording required vital signs and any medication refusals.	F0757		06/01/2026
F0883 SS = D	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period;	F0883	1. How will corrective action be accomplished for those residents found to have been affected by the deficient practice? R16- is up to date with all pneumococcal vaccinations and documentation is available in the EMR. R19 has been offered all immunizations as appropriate. 2. How will the facility identify other residents having the potential to be affected by the same deficient practice? Residents have been audited	06/01/2026

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F0883 SS = D	Continued from page 78 (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to ensure recommended influenza, pneumococcal, and Covid-19 vaccinations, as outlined by the Centers for Disease Control (CDC), were offered and/or provided in a timely manner to	F0883	Continued from page 78 and the appropriate pneumococcal immunizations have been identified. All residents will receive the appropriate vaccine, per their wishes, within the next 30 days. 3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur? The clinical leadership team and HIM department has been provided education related to expectations for pulling MIIC records and documenting these in the medical record by the Regional Director of Clinical Services. The clinical leadership team was provided education related to obtaining consent and providing vaccinations as outlined per community policy by the Regional Director of Clinical Services. 4. Monitoring to ensure compliance DON/designee will audit 5 residents per week x4 weeks to ensure appropriate pneumococcal recommendations and vaccinations have been offered and provided per residents' wishes. The results of the audits will be reviewed at the QAPI meeting for determination of ongoing audits.	06/01/2026

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F0883 SS = D	Continued from page 79 reduce the risk of severe disease for 2 of 5 residents (R16 and R19) reviewed for immunizations. Findings include: R16's comprehensive/admission Minimum Data Set (MDS) assessment, completed on 4/2/26, indicated he was admitted to the facility on 3/20/26, and was cognitively intact, and was independent with activities of daily living (ADL's-dressing, grooming, mobility, and hygiene), however, used a walker/wheelchair. R16's medical diagnoses included end stage renal disease (ESRD-a chronic kidney disease where kidneys can no longer function properly)with dependence on renal dialysis (a process to help the body rid the wastes the kidney is no longer able to remove), multiple cardiac diseases including coronary artery disease, heart failure, hypertension, and aortic stenosis. On 4/21/26 at 4:40 p.m. a review of R16's immunization status identified R16 had received the Pneumococcal Conjugate Vaccine (pneumonia vaccine) on 7/2/15 and 12/22/22, however, the documentation lacked indication as to what vaccination had been given (PCV13, PCV15, and PCV20-varied types available). A review of consents was completed with no indication that any additional Pneumovax was offered, nor was a review of vaccinations identified within the electronic medical records (EMR) to indicate which vaccines were provided, nor a determination made as to whether or not additional pneumonia vaccine(s) should have been offered. On 4/23/26, at 10:20 a.m. during an interview with the director of nursing (DON) regarding the process of review of resident's immunization status upon admission. DON had identified during interview that both she and Information Technologist (IT)-A had access to MIIC (Minnesota Immunization Information Connection) and were responsible for review of the registry to assure that all immunizations were current the time of admission. This process was to verify which immunizations had been completed for the residents, as well as to identify if there were further immunizations recommended, aside from what has been completed. DON stated if the resident was cognitively able to choose which vaccinations they wished to receive, the resident was consulted. If they were unable to choose independently, the responsible party was consulted regarding vaccination. DON stated the immunizations reviewed included the following vaccines: Pneumococcal, Influenza, and Covid. On 4/23/26 after 5:00 p.m. a review of the electronic medical record (EMR) was completed and it was	F0883		06/01/2026

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0883 SS = D	Continued from page 80 noted that there was additional information added to R16's Immunization Record which included an additional pneumovaccine, PPSV2, given historically on 8/25/11. Additionally, there was subsequent information added which identified on 7/2/15 it was the PCV13 pneumonia vaccine given, and on 12/22/22, the PCV20 was given. In light of this, upon review of PneumoRecs (a resource which identified which vaccinations should be given, based on what the resident has had previously), their pneumococcal vaccinations were complete, however, this information had not been identified prior to interview with director of nursing (DON), and the third dose had not been listed for 8/25/11. R19's comprehensive/admission Minimum Data Set (MDS) assessment, completed on 4/30/26, indicated she was admitted to the facility on 3/19/26, had some level of cognitive impairment, and received assistance to complete activities of daily living (ADL's), and used a wheelchair for mobility. R19's medical diagnoses included hypertension (high blood pressure), diabetes (a disease which impacts the body's ability to manage sugar in the diet), and Klebsiella pneumoniae (the causative agent of a disease that is (e.g., pneumonia, sepsis, urinary tract infection). On 4/21/26 at 4:40 p.m., a review of R19's EMR identified under the Immunization Record tab, indicated R19 had received a Pneumovax 23 pneumonia vaccine on 6/4/07. Upon review of the documentation, there had not been documentation reflective of review of the pneumonia vaccine provided, and what was subsequently indicated, as well as what information was provided. to the resident's responsible party. The documentation lacked indication as to whether R19 had received PCV13. Upon review of PneumoRecs identified it was the recommendation to give one dose of PCV15 or PCV20 at least one year after last dose of PPSV23, with the last vaccine given 6/4/07. On 4/23/26 at 10:20 a.m. the DON stated there was no indication of any vaccines having been offered. A review of vaccine consents was also completed at this time, and lacked indication further vaccines were offered. An email received from DON at 4/24/26 at 9:44 a.m. indicated R19's record had been reviewed, and a consent was to be sent out regarding the Pneumovax vaccine. This had not been completed	F0883		06/01/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245448	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/27/2026

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F0883 SS = D	Continued from page 81 prior to the interview completed. The facility policy, Infection Prevention and Control Policy and Procedure, reviewed 1/25, identified the elements of the program included definition of, and management of, appropriate resident health initiatives, such as the immunization program (influenza, pneumonia, etc.); and Tuberculosis screening on admission and following the discovery of a new case, and management of active cases consistent with State requirements. An additional policy, Group Vaccination (Influenza/Pneumococcal) Notification, revised 8/18, identified all residents admitted to the facility will be screened to determine if they are current on adult immunizations. The policy further indicated the documentation was to be maintained in the resident's medical record. The Notification of Group Vaccination, which included notification of benefits and potential side effects, was to be given to the resident or responsible part and was to be documented in the resident's medical record.	F0883		06/01/2026

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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 4/20/26 to 4/27/26, 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 complaints were reviewed: H54481254C (iQIES #2798440), with a licensing order	20000		06/01/2026

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 **04/27/2026**

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20000	Continued from page 1 issued at F812 Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far-left column entitled “ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor’s findings are the Suggested Method of Correction and Time period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin https://www.health.state.mn.us/facilities/regulation/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		06/01/2026
20510	Use of Restraints CFR(s): MN Rule 4658.0300 Subp. 2 Subp. 2. Freedom from restraints. Residents must be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This LICENSURE REQUIREMENT is NOT MET as	20510	corrected	06/01/2026

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20510	Continued from page 2 evidenced by: Based on record review and interview, the facility failed to ensure residents were free from unnecessary psychotropic medications, including failure to ensure PRN psychotropic medications had appropriate stop dates, failure to attempt and document gradual dose reductions (GDRs), failure to obtain and monitor laboratory testing as indicated, and failure to monitor for adverse consequences, for 4 of 8 residents (R11, R23, R27, and R29) reviewed for unnecessary medications. Findings include: R27's significant change MDS dated 3/25/26, identified R27 had intact cognition and required assistance with ADL's. R27's diagnoses included depression (persistent sadness or loss of interest) and schizophrenia (a chronic mental disorder affecting thinking, perception, and behavior). The MDS also identified R27 was prescribed psychotropic medications. R27's physician's order summary, with a print date of 2/23/26, indicated R27 had an order for lorazepam (used to treat anxiety disorders) 0.5 mg, to be administered by mouth every 6 hours as needed (PRN) for anxiety, initiated on 02/23/2026. Further review of the EMR lacked evidence the PRN lorazepam order included a 14-day stop date or that the order was discontinued, renewed, or clinically re-evaluated after 14 days. R27's Psychoactive Medication Review assessment, completed on 3/22/26, indicated R27 was currently receiving a psychoactive medication. The assessment question, "Has a gradual dose reduction (GDR) been attempted in the past quarter?" was marked "N/A." The assessment indicated a medication reduction was contraindicated, noting the resident was on an optimal dose and clinically stable, with a referenced medical provider note dated 2/23/26. Further review of the electronic medical record (EMR) lacked evidence of documentation to support a GDR discussion or clinical rationale on 2/23/26. During interview on 4/23/2026 at 10:08 a.m., licensed practical nurse (LPN)-C stated R27 frequently requested lorazepam for shortness of	20510		06/01/2026

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20510	Continued from page 3 breath (SOB) and confirmed the medication did not have an end date. The LPN further stated orthostatic blood pressures were only obtained if they appeared on the Treatment Administration Record (TAR) and confirmed there was no order for orthostatic blood pressure monitoring for R9. During interview on 4/27/26 at 1:17 p.m., LPN-G confirmed R27's PRN lorazepam order did not include an end date. During interview on 4/27/26 at 12:53 p.m., consultant pharmacist (CP) stated PRN psychotropic medications should have a 14-day duration with a provider order, including documentation to support continued use beyond that timeframe. The CP stated gradual dose reductions (GDRs) should be completed in accordance with regulations, including attempts twice in the first year and annually thereafter, unless clinically contraindicated and documented by the provider. The CP further stated orthostatic blood pressures should be obtained to monitor for potential adverse effects of medications, particularly psychotropic medications. During interview on 4/27/26 at 1:48 p.m., the director of nursing (DON) and consultant nurse (C-RN) stated residents receiving psychotropic medications should be monitored for behaviors, side effects, effectiveness, and adverse effects. The DON and C-RN stated orthostatic blood pressures should be obtained for residents receiving antipsychotic medications to monitor for potential adverse effects. The DON and C-RN further stated gradual dose reductions (GDRs) should be completed and reviewed to ensure psychotropic medications are not unnecessary. They acknowledged there was no documented evidence GDRs had been completed for R27. The DON and C-RN also stated PRN psychotropic medications should have a 14-day stop date unless there is documented clinical justification for extended use, including ongoing provider monitoring and documentation supporting continued need. The DON and C-RN confirmed R27's PRN lorazepam order did not include a stop date. The facility's Psychotropic Medications policy (revised 4/24, 7/25) indicated psychotropic medications should only be used when necessary to treat a specific condition and must be supported by an appropriate diagnosis. The policy required identification and ongoing monitoring of target	20510		06/01/2026

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20510	Continued from page 4 behaviors, including documentation of behaviors, non-pharmacological interventions, side effects, and effectiveness of the medication. Psychotropic medication use was to be reflected in the care plan and routinely reviewed to ensure the lowest effective dose. Additional monitoring included assessments for movement disorders and monthly orthostatic blood pressures, when applicable. The policy further required PRN psychotropic medications to have a 14-day stop date unless renewed by the provider with documented clinical rationale for continued use. All psychotropic medication use required provider orders specifying indications and documented informed consent. In review of R29's electronic medical Admission Record print date 4/24/26 ,were the following diagnoses: Alzheimer's disease with late onset, general anxiety disorder, dementia in other disease classified elsewhere, moderate without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety, personal history of malignant neoplasm of the breast (a disease where cells in the breast grow out of control, forming a tumor that can invade surrounding tissues or spread (metastasize) to other body parts), and encounter with palliative care. R29's admission comprehensive Minimum Data Set (MDS) dated 4/20/26, documented R29 was dependent on staff for all activities of daily living, was able to feed self after set up and was severely cognitively impaired. A review of R29's physician's orders (print date of 4/24/26) documented the following psychotropic medications: Haloperidol Oral Tablet 0.5 milligrams (mg) - give 0.5 mg by mouth three times a day for agitation / delirium / nausea related to dementia in other diseases classified elsewhere, moderate, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety. Haloperidol Oral Tablet 0.5 mg - give 0.5 mg by mouth every 1 hour as needed for agitation related to dementia in other diseases classified elsewhere, moderate, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety. Lorazepam Oral Concentrate 2 mg / milliliters (ml), give 0.25 ml by mouth every 6 hours as needed for agitation. In review of R29's recent PARK - Psychoactive Medication Review (dated 3/5/26) indicated only that R29 was receiving lorazepam 0.5 mg [every] 6 [hours] [as needed] for agitation. The assessment did not document the regularly scheduled haloperidol three times a day, nor the "as needed" haloperidol dosing, which R29 was prescribed. A review of R29's electronic medication administration records for March 2026 and April 2026, R29 received Lorazepam Oral	20510		06/01/2026

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20510	Continued from page 5 Concentrate 2 mg / milliliters (ml), give 0.25 ml by mouth every 6 hours as needed for agitation on the following dates:March 26, 2026 at 12:30 a.m.March 27, 2026 at 1:44 a.m.April 2, 2026 at 7:35 p.m.April 3, 2026 at 5:19 p.m.April 12, 2026 at 11:06 p.m.April 13, 2026 at 3:52 a.m. In review of R29's electronic medical record, documented a progress not from the consulting pharmacist (PharmD), communicating with the facility which documented the following: " Medication regimen reviewed. See communication to nursing regarding one nonsignificant irregularity and provider regarding one nonsignificant irregularity." A review of the communication form sent to the facility to address (dated 4/14/26), the PharmD requested the facility to follow up on the following recommendations: "1. This resident has an order for [as needed] lorazepam and [as needed] haloperidol. Just a friendly reminder the [as needed] lorazepam requires a 14day stop date per nursing home regulations. 2. To monitor her responses to these, recommend adding target behavior and side effects monitoring to the [treatment record - TAR]." During an interview on 4/24/26 at 9:23 a.m., the director of nursing (DON) stated she had not yet gone through all the PharmD recommendations from this month. DON stated the floor staff should have documented the 14 day documentation when the first dose was given and updated R29's primary physician. In a telephone interview on 4/27/26 at 12:54 p.m., the consulting pharmacist (PharmD) - stated that PRN psychotropic medications should be stopped and reviewed after 14 days of the first dose. The MD /NP needs to document rational for continued use, and a new order for the medication and instruction for a 14 stop date once it is again initially given. Per the CMS guidelines. During clarifying interview on 4/27/26 at 2:01 p.m., DON and the consulting registered nurse (C-RN) Kelly Corporate, C-RN stated it would be the expectation of the facility when a resident's PRN (as needed) psychotropic medication is initially given, the nurse giving the dose should document a 14 day stop date. When the 14 day stop date occurs, the facility should contact the primary / nurse practitioner and have the medication and effectiveness reviewed and rationale for a continued order of the medication. C-RN further stated it would be the expectation of the facility that all pharmacy recommendations be handled within 7-10 days, "while we wouldn't wait to have our medications reviewed."	20510		06/01/2026

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20510	Continued from page 6 R23's quarterly Minimum Data Set (MDS) dated 1/23/26, indicated R23 had severe cognitive impairment and was moderate to maximum assistance with activities of daily living (ADLs). The MDS also indicated R23 took an antipsychotic medication. R23's diagnoses included bipolar disorder, anxiety, major depression dementia, neurocognitive disorder with lewy bodies (a progressive, irreversible brain disorder caused by abnormal protein deposits that disrupt brain function), bradycardia, muscle weakness and osteoporosis. R23's care plan revised 2/2/26, indicated R23 used psychotropic medications Aripiprazole and Olanzapine related to behavior management, disease process bipolar disorder with delusions/hallucinations, and included an intervention to monitor/document for side effects and effectiveness. R23's physician orders printed 4/24/26, indicated R23 had orders for aripiprazole (antipsychotic medication) 10 milligrams (MG) by mouth daily for paranoid delusion/hallucinations, olanzapine (antipsychotic medication) 5 mg twice daily for bipolar disorder, and venlafaxine (used to treat depression and anxiety) 37.5 mg twice daily for bipolar disorder. R23's electronic medical record (EMR) was reviewed, located labs completed on 6/25/25 for cholesterol levels and on 9/3/24 with potassium and hemoglobin levels, however R23's EMR lacked evidence of other monitoring labs while prescribed antipsychotic medications. Consultant Pharmacist's Medication Regimen Reviews for the months of October 2024 to March 2026 were reviewed, each indicated medication was reviewed for irregularities and no significant irregularities were noted. Recommendations lacked direction to monitor labs. When interviewed on 4/27/26, at 1:54 p.m. assistant director of nursing (ADON) stated would have to look into labs for R23, ADON was unable to locate labs other than cholesterol levels, potassium and hemoglobin.	20510		06/01/2026

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20510	Continued from page 7 When interviewed on 4/27/26, at 3:05 p.m. director of nursing (DON) stated would expect labs to monitor complete blood count (CBC) and liver function tests (LFTs) for residents that took antipsychotic medication at least yearly and if there had been a change in medications. DON reviewed R23's EMR, was unable to locate a CBC and/or LFTS. Facility Psychotropic Medications policy sated 7/25, was provided, however, policy failed to address monitoring of labs while on psychotropic medications. R11's comprehensive/annual Minimum Data Set assessment dated 2/28/26, identified R11 was admitted to the facility on 2/3/25, with diagnoses which included vascular dementia, aphasia (difficulty with speaking), hemiplegia/hemiparesis (loss of mobility on one side of the body), depression and anxiety, and personality change due to physiological condition. Although R11 was identified as having cognitive impairments, it is noted R11 was able to understand others and make self understood. R11 was identified as having received personal assistance with all aspects of cares. R11's physician orders indicated on 4/1/26, orders were received for Lorazepam (an antianxiety medication) 0.5 mg (a unit of measurement) was ordered by mouth as needed for anxiety prior to dental work. The prescription lacked an end date and extended beyond the 14-day period allowed for PRN (as needed) psychotropic (mood altering) medication. The provider note of 4/1/26, identified R11 became anxious and resistant during dental procedures and initiated the order for Lorazepam, however, did not specify an end date for this prescription. R11's care plan, revised on 3/25/26, identified R11 had oral/dental problems related to poor nutrition and poor oral hygiene. Care plan identified further dental work was indicated and restoration was not recommended. R11 had historically refused dental exam/care and dentist recommended sedation. On 4/22/26 at 3:19 p.m., Assistant Director or Nursing (ADON) stated typically psychotropic medications had a duration of 14 days unless otherwise specified. ADON stated this one was for the dental work, so it is very time specific (only	20510		06/01/2026

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20510	Continued from page 8 when dental work was to be provided). ADON stated with seizures and dental work, there can be a longer duration (beyond the 14 days), however, acknowledged a date for follow up review was not identified, which would have been the “preferred way”. SUGGESTED METHOD OF CORRECTION: The facility will ensure psychotropic medications are managed according to physician orders and standards of practice. Staff will be re-educated on completing and documenting gradual dose reductions (GDRs), ensuring PRN psychotropic medications have a 14-day stop date unless extended by the provider with documented rationale, and obtaining orthostatic blood pressures as ordered. The director of nursing or designee will complete audits of residents receiving psychotropic medications and those with orthostatic blood pressure orders to ensure compliance. Results will be reviewed and ongoing monitoring will be implemented to maintain compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	20510		06/01/2026
20555	Comprehensive Plan of Care; Development CFR(s): MN Rule 4658.0405 Subp. 1 Subpart 1. Development. A nursing home must develop a comprehensive plan of care for each resident within seven days after the completion of the comprehensive resident assessment as defined in part 4658.0400. The comprehensive plan of care must be developed by an interdisciplinary team that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, with the participation of the resident, the resident's legal guardian or chosen representative. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and record review, the facility failed to develop and implement comprehensive, person-centered care plans to include Enhanced Barrier Precautions (EBP) for residents who met criteria for 2 of 4 residents (R2, R9) reviewed for infection control and care planning. Findings include:	20555	corrected	06/01/2026

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20555	Continued from page 9 R2's quarterly Minimum Data Set (MDS) dated 3/6/26, identified R2 had severe cognitive impairment and required assistance with activities of daily living (ADL)'s. R2's diagnoses included pressure ulcer of right ankle, stage 4 (a severe wound with full-thickness tissue loss exposing muscle, bone, or supporting structures), malnutrition (lack of proper nutrition due to inadequate intake or absorption), and dysphagia (difficulty swallowing). Review of R2's electronic medical record (EMR) identified the presence of a stage 4 pressure ulcer, which met criteria for EBP per current infection control guidance. R2's Order Summary Report printed 4/23/26, did not contain a physician order for EBP. R2's care plan printed 4/27/26, identified a pressure ulcer to the right ankle, stage IV (a severe wound with full-thickness tissue loss exposing muscle, bone, or supporting structures), with initial interventions initiated on 03/12/2026. The care plan included general pressure ulcer management interventions such as monitoring skin condition, evaluating ulcer characteristics, maintaining skin integrity, monitoring nutritional status, and providing wound care per treatment orders. Review of the care plan identified EBP related to the wound was not initiated until 04/23/2026. These dates indicated a delay of over one month from the identification of the stage IV pressure ulcer on 03/12/2026 to the implementation of critical infection prevention interventions, resulting in a care plan that was not comprehensive and failed to reflect timely, person-centered interventions to address the resident's risk for infection transmission. During observation on 4/20/26 at 11:42 a.m., no signage was posted outside of R2's room to indicate EBP, and EBP precautions were not in place. A PPE cart was located in the hallway between two residents' rooms, without clear designation for use specific to R2. R9's quarterly MDS dated 1/16/26, identified R9 had moderate cognition and required assistance with ADL's. R9's diagnoses included urinary retention (inability to completely empty the bladder) and benign prostatic hyperplasia with lower urinary tract symptoms (enlarged prostate causing urinary symptoms such as difficulty urinating). The MDS also indicated R9 had a suprapubic catheter (a catheter surgically inserted through the abdomen into the bladder to drain urine).	20555		06/01/2026

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20555	Continued from page 10 Review of R9's EMR identified the presence of a suprapubic catheter, which met criteria for EBP per current infection control guidance. R9's Order Summary Report printed 4/23/26, did not contain a physician order for EBP. Care plan identified R9 had a suprapubic catheter related to diagnoses including atonic bladder (loss of bladder muscle function), benign prostatic hyperplasia [BPH], and urinary retention (inability to empty the bladder), with interventions initiated on 12/03/2025. The care plan included interventions to monitor intake and output, assess for pain and discomfort, monitor for signs and symptoms of urinary tract infection (UTI), and ensure proper positioning of the catheter bag below the level of the bladder. Review of the care plan identified the intervention for EBP related to the suprapubic catheter was not initiated until 04/23/2026, with revision on 04/24/2026. These dates indicated a delay of over four months from the initiation of the suprapubic catheter care plan on 12/03/2025 to the implementation of EBP, despite the presence of an indwelling catheter which met criteria for EBP. During interview on 4/22/26 at 2:23 p.m., nursing assistant (NA)-A stated staff would know a resident was on precautions by a sign posted outside the resident's room and the presence of a cart containing gowns and gloves. During interview on 04/23/2026 at 10:08 a.m., licensed practical nurse (LPN)-C stated a resident on precautions would have a bin outside the door containing PPE, and signage would be posted to alert staff the resident was on precautions. LPN-C confirmed R2 was not on EBP prior to the morning of 04/23/2026 and stated R9 was on precautions; however, EBP was not included in the care plan and there was no corresponding physician order. During interview on 4/23/26 at 3:35 p.m., assistant director of nursing (ADON) stated staff would know a resident was on precautions by the presence of a PPE cart outside the room and signage posted on the door. The ADON acknowledged precautions should be included in the care plan and that a physician order should be obtained and reflected in the medical record to ensure all staff were aware. During interview on 4/23/26 at 4:01 p.m., director of nursing (DON) stated EBP would be indicated by signage posted outside the resident's door and the presence of a PPE bin. The DON confirmed there	20555		06/01/2026

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20555	Continued from page 11 was no physician order for EBP but acknowledged EBP should be included in the care plan and that the care plan should reflect the resident's care needs and guide staff in the provision of care. The facility policy titled Care Plan Policy and Procedure (revised 2/25, 7/25) indicated the facility was responsible to develop a baseline care plan within 48 hours of admission and a comprehensive, individualized care plan by day 21. The policy required care plans to include specific problems, goals, and interventions, and to be updated to reflect changes in the resident's condition. The policy further indicated care plans should be reviewed regularly, including significant changes, and should guide the care provided to the resident. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee should review and revise policies and procedures related to creating a comprehensive care plan to ensure cares meet the specific needs of each individual resident. The director of nursing or designee should develop a system to educate staff and develop a monitoring system and perform measurable audits to ensure individual care plans are created and implemented. The results of those audits should be taken to the QAPI committee to determine compliance or the need for further monitoring. The administrator should be responsible to ensure oversight occurs. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	20555		06/01/2026
21090	Food Supplies; Food Containers CFR(s): MN Rule 4658.0650 Subp. 3 Subp. 3. Food containers. Food, whether raw or prepared, if removed from the container or package in which it was obtained, must be stored in a clean, covered container. The container need not be covered during necessary periods of preparation or service. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review, the facility failed to ensure food inventory purchased and stored were rotated and utilized before the expiration dates. This had the potential to affect 82 out of 85 residents, and any visitors / staff who obtained meals from the facilities food services.	21090	corrected	06/01/2026

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21090	Continued from page 12 Findings include - During full kitchen tour on 4/21/26 at 2:10 p.m., the dry storage room (the area of the kitchen where food items are stored which do not require refrigeration) of the kitchen was reviewed. On the top shelf of one of the storage racks the following items were noted: - a clear 5 gallon clear plastic food storage container which contained approximately 2 pounds of white rice. The container was covered with a loosely fitting piece of aluminum foil, with the date of "4/9" marked in green marker.- 2 1-gallon containers of salad dressing (similar to "Miracle Whip") with the expiration date of March 2026- 3 1-gallon containers of prepared yellow mustard with the expiration dated of November 2025 In an interview on 4/21/26 at 2:10 p.m., the kitchen manger (KM) and the clinical certified dietary manager (CDM) verified these findings. The CMS stated the rice container should have had a matching lid which would have sealed the container. The CDM further stated the gallons of salad dressing and prepared mustard should have been rotated and used before the expiration dates. CDM further stated the department had begun a marking system for a "received date", which none of the 5 condiment containers were marked with. KM confirmed. In a further interview on 4/21/26 at 2:27 p.m., a cook (Cook)-A stated when food items were needed from the dry storage, they do not always look at the expiration date, but they do check to see the containers were sealed and not dented / leaking. The facility policy, entitled: Date Marking for Food Safety (undated) documented the following: "Policy:The facility adheres to a date marking system to ensure the safety of ready-to-eat, time/temperature control for food safety. Policy Explanation and compliance Guidelines for Staffing: 1. Refrigerated, ready-to-eat, time/temperature control for safety food (i.e.: perishable food) shall be held at a temperature of [41 degrees Fahrenheit] or less.2. Dry storage shall be marked to indicate the date in which food would expire and thus discarded prior to serving.3. The individual opening or preparing food shall be responsible for date marking the food at the time the food is opened or prepared. Prepared food shall be discarded 72 hours post opening.4. The Head Cook, or designee, shall be responsible for checking the refrigerator daily for food items that are expiring, and shall discard accordingly. References:Food and Drug Administration, U.S. Department of Health and Human Services. Food Code (2022)F. Section 3-501.17 Ready-to-Eat, Time/Temperature Control for Safety Food, Date Marking." SUGGESTED METHOD OF CORRECTION: The dietary manager, or designee, could ensure appropriate sanitation and	21090		06/01/2026

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21090	Continued from page 13 proper disposal of food items in the kitchen. In addition, the dietary manager, or designee, could ensure proper holding temps of food served to residents. The facility could update or create policies and procedures and educate staff on these changes and perform competencies. The dietary manager, or designee could perform audits and report audit findings to the Quality Assurance Performance Improvement (QAPI) for further recommendations or to determine compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21090		06/01/2026
21390	Infection Control CFR(s): MN Rule 4658.0800 Subp. 4 A-I Subp. 4. Policies and procedures. The infection control program must include policies and procedures which provide for the following: A. surveillance based on systematic data collection to identify nosocomial infections in residents; B. a system for detection, investigation, and control of outbreaks of infectious diseases; C. isolation and precautions systems to reduce risk of transmission of infectious agents; D. in-service education in infection prevention and control; E. a resident health program including an immunization program, a tuberculosis program as defined in part 4658.0810, and policies and procedures of resident care practices to assist in the prevention and treatment of infections; F. the development and implementation of employee health policies and infection control practices, including a tuberculosis program as defined in part 4658.0815; G. a system for reviewing antibiotic use; H. a system for review and evaluation of products which affect infection control, such as disinfectants, antiseptics, gloves, and incontinence products; and I. methods for maintaining awareness of current standards of practice in infection control. This LICENSURE REQUIREMENT is NOT MET as evidenced by:	21390	corrected	06/01/2026

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21390	Continued from page 14 Based on observation, interview and document review, the facility failed to establish and maintain an infection control program, failed to have a system for preventing, identifying, reporting, investigating, and controlling infections that occurred in the facility. The facility failed to identify a potential respiratory illness outbreak with 5 residents (R38, R24, R43, R78, and R28) showing signs of illness between 4/15/26 and 4/24/26, the facility failed to assess, monitor, and document their symptoms, conduct any outbreak testing, or place on transmission-based precautions (TBP) to prevent the spread to others. In addition, the facility failed to identify the need for and implement enhanced barrier precautions (EBP) for 2 of 2 residents (R16 and R29) reviewed who required EBP. The facility's system failure had the potential affect all 85 residents who currently resided in the facility. Findings include: When interviewed on 4/22/26 at 10:00 a.m., the director of nursing (DON) stated she had been the infection preventionist since October 2025. The DON described the infection surveillance program as receiving a list of antibiotics at the end of the month and then entering them into a tracking log. Infections were not entered onto the log or tracked as they occurred in the facility, nor where they occurred in the building. No information about residents who had signs of illness such as cough or diarrhea were entered into the tracking form unless an antibiotic was initiated. She had not been able to implement a program where infection symptoms were tracked timely in order to identify if an outbreak was potentially occurring in the facility. However, staff did inform her when residents were showing signs of illness such as cough, diarrhea or other symptoms. When interviewed on 4/22/26 at 3:19 p.m., the DON stated the facility did not have a system for antibiotic time out where anyone who was started on an antibiotic would be evaluated for appropriateness of the antibiotic, any lab cultures would be reviewed to determine if current antibiotic was appropriate and resident condition would be evaluated to determine if condition was improving. The DON had access to any labs sent in but did not access them herself for evaluation. R38's annual Minimum Data Set (MDS) dated 2/15/26 identified moderate cognitive impairment, required assistance with most activities of daily living (ADL's) and diagnoses included vascular	21390		06/01/2026

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21390	Continued from page 15 dementia, hypertension, asthma and dysphagia (difficulty swallowing). R38's provider note dated 4/15/26, identified she was seen for low back pain and a wet cough for 5 days as well as difficulty urinating and urinary frequency. The provider ordered a chest x-ray and urine sample. R38's physician orders dated 4/16/26 included R38 was to start an antibiotic, Doxycycline 100 mg (milligrams) twice a day for 7 days with a new diagnosis of pneumonia. A provider note identified R38 was using a nebulizer 3 times a day and was waiting on the urine specimen results. The chest x-ray results were abnormal. R38's progress note dated 4/16/26 identified a urine specimen was obtained at 7:00 a.m. and sent to the lab. R38's progress note dated 4/18/26 identified R38 was not feeling well, was refusing to eat and was nauseated, vital signs and oxygen saturations were within normal limits for R38 except had a rapid pulse at 104 (normal 60-100). It was noted the antibiotic ordered on 4/16/26 had not been started yet and would be initiated. R38's provider note dated 4/22/26 identified, "patient was seen today for a follow-up after being diagnosed with pneumonia and staff report she is not improving that much. Patient is lying in bed she does appear to be ill." "Will add Augmentin (antibiotic) for dual therapy for her pneumonia and see if it helps patient." The urine analysis and culture (UA/UC) results were requested. R38's medical record failed to include any illness monitoring. R38's vital signs were documented for 4/8/26, 4/15/26 and 4/22/26 as routine weekly vital signs. Even though R38's symptoms of a wet cough started approximately 4/8/26, there were no lung sounds, oxygen saturations, or routine vital signs and condition monitoring in the medical record except for once on 4/18/26. During observation on 4/24/26 at 10:05 a.m., R38 was in bed in her room. There was no signage outside of room or supplies located to indicate transmission-based precautions had been initiated for respiratory symptoms. When interviewed on 4/24/26 at 9:53 a.m., licensed practical nurse (LPN)-A stated when a resident shows signs of illness, the nurses will assess the	21390		06/01/2026

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21390	Continued from page 16 resident including vital signs and lung sounds every shift and monitor for about 3 days and keep an eye on the resident. LPN-A did not know why monitoring had not been started for R38 despite her cough and start of antibiotics. When interviewed on 4/24/26 at 10:01 a.m., R38 stated she has had a cough for some time but is improving now. When interviewed on 4/24/26 at 11:30 a.m., the DON was unable to find any UA/UC results for R38 in the medical record. The DON stated residents who are showing signs of illness should have frequent vital signs, lung sounds and oxygen saturations and if stable for 3 days could go down to every shift. There was no system in place to ensure residents who exhibited signs of illness such as R38 illnesses were monitored in this way. She had hoped the nurses would implement and document this. The DON stated she would have expected a resident condition note to be put in the medical record every shift especially if staying in bed and not feeling well. Despite a wet cough for many days, R38 had not been placed on transmission-based precautions (TBP) and no testing had been ordered by the provider for influenza, RSV or COVID-19. R24's quarterly MDS dated 3/2/26 identified severe cognitive impairment, required assistance with most ADL's and diagnosis included dementia. R24's progress note dated 4/17/26 at 9:52 p.m. identified vital signs were stable and had received an albuterol nebulizer (used for respiratory symptoms) related to an audible wheeze and cough. Oxygen saturations were at 91% (normal 95-100%). The on-call provider was notified and orders were obtained for a chest x-ray and to administer the Albuterol nebulizer twice a day and every 4 hours as needed for cough. R24's progress note dated 4/18/26 at 1:14 p.m. identified a nebulizer treatment was effective for wheezing and cough. At 9:39 p.m. the chest x-ray results returned and were normal. R24's medical record between 4/18/26 and 4/24/26 failed to include illness monitoring every shift or any assessment of how she was progressing. The record included routine weekly vital signs on 4/21/26. No further lung sounds or oxygen saturations were documented. R24 had not been placed on TBP for cough. No testing for potential contagious illness had been ordered or obtained.	21390		06/01/2026

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21390	Continued from page 17 When interviewed on 4/24/26 at 11:17 a.m. the DON stated R24 was noted to have a cough on 4/17/26. The DON reviewed R24's medical record and identified there was no illness monitoring in place related to the cough. She would have expected to see documentation of lung sounds, cough, assessment and vital signs routinely. R24 had not been placed on TBP and no testing had been ordered or conducted for potential respiratory illness outbreak. R43's quarterly MDS dated 3/5/26 identified moderate cognitive impairment and was independent with personal cares except bathing, diagnoses included dementia, and congestive heart failure. R43's care plan dated 3/5/26 identified shortness of breath related to emphysema and chronic obstructive pulmonary disease (COPD). R43's progress note dated 4/22/26 at 11:37 a.m. identified resident had a congested non productive cough, was afebrile and was given cough syrup. R43's progress notes dated 4/22/26 at 11:57 a.m. identified the provider was updated R43 was requesting cough syrup and new orders were obtained for Guiafed every 4 hours as needed for 3 days. R43's progress note dated 4/23/26 at 2:21 a.m. included, "Resident continues to have a congested cough. Cough syrup given. Has been up and about and told writer he was feeling better." R43's progress note dated 4/24/26 at 3:10 a.m. included, "Respiratory evaluation done on resident. The resident stated that he had some mucus with some blood earlier in the day and that this had occurred in the past. He reports congestion present for approximately the last 2 weeks. No shortness of breath but occasional cough present." VS were stable and had a history of mucus with smoking history and nurse practitioner saw him earlier in the week. During observation on 4/24/26 at 10:01 a.m., R43 was in his room on bed. R43 stated he had a "bad cold," and had been coughing and sneezing up blood off and on. R43 was coughing during interview. R43 was not on TBP for cough. When interviewed on 4/24/26 at 11:17 a.m., the DON stated R43 was noted to start coughing on 4/22/26. The DON reviewed the medical record and identified no follow up documentation had occurred about the	21390		06/01/2026

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21390	Continued from page 18 cough; no illness monitoring had been documented. R43 had not been placed on TBP and no testing for potential respiratory outbreak had been ordered or conducted. R43 was placed on acute change charting for 72 hours due to congestion and occasional cough today after being questioned by surveyor. R78's quarterly MDS dated 4/13/26 identified moderate cognitive impairment, required assistance with ADL's and diagnosis included Alzheimer's disease. R78's progress note dated 4/10/26 at 10:28 p.m. identified, resident complained of cold symptoms, occasional cough and hoarse voice. R78 was provided with cough syrup. There was no monitoring placed to assess R78 for continued respiratory symptoms. However, R78's temperature was taken 3 times on 4/11/26 and 4/12/26 and was afebrile. No oxygen saturations were taken in this time frame. There were no further progress notes identifying cold symptoms until seen by provider on 4/23/26, "Patient was seen today by the request of staff and family as they were concerned about patient having a cough over the last couple days. Patient was seen in her room she was sitting up at edge of her bed she reports that her cough has improved significantly and she does not feel she needs any intervention at this time." There were no new orders. R78 had not been placed on TBP even though she had a cough for "several days" and had not been tested for potential contagious respiratory illness. On 4/23/26 at 9:51 a.m., licensed practical nurse (LPN)-D identified R78 had been coughing randomly, and staff were monitoring her status. When interviewed on 4/24/26 at 11:17 a.m., the DON stated R78 had been coughing this week and had seen provider with no new orders on 4/22/26. The DON stated staff should be monitoring for symptoms but noted no documentation had been initiated. R78 had not been placed on TBP and had not been tested for potential respiratory outbreak. R28's annual MDS dated 3/4/26 identified significant cognitive impairment, required assistance with most ADL's and diagnoses included Alzheimer's disease and congestive heart failure. During observation on 4/24/26 at 10:08 a.m. R28 was heard coughing. When interviewed R28 stated	21390		06/01/2026

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21390	Continued from page 19 he had been coughing for quite a while, “I cough up some stuff.” The cough was noted to be loose and productive and used tissue to capture the mucous brought up with the cough. R28’s progress note dated 4/24/26 at 3:41 p.m., identified R28 had stated he had been coughing for 2 days with light mucus. R28 had not shortness of breath, lung sounds were clear and vital signs stable. R28 had not been placed on TBP and no testing for potential contagious illness had been ordered or completed. When interviewed on 4/24/26 at 11:17 a.m., the DON stated R28 has a frequent cough with medical diagnosis of such and unsure if would be anything contagious. R28 had not been placed on TBP and no respiratory illness testing had been completed. R28 had been placed on acute illness charting for 72 hours. During observation on 4/24/26 at 10:01 a.m. it was noted the 5 residents were observed with a cough (R24, R28, R38, R43, and R78), three of the five residents resided in the same hall, with two being next to one another, and the third being a few doors down on the opposite side of the hall. The DON provided infection “surveillance logs” on 4/23/26 at 5:22 p.m. The DON identified the logs are created off of an antibiotics prescribed list, residents and infections were not added to logs as the illnesses occurred, but rather at the end of each month. The logs also did not account for residents who may show signs of infection such as diarrhea or cough that did not require an antibiotic. When reviewed the logs failed to identify start date of symptoms, any testing performed, or dates of resolution of symptoms. The facility policy, Infection Prevention and Control Policy (IPCP) and Procedure, dated 2019, last reviewed 1/25, identified the IPCP to include the system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility. The intent of the IPCP was to establish facility wide systems for the prevention, identification, investigation, and control of infections with an ongoing system of surveillance to identify possible communicable diseases or infections before they can spread to other people. The role of surveillance was to include process and outcome surveillance, to include monitoring, data analysis, documentation, and reporting as required. Activities were to be	21390		06/01/2026

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21390	Continued from page 20 conducted to identify practice, infection trends, and early identification of new infections and potential outbreak situations. The policy also identified standard and transmission-based policies were to be developed and precautions were to be followed to prevent the spread of infections, to include the selection of the precaution indicated, as well as to include the level of personal protective equipment (PPE) to be used. The policy further identified the type and duration of the isolation would be determined dependent on the infectious agent or organism involved. Although the policy identified transmission-based precautions, and isolation, the policy lacked identification, or definition of enhanced barrier precautions. The policy also identified an antibiotic stewardship program, which included protocols and a system to monitor antibiotic use, was to be included within the IPCP and procedure. The policy also identified the process was to include documentation of incidents identified under the facility's IPCP and the corrective action taken by the facility. R16’s admission MDS dated 3/26/26 identified cognitively intact, was independent with ADL’s, and diagnoses including on dialysis for end stage kidney disease and hyperparathyroidism (overactive parathyroid glands causing abnormal calcium and phosphorus levels) and long term anticoagulation use. R16’s care plan dated 4/8/26 identified R16 required offsite hemodialysis on Tuesdays, Thursdays, and Saturdays related to ESRD and included interventions related to the AV fistula for staff to assess the site every day and as needed for signs of infection, tenderness, drainage, bruit and thrill. R16’s medical record identified they also had a central venous catheter (CVC) which is a large bore tube placed into a large vein int he chest for urgent dialysis access. Typically, this is used only for a short period of time when the AV fistula is not accessible. This type of catheter/vascular access is at a very high risk of catheter related blood stream infections. 16’s care plan did not identify this access site and did not direct any special infection control techniques. Guidance from the Centers for Disease Control and Prevention (CDC) identified residents with dialysis	21390		06/01/2026

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21390	Continued from page 21 access devices were at increased risk for transmission of multidrug-resistant organisms (MDROs) and required Enhanced Barrier Precautions (EBP). During observation on 4/21/26 at 11:28 a.m. R16's room lacked any personal protective equipment (PPE) that would be used for EBP. When interviewed on 4/22/26, nursing assistant (NA)-A stated R16 was not on EBP. When interviewed on 4/23/26 at 10:08 a.m., licensed practical nurse (LPN)-C stated if residents are on EBP they put a sign on their door and place PPE outside the room. R16 was not on EBP. When interviewed on 4/23/6 at 2:55 p.m., registered nurse (RN)-A stated R16 was not on EBP. When interviewed on 4/23/26 at 3:35 p.m. the assistant director of nursing (ADON) stated residents with indwelling catheters required EBP and confirmed R16 was not on EBP, but should have been. When interviewed on 4/23/26 at 4:01 p.m. the DON stated residents with vascular access devices should be on EBP and verified R16 was not and should have been. R29's admission MDS dated 4/20/26 included severe cognitive impairment, was dependent upon staff for ADL's and had diagnoses including Alzheimer's disease and a sacral pressure ulcer stage 4 (down to bone). During observations on 4/20/26, 4/21/26, 4/22/26, 4/23/26 and 4/24/26, there was no signage outside of room, nor was there any PPE available for staff outside or inside R29's room. When interviewed on 4/22/26 at 8:39 a.m., LPN-A stated she had performed pressure ulcer care for R29 at 7:00 a.m. LPN-A stated R29 is not on any type of precautions. During observation on 4/23/26 at 9:17 a.m., the ADON entered R29's room for a dressing change. The ADON did not put on a gown, they washed their hands, put on gloves, removed the dressing over the pressure ulcer, doffed gloves and used hand sanitizer. The ADON replaced gloves and finished the dressing change.	21390		06/01/2026

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21390	Continued from page 22 When interviewed on 4/23/26 at 9:36 a.m., the ADON stated R29 did not need to be on any type of precautions and just glove use during dressing change was adequate. Since the resident had been in the facility less than 90 days, the wound was not considered a chronic wound. Facility policy entitled: Enhanced Barrier Precautions (copyright 2025 The Compliance Store, LLC.) Initiation of Enhanced Barrier Precautions: a. Enhanced barrier precautions will be implemented for residents requiring EBP per CMS regulatory guidelines, including but not limited to residents with wounds, such as pressure ulcers, diabetic foot ulcers, unhealed surgical wounds, and venous stasis ulcers, and/or indwelling medical devices (e.g., central live, urinary catheters, feeding tubes, tracheostomy/ventilator tubes, hemodialysis catheters. PICC lines, midline catheters) and access ports. 4. Enhanced barrier precautions should be used for the duration of the affected residents' stay in the facility or until resolution of the wound or discontinuation of the indwelling medical device that placed them at higher risk." The Center for Disease Control's (CDC) Viral Respiratory Pathogens Toolkit for Nursing Homes dated 3/30/26, indicated when an infection is due to a respiratory virus, it is important to take rapid action to prevent the spread to others in the facility. Appropriate transmission-based precautions should be initiated for symptomatic residents based upon the suspected cause of infection. The CDC's Transmission Based Precautions dated 4/3/24, indicated droplet precautions should be used for patients known or suspected of being infected with pathogens transmitted by respiratory droplets that are generated by a patient who is coughing, sneezing, or talking. Droplet precautions include hand hygiene, face mask covering the nose and mouth, and eye protection. Additionally, the Frequently Asked Questions (FAQ's) about EBP, dated 6/28/24, identified EBP as an infection control measure designed to decrease transmission of multi-drug-resistant organisms (MDROs) in nursing homes. EBP involved gown and glove use during high-contact resident care activities for residents known to be colonized, or infected, with a MDRO, as well as those who were at increased risk of MDRO acquisition (e.g. residents with wounds or indwelling	21390		06/01/2026

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21390	Continued from page 23 medical devices). SUGGESTED METHOD OF CORRECTION: An infection control plan would be created to ensure a system for surveillance was in place which identified potential illness and infections which would decrease the spread of illness and infections from residents/staff/others. Additionally, the facility infection preventionist (IP) would assure a system was in place to ensure the appropriate isolation precautions were in place for residents as indicated, and would ensure that appropriate personal protective equipment was worn at all times. The IP would implement and maintain a system for tracking and trending of test results and implement an antibiotic stewardship program, which would include a system for antibiotic time out according to physician orders and standards of practice. Staff will be re-educated on completing and documenting monitoring of symptoms of illness and infections, such as lung sounds, vital sounds and other pertinent information. The director of nursing or designee will complete audits of residents who display potential signs and symptoms of illness and infections and include tracking of symptoms and testing performed. Results will be reviewed and ongoing monitoring will be implemented to maintain compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21390		06/01/2026
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	21426	corrected	06/01/2026

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21426	Continued from page 24 maintained by the nursing home. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to consistently identify the date and time the two step tuberculosis test (TST-Mantoux) was read for 1 of 5 residents (R11) screened with the for tuberculosis during the admission process. R11’s comprehensive/annual Minimum Data Set assessment dated 2/28/26, identified R11 was admitted to the facility on 2/3/25, with diagnoses which included vascular dementia, aphasia (difficulty with speaking), hemiplegia/hemiparesis (loss of mobility on one side of the body), depression and anxiety, and personality change due to physiological condition. Although R11 was identified as having cognitive impairments, it is noted R11 was able to understand others and make self understood. R11 was identified as having received personal assistance with all aspects of cares. A review of R11's Immunization Report, indicated R11 received a TB (Tuberculosis) 2-Step Mantoux Skin Test (Step 1) in his left forearm on 2/3/25. The results were read as "Negative-0 mm (zero mm-a unit of measurement)" and the status indicated negative. The information listed on the Immunization Report lacked the date and the time the Mantoux was read. A review of the same document indicated Step 2 was administered on 2/17/25 and was the results were also identified as "Negative (0 mm)" with the status listed as negative. The Immunization Report lacked the date and the time the Mantoux was read. On 4/23/26 at 10:02a.m. the director of nursing stated tuberculosis testing was completed for all residents, unless contraindicated, upon admission was a 2-Step Mantoux, DON stated the second step was administered two weeks after the first administration of the test. DON stated the Mantoux should be "read" between 48-72 hours after administration, and this date and time should be documented by staff of the Treatment Administration Record (TAR). DON stated the results are entered on the Immunization Report, however, the date listed there was the date it was administered, not read. DON stated the documentation of the date and time read was recorded on the TAR. DON acknowledged R11's TAR for February 2025 lacked indication of the either Step 1 or Step Mantoux's being read. The facility policy, Tuberculosis, revised 2/25	21426		06/01/2026

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21426	Continued from page 25 indicated each new resident will have a 2-Step Mantoux upon admission, unless otherwise ordered by the attending physician. The policy indicated the resident's clinical record must contain a report of a tuberculin test with the three months prior to the admission or within 72 hours after admission. The policy lacked the perimeters to identify the results of the 2-Step Mantoux must be read within 48-72 hours after administration. SUGGESTED METHOD FOR CORRECTION: The director of nursing could review and revise the current TB policy to ensure residents are screened for symptoms of TB when admitted to the facility. The Quality Assurance and Assessment committee could randomly audit records to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	21426		06/01/2026
21530	Drug Regimen Review CFR(s): MN Rule 4658.1310 A.B.C A. The drug regimen of each resident must be reviewed at least monthly by a pharmacist currently licensed by the Board of Pharmacy. This review must be done in accordance with Appendix N of the State Operations Manual, Surveyor Procedures for Pharmaceutical Service Requirements in Long-Term Care, published by the Department of Health and Human Services, Health Care Financing Administration, April 1992. This standard is incorporated by reference. It is available through the Minitex interlibrary loan system. It is not subject to frequent change. B. The pharmacist must report any irregularities to the director of nursing services and the attending physician, and these reports must be acted upon by the time of the next physician visit, or sooner, if indicated by the pharmacist. For purposes of this part, "acted upon" means the acceptance or rejection of the report and the signing or initialing by the director of nursing services and the attending physician. C. If the attending physician does not concur with the pharmacist's recommendation, or does not provide adequate justification, and the pharmacist believes the resident's quality of life is being adversely affected, the pharmacist must refer the matter to the medical director for review if the medical director is not the attending physician. If the medical director determines that the attending	21530	corrected	06/01/2026

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21530	Continued from page 26 physician does not have adequate justification for the order and if the attending physician does not change the order, the matter must be referred for review to the quality assessment and assurance committee required by part 4658.0070. If the attending physician is the medical director, the consulting pharmacist must refer the matter directly to the quality assessment and assurance committee. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on record review and interview, the facility failed to ensure the recommendations from the monthly medication regimen review (MRR) conducted by the consultant pharmacist were reviewed and acted upon in a timely manner, in accordance with professional standards of practice, for 2 of 6 residents reviewed for unnecessary medications (R9 and R65). Findings include: R65's quarterly Minimum Data Set (MDS) assessment, completed on 2/23/26, identified R65 was admitted to the facility on 11/21/25 had impaired cognition, and required assistance with activities of daily living (ADL's-eating, dressing, grooming, bathing, and mobility). R65's medical diagnoses included: Alzheimer's disease and non-Alzheimer's dementia, anxiety, depression, hypertension (high blood pressure), orthostatic hypotension (a drop in blood pressure which occurred with a change in position and adult failure to thrive. A review of the consulting pharmacist reports was completed from the time of R65's admission date of 11/21/25. It was noted the consulting pharmacist's reviews were in place for the following dates: 11/24/25), 1/19/26, 2/17/26, 3/15/26 and 4/15/26. A consultant pharmacist review was not present for the month of December 2025. On 4/23/26, at 7:32 a.m. the director of nursing (DON) stated she had spoken with the Consultant Pharmacist (PharmD)-B and it was noted the review was missed in the month of December as R65 had moved from the transitional care unit to the long-term care unit. DON stated medical record reviews were expected to be reviewed by the Consultant Pharmacist monthly. On 4/27/26, at 12:59 p.m. it was noted by PharmD-A that R65 had changed units in December of 2025 and a record review was not completed that	21530		06/01/2026

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21530	Continued from page 27 month. The facility's Pharmacy Recommendations policy, revised 7/25, required a review of resident medication regime is done monthly by the pharmacy consultant with recommendations addressed to the physicians and nursing. (Please add this to the front of Lanisha's policy information) Findings include: R9's quarterly Minimum Data Set (MDS) dated 1/16/26, identified R9 had moderate cognitive impairment and required assistance with activities of daily living (ADL)'s. R9's diagnoses included Alzheimer's disease with late onset (a progressive brain disorder affecting memory and thinking), non-Alzheimer's dementia (decline in memory and thinking not caused by Alzheimer's disease), anxiety disorder (excessive worry or fear), and COPD (chronic obstructive pulmonary disease; a lung disease that makes it hard to breathe). Review of the consultant pharmacist's monthly medication regimen review (MRR), dated 1/19/26, identified recommendations related to R9's medication regimen, indicating, "resident is receiving citalopram and olanzapine. Please make sure we have patient specific target behavior monitoring, side effect monitoring, and orthostatic blood pressure monitoring in place." Review of the consultant pharmacist's MRR, dated 2/16/26, identified recommendations related to R9's medication regimen, indicating, "the resident has an order for trazodone, citalopram, and olanzapine and to monitor his response to these, recommend adding appropriate target behavior, orthostatic blood pressure, and side effect monitoring to the TAR." Review of R9's electronic medical record (EMR) and physician order records lacked evidence the facility reviewed, acknowledged, or acted upon the consultant pharmacist's recommendations in a timely manner. There was no documented evidence the recommendations were communicated to the physician, implemented, or that a rationale was provided for not implementing the recommendations. During interview on 04/27/2026 at 12:53 p.m., consultant pharmacist (CP) stated monthly medication regimen reviews were conducted to identify irregularities and ensure safe and appropriate medication use. The CP stated MRR recommendations were typically expected to be addressed within the following month, unless the	21530		06/01/2026

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21530	Continued from page 28 provider had not yet seen the resident, in which case it could extend up to two months. The CP stated recommendations should be addressed as soon as possible. The CP further stated if recommendations were not addressed by the following month, a pending report would be issued, which included the same recommendations for follow-up and resolution. During interview on 4/27/26 at 1:48 p.m., director of nursing (DON) and consultant nurse (C-RN) stated the expectation was for MRR recommendations to be addressed within 30 days. The DON and C-RN further stated R9's MRR would have been considered a nursing MRR, which should have been addressed immediately or within a few days. The DON and C-RN confirmed the recommendations for R9 were missed and not followed up in a timely manner. The facility's Pharmacy Recommendations policy, revised 7/25, required that monthly medication regimen review (MRR) recommendations made by the consultant pharmacist be communicated to nursing and physicians, documented in the medical record, and addressed timely. The policy indicated physicians were to respond by either implementing recommendations with orders or documenting rationale for disagreement. Unresolved recommendations were to be tracked, re-reviewed the following month, and followed up by nursing, with ongoing non-response escalated to the medical director for further action. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and revise policies and procedures for pharmacy reviews and irregularities. The director of nursing or designee could develop a system to educate staff and develop a monitoring system to ensure pharmacy reviews are timely and irregularities are being acted upon. The quality assurance committee could monitor these measures to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty One (21) days	21530		06/01/2026
21540	Unnecessary Drug Usage; Monitoring CFR(s): MN Rule 4658.1315 Subp. 2 Subp. 2. Monitoring. A nursing home must monitor each resident's drug regimen for unnecessary drug usage, based on the nursing home's policies and	21540	corrected	06/01/2026

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21540	Continued from page 29 procedures, and the pharmacist must report any irregularity to the resident's attending physician. If the attending physician does not concur with the nursing home's recommendation, or does not provide adequate justification, and the pharmacist believes the resident's quality of life is being adversely affected, the pharmacist must refer the matter to the medical director for review if the medical director is not the attending physician. If the medical director determines that the attending physician does not have adequate justification for the order and if the attending physician does not change the order, the matter must be referred for review to the Quality Assurance and Assessment (QAA) committee required by part 4658.0070. If the attending physician is the medical director, the consulting pharmacist shall refer the matter directly to the QAA. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and record review, the facility failed to ensure medications were administered in accordance with professional standards of practice, including failure to follow physician orders to monitor blood pressure and pulse parameters prior to administration of a beta-blocker medication, for 1 of 1 resident (R16) reviewed for unnecessary medications. Findings include: R16's admission Minimum Data Set (MDS) dated 3/26/26, identified R16 had intact cognition and was independent with activities of daily living (ADL)'s. R16's diagnoses included hypertension (high blood pressure), atrial fibrillation (an irregular heart rhythm), coronary artery disease (narrowing or blockage of the heart’s blood vessels), heart failure (a condition where the heart cannot pump blood effectively), and end stage renal disease (advanced kidney failure requiring dialysis). Review of R16’s physician orders, print date of 4/22/26, identified an order for Metoprolol Tartrate 50 MG (milligram), give 50 mg by mouth two times a day for ESRD, with parameters to hold the medication for systolic blood pressure (SBP) less than 90 or pulse less than 50, initiated on 3/20/2026. Review of R16’s medication administration records (MAR) from 3/20/26 to 4/22/26 identified Metoprolol Tartrate was administered as ordered; however, there was no documentation to indicate R16’s blood	21540		06/01/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **04/27/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARK RIVER HEALTHCARE AND REHABILITATION CENTER LLC	**9899 AVOCET STREET NORTHWEST , COON RAPIDS, Minnesota, 55433**

(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
21540	Continued from page 30 pressure or pulse were obtained prior to administration, as required by the physician's order. During interview on 4/22/26 at 2:09 p.m., trained medication aide (TMA)-A reviewed R16's medication record, confirmed Metoprolol had parameters to hold for SBP less than 90 or pulse less than 50, and stated they were not obtaining blood pressure or pulse prior to administration. During interview on 4/23/26 at 10:08 a.m., licensed practical nurse (LPN)-C stated there were no residents, to her knowledge, who currently had medication parameters requiring vital signs prior to administration. LPN-C further stated she did not obtain any vital signs that morning related to medication administration. During interview on 4/23/26 at 3:35 p.m., assistant director of nursing (ADON) stated Metoprolol had parameters on the order to hold the medication based on vital signs and confirmed vital sign monitoring was not in place and was not being completed prior to medication administration for R16. During interview on 4/27/26 at 1:17 p.m., LPN-G confirmed blood pressure and pulse should be obtained prior to administering medications with parameters and acknowledged this was not initiated for R16 until 4/23/26. During interview on 4/27/26 at 1:48 PM, director of nursing (DON) and consultant nurse (C-RN) stated staff were expected to follow physician orders, including obtaining vital signs prior to administration of medications with hold parameters. The DON stated when medications have parameters for holding, vital signs must be obtained prior to administration and the medication should be held if the resident is outside of those parameters, as this is a provider order. Review of the facility's Medication Administration policy, revised 7/25, identified medications were to be administered by licensed or authorized staff in accordance with physician orders and professional standards of practice. The policy required staff to obtain and document vital signs when indicated by the order and to hold medications if vital signs were outside prescribed parameters. The policy further required adherence to the six rights of medication administration and accurate documentation on the medication administration record (MAR), including recording required vital signs and any medication refusals.	21540		06/01/2026

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21540	Continued from page 31 SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON) and consulting pharmacist could review and revise policies and procedures for proper monitoring of medication usage. The DON or designee, along with the pharmacist, could audit medication reviews on a regular basis to ensure compliance. TIMEFRAME FOR CORRECTION: Twenty-one (21) days.	21540		06/01/2026
21565	Administration of Medications Self Admin CFR(s): MN Rule 4658.1325 Subp. 4 Subp. 4. Self-administration. A resident may self-administer medications if the comprehensive resident assessment and comprehensive plan of care as required in parts 4658.0400 and 4658.0405 indicate this practice is safe and there is a written order from the attending physician. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and record review, the facility failed to ensure residents were permitted to make choices regarding self-administration of medications and that physician orders and care processes reflected the residents' current abilities or choices , for 3 of 3 residents (R27, R43 and R48) reviewed for self-administration of medications. Findings include: R27's significant change Minimum Data Set (MDS), dated 3/25/26, identified R27 had intact cognition and required assistance with activities of daily living (ADLs). R27's diagnoses included chronic respiratory failure with hypoxia (long-term inability of the lungs to maintain adequate oxygen levels), schizophrenia (a chronic mental disorder affecting thinking, perception, and behavior), chronic obstructive pulmonary disease [COPD] (a chronic lung disease that obstructs airflow and makes breathing difficult), dysphagia (difficulty swallowing), parkinsonism (a condition causing movement symptoms similar to Parkinson's disease, such as tremors and stiffness), and dependence on supplemental oxygen (requires additional oxygen to maintain adequate breathing). The MDS also indicated R27 was receiving oxygen therapy.	21565	corrected	06/01/2026

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21565	Continued from page 32 During observation on 04/20/2026 at 1:48 p.m., R27 was sitting in a recliner in his room with a nebulizer treatment running and the mask in place. The resident appeared to be sleeping, with his head slumped forward and the bottom of the mask positioned away from his chin. No nursing staff were present in the room at the time of observation. There was no evidence of a current self-administration of medication (SAM) assessment supporting the resident independently managing the treatment. During record review of R27's electronic medical record (EMR) on 4/22/26, the most current self-administration assessment (PARK–Self-Administration of Medication Quarterly Review – V3, dated 3/19/26) indicated the question, "Does resident self-administer medication?" was marked "No," with the directive, "If resident does not self-administer medication, DO NOT PROCEED." The remaining sections of the assessment were left blank, indicating the resident was not currently self-administering medications. Review of R27's EMR banner on his profile page, print date of 4/27/26, did not indicate R27 was approved or assessed to self-administer nebulizer treatments. Review of R27's physician orders on 4/22/26 identified an active order indicating it was "okay to self-administer (SAM) nebulizer once set up by staff, every shift," dated 12/10/2025. Despite this order permitting self-administration, there was no evidence the order had been clarified, discontinued, or revised to reflect R27's current preference or competency. R48 R48's annual MDS, dated 2/13/26, identified R48 had intact cognition and required assistance with ADLs. R48's diagnoses included Alzheimer's disease (a progressive brain disorder affecting memory and thinking), anxiety disorder (excessive worry or fear), depression (persistent sadness or loss of interest), and chronic obstructive pulmonary disease [COPD] (a chronic lung disease that obstructs airflow and makes breathing difficult). During observation and interview on 4/22/26 at 8:54	21565		06/01/2026

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21565	Continued from page 33 a.m., trained medication aide (TMA)-B sanitized hands and entered R48's room with medications. An inhaler was observed on R48's bed within reach. TMA-B stated a physician order was required for medications to be left at bedside. R48 stated she used the inhaler as needed. The inhaler was identified as Levalbuterol Tartrate (a bronchodilator used to treat or prevent bronchospasm in individuals with asthma or COPD) 45 mcg (micrograms)/act (actuation). During record review of R48's EMR, the most current self-administration assessment (PARK–Self-Administration of Medication Annual Review – V3, dated 1/24/26) indicated the question, "Does resident self-administer medication?" was marked "No," with the directive, "If resident does not self-administer medication, DO NOT PROCEED." The remaining sections of the assessment were left blank, indicating the resident was not currently self-administering medications. Review of R48's EMR banner on her profile page, print date of 4/27/26, did not indicate R48 was approved or assessed to self-administer inhaler medication and/or to have it left at bedside. Review of R48's physician orders on 4/22/26 identified an active order for Levalbuterol Tartrate Inhalation Aerosol 45 mcg/act (Levalbuterol Tartrate), with instructions for 2 puffs inhaled orally every 4 hours as needed for shortness of breath (SOB) or wheezing, and indicating "ok to leave at bedside," dated 04/18/2024. Despite this order permitting bedside access and potential self-administration, there was no evidence the physician order had been clarified, discontinued, or revised to reflect R48's current preference or competency. During interview on 4/22/26 at 8:52 a.m., TMA-A stated staff identified whether a resident could self-administer medications by reviewing the EMR banner, which indicated if the resident was able to do so. During interview on 4/22/26 at 9:08 a.m., TMA-B stated there were no residents in the facility who self-administered nebulizer treatments, as residents could remove the device or it may not be positioned correctly, resulting in ineffective treatment. TMA-B further stated there were no residents who	21565		06/01/2026

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21565	Continued from page 34 self-administered medications; however, if a medication was permitted to be kept at bedside, this would be indicated in the EMR banner. During interview on 04/22/2026 at 2:09 p.m., TMA-A stated she set up nebulizer treatments and, if she believed the resident was able to tolerate it, she left the room while the treatment was in progress. During interview on 4/23/26 at 10:03 a.m., licensed practical nurse (LPN)-A stated staff completed a self-administration assessment to determine if a resident was able to self-administer medications and, if appropriate, the physician was contacted to obtain an order. LPN-A stated residents were reassessed at least quarterly as part of the MDS assessment process. During interview on 4/23/26 at 10:08 a.m., LPN-C stated residents were assessed to ensure they were able to safely self-administer medications. LPN-C stated staff set up R27's nebulizer treatment, initiated the treatment, set a timer, and returned to turn it off, and did not remain with the resident during the treatment. During interview on 4/27/26 at 1:48 p.m., director of nursing (DON) and consultant nurse (C-RN) stated the process for self-administration of medications required a physician order and a nursing assessment to determine if the resident wished to and was able to safely self-administer medications. They stated the assessment was completed at least quarterly and should identify the specific medications approved for self-administration. They further stated the resident must demonstrate understanding and the ability to safely administer medications. The DON confirmed R27's and R48's most recent self-administration assessments were not accurate. The facility's Self-Administration of Drugs policy, dated 2/22, stated residents had the right to self-administer medications, and the facility was responsible for ensuring it was safe to do so. The policy required residents to be assessed on admission, quarterly, annually, with significant changes, and as needed to determine their desire and ability to self-administer. If a resident chose to self-administer, a safety assessment was to be completed, a medication-specific physician order	21565		06/01/2026

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21565	Continued from page 35 obtained, and the self-administration plan was to be included in the resident's care plan. Findings include - On 4/22/2026 at 8:39 a.m., licensed practical nurse (LPN)-A, was talking with R43. R43 came to the medication cart requesting cough syrup, while resident was complaining of a productive cough, showing LPN-A his tissue full of phlegm. LPN-A reviewed his orders in the electronic medication administration record (eMAR) and provided R43 cough syrup them took his temperature. LPN-A asked R43 if he would (Albuterol Sulfate HFA Inhalation Aerosol Solution 108 90 micrograms actual per puff). R43 stated "you don't have it here, I have it in my room." LPNA-responded, "are you sure? You can't have it in your room unless they Oked it." LPN-A again reviewed R43's eMAR and the stated, "it looks like you can have it at bedside." R43 then headed back to his room. R43's electronic medical record's Admission Record documented the following diagnoses: senile degeneration of the brain, low back pain, chronic pain syndrome, chronic obstructive pulmonary disease (COPD - a progressive, treatable, but incurable lung disease, primarily caused by smoking, that makes breathing difficult), centrilobular emphysema (the most common form of smoking-related COPD) and Alzheimer's disease late onset. R43's most recent quarterly minimum data set (MDS), dated 3/6/26, documented R43 was independent with most activities of daily living and was moderately cognitively impaired. During an observation and interview with R43 on 4/22/26 at 10:07 a.m., R43 stated he was feeling better after the cough syrup from LPN-A and taking the inhaler when he returned to his room. When asked what type of inhaler R43 kept at bedside, resident pulled open his bedside stand drawer. Inside the drawer, R43 had the following medication: Albuterol Sulfate HFA Inhalation Aerosol Solution 108 [90 micrograms actual per puff] 2 puff inhale orally every 4 hours as needed for [shortness of breath].Bengay Ultra Strength External Cream 4-10-30% (Camphor-Menthol-Methyl Salicylate) apply to shoulder, back , neck topically two times a day for low back painCortisone 10 Anti-itch Cream In review of R43's electronic medical record, most current self administration assessment (PARK-Self-Administration of Medication Quarterly Review - V 3, dated 2/22/26), the first questions: "Does resident Self Administer medication?", it was marked 'No", followed by the direction "If resident does not Self-Administer medication, DO NOT PROCEED." The remaining sections of the assessment were unanswered. In review of R43's previous PARK-Self-Administration of Medication	21565		06/01/2026

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21565	Continued from page 36 Quarterly Review - V 3 (dated 11/23/25), had indicated resident was able to self administer all three medications observed in R43's bedside stand. In further review of R43's electronic medical record, during the assessment period of resident's PARK-BIMS (Brief Interview for Mental Status 3.0 V1 (dated 11/26/25), R43's BIMS score was 13 - Cognitively Intact. The most current PARK-BIMS (Brief Interview for Mental Status 3.0 V1 (dated 2/22/26), Resident's BIMS score was assessed at 8 - Moderately Cognitively Impaired. A review of R43's eMAR (print dated 4/24/26) documented R43's Albuterol Sulfate HFA and Bengay Ultra Strength External Cream were documented R43 was able to keep the two medications at bedside. However, R43's Cortisone 10 Anti-itch Cream was not listed on resident's eMAR. In review of R43's physician's orders (print date of 4/24/26), the medication orders for the medications R43 kept in his bedside stand were documented as follows: 1. "Albuterol Sulfate HFA Inhalation Aerosol Solution 108 [90 micrograms actual per puff] 2 puff inhale orally every 4 hours as needed for [shortness of breath] replated to Chronic Obstructive Pulmonary Disease, unspecified (J44.9) May keep at Bedside" 2. "Bengay Ultra Strength External Cream 4-10-30% (Camphor-Menthol-Methyl Salicylate) apply to shoulder, back , neck topically two times a day related to Low Back Pain, unspecified (M54.50) unspervised self-administration Ok to have at bedside and to self [administer]." 3. "Cortisone 10 Anti-itch Cream - okay to have at bedside and the resident self administer as needed for itching twice daily as needed." During interview on 4/22/26 at 2:40 p.m., the director or nursing (DON) stated, even with the last quarterly self administration assessment from 2/22/26, indicated R43 didn't self administer medications, the 11/23/25, was still valid while R43 had physician's orders he could. DON stated the facility staff knew R43 well enough, and knew if they were to remove the medications from his room, R43 would ask for them back. During a clarifying interview on 4/27/26 at 2:01 p.m., with the DON and consulting registered nurse (CRN), CRN stated the facility last self administration assessment was the most current, therefore, invalidating the assessment from 11/23/25. CRN further, with s significant change in R43's BIMS scoring between 11/23/25 score of 13 (cognitively intact) and the most recent BIMS, assessed 2/22/26 of 8 (moderately cognitively impaired). R43 should have been reassessed for self administration of medications. SUGGESTED METHOD OF CORRECTION: The	21565		06/01/2026

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21565	Continued from page 37 administrator, director of nursing (DON) or designee should review and revise policies for self-administration of medication according to evidence-based practices/procedures. Nursing staff should be educated as necessary to the importance of ensuring the resident is deemed capable of administering their own medications initially, quarterly, annually, or with a change to a resident's physical or mental ability to do so. Nursing staff should also ensure there is a physician's order in place, prior to a nurse/medication aide administering medication. The DON or designee, should audit any/all resident's medical records, to ensure compliance with appropriate medication administration. The DON or designee should take that information to QAPI to ensure compliance and determine the need for further education/monitoring/compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21565		06/01/2026
21800	Patients & Residents of HC Fac.Bill of Rights CFR(s): MN St. Statute144.651 Subd. 4 Subd. 4. Information about rights. Patients and residents shall, at admission, be told that there are legal rights for their protection during their stay at the facility or throughout their course of treatment and maintenance in the community and that these are described in an accompanying written statement of the applicable rights and responsibilities set forth in this section. In the case of patients admitted to residential programs as defined in section 253C.01, the written statement shall also describe the right of a person 16 years old or older to request release as provided in section 253B.04, subdivision 2, and shall list the names and telephone numbers of individuals and organizations that provide advocacy and legal services for patients in residential programs. Reasonable accommodations shall be made for those with communication impairments and those who speak a language other than English. Current facility policies, inspection findings of state and local health authorities, and further explanation of the written statement of rights shall be available to patients, residents, their guardians or their chosen representatives upon reasonable request to the administrator or other designated staff person, consistent with chapter 13, the Data Practices Act, and section 626.557, relating to vulnerable adults. This LICENSURE REQUIREMENT is NOT MET as evidenced by:	21800	corrected	06/01/2026

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21800	Continued from page 38 Based on observation and interview, the facility failed to ensure the most up to date Nursing Home Resident Bill of Rights (RBOR) was provided to each resident residing in the facility and displayed for residents, visitors and staff to review. This had the potential to affect 63 of 85 residents currently residing in the facility as well as all staff and visitors. Findings include: On 4/20/26 at 5:08 p.m., displayed by the transitional care unit (TCU) entrance was the RBOR, revised 2016. Displayed outside of dining room in long term care was RBOR, revised 2016. During observation on 4/21/26 at 11:27 a.m., on wall by long term care entrance was a hanging bin with folder that contained paper copies of the RBOR dated February 2016. On 4/21/26 at 1:48 p.m., reviewed facility admission packet, packet contained new RBOR dated 1/1/26. When interviewed on 4/21/26 at 4:59 p.m., social services (SS)-A stated they hadn't ordered a new RBOR poster in a long time. SS-A stated new pamphlets for the admission packets were ordered in January and March. Anyone who had admitted after then would have gotten the new RBOR in the packet. However, residents that were admitted prior to the purchase in January had not been informed there was an update to the RBOR. When interviewed on 4/21/26 at 5:26 p.m., administrator stated they were not aware there were changes to the RBOR. Administrator located an email received in January from Care Providers (non-profit association representing health care facilities) that identified there was an update to the RBOR. Administrator stated the update may have been missed due to transition to new ownership. Facility Resident Bill of Rights policy dated 10/22, indicated the facility would provide the residents with prompt notice of any changes in any State of Federal laws related to resident rights or facility rules during the residents stay in the facility.	21800		06/01/2026

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21800	Continued from page 39 SUGGESTED METHOD OF CORRECTION: The administrator or designee could review its policy's and procedures for notification of resident rights upon changes to the Resident Bill of Rights. The administrator or designee could then contact the State Agency to ensure the facility has the most updated version of the Resident Bill of Rights and each admission packet includes them. The facility could develop an auditing system that monitors for ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21800		06/01/2026

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
June 23, 2026

Administrator
PARK RIVER HEALTHCARE AND REHABILITATION CENTER LLC
9899 AVOCET STREET NORTHWEST
COON RAPIDS, MN 55433

RE: CCN: 245448
Cycle Start Date: April 27, 2026

Dear Administrator:

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

As authorized by CMS the remedy of:

• Discretionary denial of payment for new Medicare and Medicaid admissions effective June 2, 2026 did not go into effect. (42 CFR 488.417 (b))

In our letter of May 18, 2026, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from April 27, 2026. This does not apply to or affect any previously imposed NATCEP loss.

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

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

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

June 23, 2026

Administrator
PARK RIVER HEALTHCARE AND REHABILITATION CENTER LLC
9899 AVOCET STREET NORTHWEST
COON RAPIDS, MN 55433

Re: Reinspection Results
Event ID: 1F3609-H2

Dear Administrator:

On May 1, 2026 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on April 27, 2026. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245448	(X2) MULTIPLE CONSTRUCTION A. BUILDING **01 - MAIN BUILD...** B. WING	(X3) DATE SURVEY COMPLETED **04/20/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARK RIVER HEALTHCARE AND REHABILITATION CENTER LLC	**9899 AVOCET STREET NORTHWEST , COON RAPIDS, Minnesota, 55433**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K0000 Bldg. 01	INITIAL COMMENTS FIRE SAFETY An annual fire safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 04/20/2026. At the time of this survey, Park River Healthcare and Rehabilitation Center was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED. Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us	K0000		05/29/2026

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

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

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K0000 Bldg. 01	Continued from page 1 THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. Park River Estates Care Center is a 1-story building without a basement. The building was constructed at three different times. The original building was built in 1967 and was determined to be of Type II(222) construction. In 1988, an addition was constructed as the South Wing that was determined to be of Type II(111) construction. Finally, another addition was added in 1992 to the East Wing and was determined to be of Type II(111). The facility was surveyed as one building because the original building and the two additions conform to the lower protected construction type allowed for existing buildings. Multiple smoke compartments separate the building for a shelter-in-place strategy. The facility is fully protected throughout by an automatic fire sprinkler system. In addition, the facility has a fire alarm system with smoke detection in corridors and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 99 beds and had a census of 85 at the time of the survey. The requirements at 42 CFR, Subpart 483.70(a), are NOT MET as evidenced by:	K0000		05/29/2026
K0712 SS = F Bldg. 01	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each	K0712	On 4/22/2026, all required fire drill documentation was reviewed, and missing sections were filled in. The facility maintenance team was educated on adding written feedback to how the fire drills went, including what was learned, opportunities for improvement.	05/29/2026

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K0712 SS = F Bldg. 01	Continued from page 2 shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This STANDARD is NOT MET as evidenced by: Based on a review of available documentation and staff interview, the facility failed to conduct fire drills per NFPA 101 (2012 edition), Life Safety Code sections 19.7.1.6. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 04/20/2026 at 10:45 AM, it was revealed by a review of available documentation that at the time of the survey the facility did not critique the fire drills and at the time of all of the fire drills the signal was received before the actual drill occurred. An interview with the Director of Maintenance and the Regional Directo of Operations verified this deficient finding at the time of discovery.	K0712	Continued from page 2 Administrator/ designee will audit fire drills monthly to ensure drill includes written feedback. Results of audit will be reported to the facility QAPI committee for determination of frequency or continuation. Maintenance Director/designee will be responsible for monitoring of compliance. The facility is alleging compliance on 5/29/2026.	05/29/2026
K0351 SS = E Bldg. 01	Sprinkler System - Installation CFR(s): NFPA 101 Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2,	K0351	Lifesaver Co. was called on the day of finding (4/20). Sprinklers were added in electrical closet (S169A and behind the dryer) on 5/18. Maintenance Director was educated on the requirement to ensure that all rooms, including mechanical and utility spaces, maintain appropriate sprinkler coverage. No audit applicable after visual and verbal confirmation of sprinklers were placed by contractor. Maintenance Director/designee will be responsible for monitoring compliance. The facility is alleging compliance on 5/29/2026.	05/29/2026

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K0351 SS = E Bldg. 01	Continued from page 3 19.3.5.10, 9.7, 9.7.1.1(1) This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to install sprinkler heads per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.5.1 and 9.7.1.1 and NFPA 13 (2010 edition), The Standard for the Installation of Sprinkler Systems, sections 8.1.1, 8.15.10 and 8.15.10.3. These deficient findings could have a patterned impact on the residents within the facility. Findings include: On 04/20/2026 at 12:13 PM, it was revealed by observation that behind the dryers did not have proper sprinkler coverage. On 04/20/2026 at 12:20 PM, it was revealed by observation that an electrical closet (S169A) did not have proper sprinkler coverage. An interview with the Director of Maintenance and the Regional Director of Operations verified these deficient findings at the time of discovery.	K0351		05/29/2026
K0353 SS = D Bldg. 01	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25	K0353	Escutcheon plates were added to sprinkler heads (freezer and cooler) on day of finding (4/20). Additionally, sprinkler heads in the laundry room were cleaned on day of finding (4/20). House wide audit completed on all sprinkler heads to ensure they have appropriate escutcheon plates in place and are clean. Maintenance was educated on proper sprinkler inspection and maintenance. Facility maintenance director/ designee will audit x 5 sprinklers for x4 weeks to ensure there are no gaps between the ceiling tile and sprinkler head and sprinkler head is free of dust. Results of audit will be reported to the facility QAPI committee for determination of frequency or continuation. Maintenance Director/designee will be responsible for monitoring compliance. The facility is alleging compliance on 5/29/2026.	05/29/2026

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K0353 SS = D Bldg. 01	Continued from page 4 This STANDARD is NOT MET as evidenced by: Based on observation and interview, the facility failed to maintain the sprinkler system in accordance with NFPA 101, 2012 edition, Sections 19.3.5.3, 9.7.5, NFPA 25, 2011 edition, sections 5.1, 5.1.1, 5.1.1.1, 5.1.1.2, 5.2.1.1.2, 5.2.1.1.4 and Table 5.1.1.2. These deficient findings could have an isolated impact on the residents within the facility. Findings include 1. On 04/20/2026 at 12:18 PM, observation revealed that 6 of the 7 sprinkler heads were loaded with dust in the Laundry Room. 2. On 04/20/2026 at 12:18 PM, it was revealed by observation that 2 escutcheon plates for sprinkler heads in the kitchen freezer were missing in the freezer and cooler. An interview with the Director of Maintenance and the Regional Director of Operations verified these deficient findings at the time of discovery.	K0353		05/29/2026