DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
August 19, 2026

Administrator
BENEDICTINE CARE COMMUNITY
201 9TH STREET WEST
ADA, MN 56510

RE: CCN: 245502
Cycle Start Date: June 10, 2026

Dear Administrator:

On July 28, 2026 and August 4, 2026, the Minnesota Departments of Health and Public Safety, completed revisits to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245502	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Benedictine Care Community	**201 9TH STREET WEST , ADA, Minnesota, 56510**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E0000	Initial Comments On 6/7/26 through 6/10/26, 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		06/26/2026
F0000	INITIAL COMMENTS On 6/7/26 through 6/10/26, a standard recertification survey (S5502040-0) was conducted at your facility. Complaint investigations were 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: H55022751C (2792538), H55022752C (2784421), H55022754C (2717252), H55022755C (2700268), H55022756C (2700208), H55022757C (2700214), H55022758C (2700263), H55022759C (2700191), H55022753C (3031510). 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		06/26/2026
F0725 SS = F	Sufficient Nursing Staff CFR(s): §483.35(a)(1)(2) §483.35 Nursing Services.	F0725	CMS Plan of Correction – F725 (S/S F) Compliance Date: July 8th, 2026	07/08/2026

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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F0725 SS = F	Continued from page 1 The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity, and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.71. §483.35(a) Sufficient Staff. §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to provide sufficient nursing staff to meet residents' assessed needs and provide required care and services. The facility's staffing shortages resulted in delayed toileting assistance, delayed eating assistance, loss of dignity, and transfers performed contrary to assessed needs and facility policy for 2 of 6 residents (R23, R24) reviewed in the sample requiring staff assistance with quality-of-care needs. The facility's ongoing staffing shortages had the potential to affect all 36 residents residing in the facility. Findings include: The Centers for Medicare and Medicaid Services (CMS) PBJ Staffing Data Report CASPER Report 1705	F0725	Continued from page 1 Director of Nursing: Eliza Messerschmidt, RN, DNS-CT Administrator: Jason Carlson, LNHA Changes Implemented: July 1, 2026 1. Corrective Action for Residents Found to be Affected Resident R24 was immediately assessed by the interdisciplinary team. Care plans, transfer requirements, toileting schedules, dignity interventions, and staffing assignments were reviewed and updated as indicated. Staff received immediate education regarding timely toileting assistance, resident dignity, call light response, and compliance with two-person mechanical lift transfer requirements. Resident R23 was assessed regarding dining assistance needs. Care plans, nutritional interventions, dining supervision requirements, and meal assistance needs were reviewed. Staff received immediate education regarding timely meal assistance and monitoring of residents requiring assistance during meals. Any additional residents identified as requiring extensive assistance with transfers, toileting, dining, or activities of daily living were reviewed to ensure current staffing assignments adequately supported resident needs. 2. Identification of Other Residents with the Potential to be Affected All residents residing in the facility had the potential to be affected by the deficient practice. A facility-wide review was conducted by the Director of Nursing, Clinical Manager, and interdisciplinary team. The review included staffing schedules, resident acuity, transfer requirements, toileting programs, dining assistance needs, call light response practices, and care plan interventions. Residents requiring extensive assistance, mechanical lift transfers, dining assistance, frequent toileting	07/08/2026

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F0725 SS = F	Continued from page 2 D identified the following: FY [fiscal year] Quarter 3 2025 (April 1 - June 30) identified the metric for excessively low weekend staffing was triggered. The trigger is defined as submitted staffing data that was excessively low. FY Quarter 4 2025 (July1 -September 30) identified the metric for excessively low weekend staffing was triggered. The trigger is defined as submitted staffing data that was excessively low. FY Quarter 1 2026 (October 1 - December 31) identified the metric for excessively low weekend staffing was triggered. The trigger is defined as submitted staffing data that was excessively low. On 6/7/26 at 11:40 a.m., the survey team approached the facility at the entrance door, and it was locked. The phone on the wall was used to call to gain entry into the building. The call was answered and then immediately hung up. the survey team knocked on the glass door and licensed practical nurse (LPN)-A could be seen standing at the medication cart. LPN-A looked at the team but did not respond. The team attempted to call again and was immediately given an entry code for the lock, and the call was disconnected. The team attempted several times to enter the code, but eventually nursing assistant (NA)-A let the team in. At that time, LPN-A stated the facility was working “short”, as a day shift nurse did not show up that morning to work. The night nurse stayed until 10:30 a.m. but then left the facility. LPN-A stated she attempted to call staff in to work but had been answering call lights, assisting the nursing assistants (NA) as much as possible and trying to complete her own duties as well. LPN-A stated she had two nursing assistants in the facility. LPN-A showed a binder that contained a phone tree but stated she just hadn’t had time to call anyone. LPN-A was visibly frustrated with facial grimacing, and she was rubbing her forehead. The nursing assistants were busy in rooms. Many resident room doors were shut. FACILITY ASSESSMENT and SCHEUDLE REVIEW: The Facility Assessment updated 1/22/26, identified the following staffing needs with an average daily census of 42: Licensed nurses providing direct care, every day of the week for AM and evening shift had two staff and night shift had one staff. Unlicensed staff (nursing assistant/trained medication assistant), every day of the week for AM and evening shift had four staff and night shift had 2 staff.	F0725	Continued from page 2 assistance, or complex nursing services were specifically reviewed to ensure staffing resources and assignments were adequate to meet assessed needs. 3. Systemic Changes Implemented Effective July 1, 2026, the facility implemented the following systemic corrective actions: • Reviewed and revised staffing schedules to align with the Facility Assessment and current resident acuity. • Continued utilization of agency staffing resources as needed to maintain safe staffing levels. • Implemented an enhanced staffing escalation process including notification of the DON and Administrator when staffing concerns are identified. • Expanded call-in procedures and staffing contingency plans. • Implemented twice weekly staffing review meetings to evaluate census, acuity, staffing coverage, and anticipated staffing concerns. • Revised float staff assignments to include assigned resident groups for improved accountability. • Educated licensed nurses, nursing assistants, trained medication aides regarding: - Timely call light response - Toileting assistance expectations - Dining assistance requirements - Resident dignity and resident rights - Transfer safety requirements - Compliance with care plans and assessed needs - Reporting staffing concerns through the chain of command • Implemented leadership rounds to monitor call light response, dining room coverage, transfer assistance, resident care completion, and resident satisfaction.	07/08/2026

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F0725 SS = F	Continued from page 3 The facility provided a working schedule for the week of survey and identified the Sunday 6/7/26, AM shift 6:00 a.m. to 2:30 p.m., had one nurse working and two nursing assistants (NA) working. The nurse staff posting dated 6/7/26 identified the resident census was 36. The working nursing schedules from FY Quarter 1 2026 (October 1 - December 31) were reviewed for weekend staffing patterns and identified the following: Saturday 10/4/25, AM shift 6:00 a.m. to 10:00 a.m. and PM shift 2:00 p.m. to 10:30 p.m., only 3 NAs scheduled on each of the identified shifts. Sunday 10/5/25, AM shift 6:00 a.m. to 10:00 a.m. and PM shift 2:00 p.m. to 11:30 p.m., only 3 NAs scheduled on each of the identified shifts. Saturday 10/11/25, AM shift 6:00 a.m. to 10:00 a.m. and PM shift 2:00 p.m. to 10:30 p.m., only 3 NAs working on each of the identified shifts. Sunday 10/12/25, AM shift 6:00 a.m. to 2:30 p.m., only 2 NAs were scheduled. On PM shift 2:00 p.m. to 10:30 p.m., only 3 NAs were scheduled on the identified shifts. Saturday 10/18/25, AM shift 6:00 a.m. to 2:30 p.m., only 3 NAs were scheduled on the identified shift. Sunday 10/19/25, AM shifts from 11:00 a.m. to 2:30 p.m., and PM shift 2:00 p.m. to 6:00 p.m., only 3 NAs were scheduled on the identified shifts. Saturday 10/25/25, PM shift 2:00 p.m. to 10:30 p.m., only 3 NAs were scheduled on the identified shift. Sunday 10/26/25, AM shift 6:00 a.m. to 10:00 a.m., only 2 NAs were scheduled . At 11:00 a.m. to 2:30 p.m. and PM shift 2:00 p.m. to 10:30 p.m., only 3 NAs were scheduled on the identified shifts. Saturday 11/1/25, AM shift 11:00 a.m. to 2:30 p.m. and 2:00 p.m. to 6:00 p.m., only 3 NAs were scheduled on the identified shifts. Sunday 11/2/25, AM shift 6:00 a.m. to 10:00 a.m. and PM shift 2:00 p.m. to 6:00 p.m., only 3 NAs were scheduled on the identified shifts. Saturday 12/6/25, AM shift 10:00 a.m. to 2:30 p.m. and PM shift 2:00 p.m. to 10:30 p.m., only 3 NAs were scheduled on the identified shifts.	F0725	Continued from page 3 Education was initiated and completed for current staff, with ongoing education provided during orientation and annual competency validation. 4. Monitoring and Quality Assurance The Director of Nursing, Clinical Manager, or designee will monitor compliance through the following audit process: Staffing Audits • Daily staffing schedule review for all shifts x 4 weeks. • Weekly staffing review thereafter x 3 months. Resident Care Audits • Five resident observations weekly x 12 weeks to evaluate: - Timeliness of toileting assistance - Timeliness of call light response - Compliance with transfer requirements - Resident dignity during care Dining Audits • Observation of at least two meal services per week x 12 weeks to ensure residents requiring assistance receive timely meal support. QAPI Oversight • Audit findings will be reviewed monthly through the QAPI Committee. • Negative findings will result in immediate corrective action, additional staff education, increased monitoring, and follow-up auditing until sustained compliance is achieved. The facility alleges compliance on July 8th, 2026, when all corrective actions were completed and	07/08/2026

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F0725 SS = F	Continued from page 4 Sunday 12/7/25, AM shift 6:00 a.m. to 10:00 a.m. and PM shift 2:00 p.m. to 10:30 p.m., only 3 NAs were scheduled on the identified shifts. Saturday 12/13/25, AM shift 6:00 a.m. to 10:00 a.m., only 3 NAs were scheduled on the identified shift. Sunday 12/14/25, AM shift 6:00 a.m. to 10:00 a.m., only 3 NAs were scheduled on the identified shift. Saturday 12/20/25, AM shift 6:00 a.m. to 2:30 p.m., only 3 NAs were scheduled on the identified shift. Sunday 12/21/25, AM shift 6:00 a.m. to 2:30 p.m., only 2 NAs were scheduled and PM shift 6:00 p.m. to 10:30 p.m., only 3 NAs were scheduled on the identified shifts. See also F677: Based on observation, interview, and document review, the facility failed to provide activities of daily living (ADL) care and services necessary to maintain residents' abilities by failing to provide timely toileting assistance for 1 of 6 residents (R24) reviewed who required staff assistance with toileting and transfers; and failed to provide timely supervision and assistance with eating for 1 of 6 residents (R23) reviewed who required staff assistance during meals. R24: R24’s admission Minimum Data Set (MDS) dated 5/6/26, identified R24 had mild cognitive impairment and was dependent on staff for toileting and transfers and was frequently incontinent with bowel and bladder. Diagnoses included non-traumatic spinal cord dysfunction, diabetes, and dementia. R24’s care plan revised 5/27/26, R24's care plan dated 5/27/26 identified she was dependent on staff for transfers and toileting, required a full-body mechanical lift with assistance of two staff for transfers, and was to be offered toileting every three hours and upon request to maintain skin integrity and dignity. During an observation on 6/7/26 at 11:30 a.m., R24 was lying in bed with her head of bed (HOB) at 30 degrees. R24 was wearing a dusky purple sweatshirt and no pants. There was a fleece blanket across the foot of R24’s bed but it was not covering R24. R24 was wearing an incontinent brief with no pants and had her knees bent with her feet resting on the bed. R24 was crying and stated staff told R24 she had to stay in bed and couldn’t get up. “I don’t know why.” R24 then stated, “they told me to pee my	F0725	Continued from page 4 systems were established to ensure ongoing compliance with F725.	07/08/2026

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F0725 SS = F	Continued from page 5 pants, and they'd clean me up here." R24 stated this happened "all the time". At that time, nursing assistant (NA)-B stepped into the room and told R24 NA-B needed to help another resident and would be back. NA-B turned off R24's call light and left the room. R24 continued to cry and stated nursing assistants said that and shut off R24's call light "just about every day" and "they say they're short". R24 sobbed and stated "I hate it here. It's awful. I hate peeing in my pants." At 12:10 p.m., NA-B entered R24's room and told R24 she was wet, so she needed to be cleaned up. NA-B put on gloves then told R24 she didn't need to cry because she was there. R24 stated "I want to get up". At 12:11 p.m. NA-B unfastened R24's incontinent brief and used disposable wipes to clean R24's skin of feces and urine. R24 stated that her skin was itchy, NA-B told R24 that R24 had "pooped" and NA-B would clean R24's skin well. At 12:13 p.m., NA-B rolled R24 to the right and R24 began crying and stated, "I can't do this". NA-B told R24 that they were almost done. R24's skin on her upper thighs and buttocks was reddened but had no open areas. NA-B applied barrier cream then a clean brief. At 12:16 p.m., NA-B put on R24's pants. NA-B then removed her gloves and removed the trash from the trash containers and asked for assistance with R24's transfer over the walkie. NA-B exited the room. At 12:19 p.m., NA-B returned with a full body mechanical lift sling and placed it under R24. NA-B told R24 that she needed another staff person to assist with the transfer and left the room. At 12:22 p.m., NA-A and NA-B entered the room and used the ceiling lift to transfer R24 from her bed to her wheelchair. NA-B then brought R24 to the dining room for her noon meal. During an interview on 6/7/26 at 12:28 p.m., NA-B stated the facility was working "short" that day. "You just do the best you can." NA-B stated R24 did get up into her chair for breakfast that morning, but staff laid R24 down to do incontinent care after breakfast. NA-B stated R24 was "encouraged" to stay in bed because NA-B had other residents to care for. R24 did turn on her call light and asked to get up, but R24 was assistance of two and NA-B was providing care to another resident.	F0725		07/08/2026

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F0725 SS = F	Continued from page 6 R23: R23's quarterly MDS dated 5/8/26, identified R23 was cognitively intact and independent with eating. R23 had diagnoses of obesity and mass/lump on abdomen. R23's care plan dated 5/26/26 identified R23 was independent with eating. However, R23's mini nutritional assessment dated 5/9/26, identified R23 normally ate 51-75% of most meals. R23 was assisted with meals for optimal intake. During observations on 6/7/26 at 1:04 p.m., there were not enough staff in the dining room to assist residents with eating. At 1:05 p.m., there were at least two residents who were sitting there with food in front of them and were not eating nor were staff helping them. At 1:09 p.m., R23 was identified as one of the residents sitting at the table where staff are supposed to assist residents with eating. At 1:12 p.m., R23 still had her plate of food in front of her, and she had not attempted to eat. R23's potatoes and meat had formed a crust on them. R23 waited 45 minutes before staff assisted her to eat. At 1:15 p.m., R23 ate well with staff assistance. During an interview on 6/9/26 at 2:02 p.m., NA-A stated R23 had changed over the weekend, previously she just required supervision with eating. R23 had seemed to decline and had started to pocket food and had moved to a different table to assist with eating because R23 needed more help with meals. During lunch on Sunday 6/7/26, the facility was short staffed and the residents in the dining room had to wait for assistance to eat and some had to wait an extended period of time before they received help. See also F550: Based on observation, interview, and record review, the facility failed to ensure dignified care was provided for 1 of 1 resident (R24) reviewed for dignity. Staff encouraged R24 to remain incontinent rather than assisting her to the toilet when requested, resulting in embarrassment, and loss of dignity. R24’s admission Minimum Data Set (MDS) dated 5/6/26, identified R24 had mild cognitive impairment and was dependent on staff for toileting and transfers and was frequently incontinent with bowel and bladder. Diagnoses included non-traumatic	F0725		07/08/2026

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F0725 SS = F	Continued from page 7 spinal cord dysfunction, diabetes, and dementia. R24's care plan revised 5/27/26, R24's care plan dated 5/27/26 identified she was dependent on staff for transfers and toileting, required a full-body mechanical lift with assistance of two staff for transfers, and was to be offered toileting every three hours and upon request to maintain skin integrity and dignity. During an observation on 6/7/26 at 11:30 a.m., R24 was lying in bed with her head of bed (HOB) at 30 degrees. R24 was wearing a dusky purple sweatshirt and no pants. There was a fleece blanket across the foot of R24's bed but it was not covering R24. R24 was wearing an incontinent brief with no pants and had her knees bent with her feet resting on the bed. R24 was crying and stated staff told R24 she had to stay in bed and couldn't get up. "I don't know why." R24 then stated, "they told me to pee my pants, and they'd clean me up here." R24 stated this happened "all the time". At that time, nursing assistant (NA)-B stepped into the room and told R24 NA-B needed to help another resident and would be back. NA-B turned off R24's call light and left the room. R24 continued to cry and stated nursing assistants said that and shut off R24's call light "just about every day" and "they say they're short". R24 sobbed and stated "I hate it here. It's awful. I hate peeing in my pants." During an interview on 6/7/26 at 12:28 p.m., NA-B stated the facility was working "short" that day. "You just do the best you can." NA-B stated R24 did get up into her chair for breakfast that morning, but staff laid R24 down to do incontinent care after breakfast. NA-B stated R24 was "encouraged" to stay in bed because NA-B had other residents to care for. R24 did turn on her call light and asked to get up, but R24 was assistance of two, and NA-B was providing care to another resident. See also F689: Based on interview and document review, the facility failed to ensure transfers were performed in accordance with assessed needs, care plan interventions, and facility policy for 1 of 3 residents (R24) reviewed for accidents. Staff performed transfers using a full-body mechanical lift with one staff member rather than the required two staff members, creating the potential for falls, entrapment, and transfer-related injury. R24's admission Minimum Data Set (MDS) dated 5/6/26, identified R24 had a mild cognitive impairment and had diagnoses that included non-traumatic spinal cord dysfunction, diabetes, and dementia. R24 was dependent on staff for toileting	F0725		07/08/2026

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F0725 SS = F	Continued from page 8 and transfers and was frequently incontinent with bowel and bladder. R24's care plan revised 5/27/26, identified R24 had self-deficit with transferring. Staff were directed to provide assistance with two staff with all transfers to and from bed, wheelchair and toilet. R24 used a full body mechanical lift. During an interview on 6/9/26 at 11:29 a.m., trained medication aide (TMA)-A stated staffing was awful. The facility used a lot of agency staff and the schedule frequently got "messed up" which added to the problem. Staff did the best they could with what they had. TMA-A tried her hardest when they had to work short to prioritize work and to help the nursing assistants as much as she was able. R24 could not wait when R24 asked to use the bathroom because she would be incontinent. TMA-A stated she wasn't going to lie and transferred R24 using the full body mechanical lift by herself. TMA-A did this because R24 had a right to get up and use the bathroom. It was also harmful to R24 skin to void in her pants. TMA-A stated she felt the transfer was safe doing that. During an interview on 6/9/26 at 11:57 a.m., R24 stated sometimes there was not enough staff at the facility, and they transfer her with the lift with only one staff member. R24 stated they say there's not enough staff and it was against the rules, but they do it. R24 never felt unsafe but knew she was not supposed to tell anyone to get anybody in trouble. "I'm just thankful to get to the toilet." STAFF INTERVIEWS: During an interview on 6/8/26 at 4:44 a.m., RN-A stated she was the unit manager and was covering night shift because the facility was short on staff. During an interview on 6/9/26 at 11:29 a.m., TMA-A stated staffing was awful. The facility used a lot of agency staffing and the schedule would get "screwed up". On 6/9/26, TMA-A had to work a double shift because her relief was scheduled on the electronic module but not on the printed schedule. The Pioneer unit needed at least 2 aides because the cares were heavier over there. There should be a float that goes between the Pioneer unit and the Wild Rose unit, but they don't like to do it and refuse to help on Wild Rose. They just don't do it. The agency staff don't know what to do when a staff member calls in for their shift. The agency staff don't have access to the texting app but they have the staff list and the have the phone tree. TMA-A was not called to work on Sunday. TMA-A had heard nothing about the staff being short staffed on	F0725		07/08/2026

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F0725 SS = F	Continued from page 9 6/7/26. Staff working the medication cart were expected to assist the nursing assistants with answering call lights and resident care, but some of the agency staff would not do it. During an interview on 6/9/26 at 11:42 a.m., NA-C stated she worked as needed, but didn't work "much". Stated the facility did call her at approximately 1:00 p.m. on 6/7/26 but NA-C could not work that day. NA-C worked 6/8/26, 6/9/26 and was scheduled to work 6/10/26 because "state" was there. "Usually when I'm working, we have everybody here because I'm the one who picked up." During an interview on 6/9/26 at 1:36 p.m., LPN-A stated she was an agency staff person so "that right there should tell you what staffing is like." Stated the facility worked "short" like they were on 6/7/26 a lot. "Every week". LPN-A stated the nurse who was supposed to work on 6/7/26 comes to work late often. The night nurse stayed to cover, but the nurse never arrived. That's when LPN-A realized she wasn't coming. LPN-A was trying to call staff to come in to work but was getting pulled in every direction because the nursing assistants needed help, plus she had nursing duties she had to attend to. During an interview on 6/9/26 at 1:49 p.m., NA-A stated the facility worked short staffed all the time and even if NA-A had a float, the float wasn't much help, so she was working alone anyway. Some of the floats just didn't want to work. They liked the social aspect of the role, but they didn't want to listen to direction, or they were slow in their tasks. Some didn't answer call lights. For example, one float wanted to sit with the residents and drink coffee and visit. The float routinely didn't look at the bath list and didn't want to answer call light. When NA-A would tell this person what to do, NA-A would get ignored. NA-A stated she had reported this to administration many times and not had a response. During an interview on 6/9/26 at 2:06 p.m., RN-A stated she had been told there were float staff ho were resistant to working on the Wild Rose unit. The floats had worked at the facility for "years" and believed they didn't have to. RN-A had spoken to the float staff individually and informed administration but had never documented this. During an interview on 6/9/26 at 2:49 p.m., the DON stated she expected staff to answer call lights when they can safely leave the person they are caring for to check on the call light to ensure it's not a safety	F0725		07/08/2026

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F0725 SS = F	Continued from page 10 concern. The DON also stated she had recognized the float staff didn't have accountability because the float didn't have an assigned resident group. The DON planned to change assignments so each nursing assistant, including the float, would have an assigned group of residents. This would include the float assigned residents from each unit. That way, the float would be assisting on each unit and there would be a way to hold the float accountable for their work.	F0725		07/08/2026
F0880 SS = F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections;	F0880	CMS Plan of Correction – F880 Infection Prevention & Control Completion Date: July 8th, 2026 Director of Nursing: Eliza Messerschmidt, RN, DNS-CT Administrator: Jason Carlson, LNHA Changes Implemented: July 1, 2026 1. Corrective Action for Residents Found to be Affected Residents identified during survey observations were immediately assessed for any potential impact related to the deficient infection prevention and control practices. Immediate corrective action included re-education of involved staff regarding hand hygiene requirements, standard precautions, transmission-based precautions, PPE utilization, environmental cleaning, and infection prevention practices. Isolation precautions were reviewed, PPE supplies and signage verified, and any deficient infection control practices immediately corrected. Residents residing on transmission-based precautions, including contact precautions, were reviewed to ensure interventions were implemented according to physician orders, facility policy, CDC guidance, and CMS requirements. 2. Identification of Other Residents with the Potential to be Affected All residents residing in the facility had the potential	07/08/2026

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F0880 SS = F	Continued from page 11 (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 prevention and control program that included a system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases. Specifically, the facility failed to timely initiate and consistently implement transmission-based precautions for 2 of 2 residents (R12. R24) reviewed who exhibited signs and symptoms of potentially infectious diarrhea; failed to consistently identify and monitor residents exhibiting signs and symptoms of potential infection through the facility's surveillance system for 2 of 2 residents (R7, R24) reviewed for infection surveillance; failed to ensure staff adhered to infection prevention practices related to hand hygiene for 1 of 3 residents (R24) reviewed for activities of daily living; and	F0880	Continued from page 11 to be affected by the deficient practice. The Director of Nursing, Infection Preventionist, Clinical Manager, and interdisciplinary team conducted a facility-wide review of hand hygiene practices, PPE utilization, isolation precautions, environmental cleaning processes, equipment disinfection, infection surveillance activities, and resident care practices. Residents with active infections, isolation precautions, wounds, indwelling devices, recent antibiotic use, multidrug-resistant organisms, and Clostridioides difficile histories were specifically reviewed for compliance with infection prevention interventions. 3. Systemic Changes Implemented Effective July 1, 2026, the facility implemented the following systemic corrective actions: • Reviewed and reinforced the Infection Prevention and Control Program. • Enhanced infection surveillance processes and reporting. • Reinforced Infection Preventionist responsibilities. • Educated all licensed nurses, nursing assistants, TMAs, ancillary staff, contract personnel, and agency staff regarding: - Hand hygiene requirements - Standard precautions - Transmission-based precautions - Proper PPE selection and utilization - Donning and doffing procedures - Environmental cleaning standards - Equipment cleaning and disinfection - C. difficile prevention and control practices - Isolation precaution requirements	07/08/2026

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F0880 SS = F	Continued from page 12 failed to implement enhanced barrier precautions for 2 of 5 residents (R6, R7) reviewed who met criteria for enhanced barrier precautions. These deficient practices had the potential to affect all 36 residents residing in the facility. Findings include: TRANSMISSION BASED PRECAUTIONS R12 R12's annual Minimum Data Set (MDS) dated 5/22/26, identified R12 had severe cognitive impairment, and included a diagnosis of chronic kidney disease. R12 required partial/moderate assistance with toileting and was always incontinent with bowel and bladder. R12's care plan revised 5/28/26, identified R12 had acute gastroenteritis (inflammation that spreads from your stomach into your intestines, causing pain, vomiting and diarrhea) as evidenced by diarrhea and/or vomiting. Placing R12 at risk for dehydration, electrolyte imbalance, impaired skin integrity, and infection transmission. Staff were directed to: Administer antiemetics, antidiarrheals, or antibiotics as ordered by provider. Monitor for medication effectiveness and side effects. Assess for abdominal pain, cramping, nausea, fever, or discomfort; report concerns to the resident's provider and treat as ordered. Assist with toileting as needed, provide perineal care after diarrhea, and apply barrier cream/protective ointments as indicated. Initiate appropriate isolation precautions per facility policy, minimize resident movement outside of room, and clean and disinfect high-touch surfaces and shared equipment. Monitor frequency, consistency, and volume of stools and/or emesis. R12's Clostridium difficile (C. diff) by Molecular Detection dated 5/27/26, identified R12 was was positive for C. diff (a highly contagious bacterium	F0880	Continued from page 12 - Reporting infection prevention concerns • Leadership rounds were implemented to monitor infection prevention compliance. • Weekly infection prevention meetings were implemented to review infection trends, outbreaks, antibiotic utilization, and compliance concerns. • All new employees and agency staff will receive infection prevention education during orientation before providing resident care. 4. Monitoring and Quality Assurance The Director of Nursing, Infection Preventionist, Clinical Manager, or designee will conduct the following audits: Hand Hygiene Audits • Ten observations weekly for four weeks. • Five observations weekly for an additional eight weeks. Isolation and PPE Audits • Five audits weekly for twelve weeks. Environmental Cleaning Audits • Five audits weekly for twelve weeks. Infection Surveillance Audits • Weekly review of infection surveillance data for twelve weeks. Leadership Rounds • Weekly infection prevention leadership rounds for twelve weeks. QAPI Oversight • Audit findings will be reviewed monthly through the QAPI Committee.	07/08/2026

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F0880 SS = F	Continued from page 13 that causes diarrhea and colitis. It often infects people who've recently taken antibiotics. Antibiotics that kill other bacteria in your gut but don't kill C. diff allow it to quickly grow out of control, (Cleveland Clinic dated 11/19/24)). R12's Enteric Pathogens by Molecular Detection dated 5/27/26, identified R12 was positive for norovirus. (Norovirus is a highly contagious virus that causes acute gastroenteritis (inflammation of the stomach and intestines). Often mistaken for the "stomach flu" or food poisoning, it results in explosive vomiting, watery diarrhea, and stomach cramps. It is notoriously difficult to kill and spreads rapidly through contaminated food, surfaces, or close contact, Cleveland Clinic dated 2/3/23) R12's nurse progress notes identified the following: 5/18/25 at 5:05 p.m., social work designee (SWD) met with resident on 5/18/26 and completed PHQ-9 Assessments (a screening tool for depression). PHQ-9 score was 3/27 indicating minimal depression. R12 answered yes to feeling down, depressed, and hopeless. R12 stated he doesn't know why he feels this way at times, but stated he was glad that his legs were getting better and was working with therapy. R12 also stated yes for poor appetite, he stated he wasn't eating much when he was feeling sick and stated he had been having loose stools these last couple of days. R12 stated he ate better today. Case manager notified about loose stools, no other concerns for R12 at this time. 5/19/26 at 9:15 a.m., Discussed at Interdisciplinary Team (IDT): weight variance. Will be followed up with provider today during rounds. 5/19/26 at 4:52 p.m., PROVIDER UPDATE: Regarding concerns with loose stools. Reviewed by provider with orders received as follows: comprehensive metabolic panel (CMP) (measures 14 different substances in your blood and is primarily used to evaluate organ function and metabolism), magnesium (Magnesium is a vital electrolyte that your nerves, muscles, and heart need to function properly), complete blood count (CBC), C-reactive protein (CRP) (CRP is a protein made by your liver that increases when there is inflammation in your body). Orders updated. However, the nursing progress note failed to identify if R12 was placed into contact precautions.	F0880	Continued from page 13 • Negative findings will result in immediate corrective action, additional education, increased monitoring, and follow-up audits until sustained compliance is achieved. The facility alleges compliance on July 8th, 2026, when all corrective actions were completed and systems were established to ensure ongoing compliance with F880 Infection Prevention and Control.	07/08/2026

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F0880 SS = F	Continued from page 14 5/20/26 at 5:15 a.m., R12 at baseline. No complaints. Incontinent of stool one time. 5/20/26 at 10:30 a.m., LAB RESULTS CRP: 2.6 RBC: 3.82 HGB: 12.2 MCV: 102.1 MCHC: 31.3 RDW: 16.3 BUN: 37 Creatinine: 1.58 GFR: 40 Glucose: 128 Albumin: 3.0 Alkaline Phosphatase: 224 Alanine Aminotransferase: 7 Provider updated. No further orders at this time. 5/20/26 at 12:30 p.m., per provider, CRP was elevated but substantially improved compared to a few weeks ago in the hospital. Electrolytes and kidney functions look okay for R12. Alkaline Phosphatase was elevated but had been elevated over the last year. Add a Gamma-glutamyl transferase (GGT) to see if the Alkaline Phosphatase elevation was likely from the liver or bone. GGT lab order added. Writer called lab to inform of add-on lab. However, the nursing progress note failed to identify if R12 was placed into contact precautions. 5/21/26 at 7:15 a.m., staff interviewed for Assessment Reference Date (ARD) ending 05/22/2026: Staff reported continence level for bladder as incontinent and bowel as incontinent. R12 was incontinent in briefs at this time and required check and change in bed or on toilet. Staff reported R12 had frequent loose stools daily since hospital	F0880		07/08/2026

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F0880 SS = F	Continued from page 15 stay. Provider aware. Imodium (anti-diarrhea medication) is in use as needed. 5/26/26 at 5:12 a.m., loose stools twice. Imodium given. However, the nursing progress note failed to identify if R12 was placed into contact precautions. 5/26/26 at 9:06 a.m., some difficulty with therapies due to loose stools per therapy. Will see about stool sample today. 5/27/26 at 11:12 a.m., spoke to R12's doctor about ongoing problems with loose stools and incontinence since hospitalization. Received order for stool culture and C-diff labs. Howe 5/27/26 5:53 p.m., R12 at baseline. No concerns noted. Obtained stool specimen and dropped off to lab as ordered for occult parasite and C-diff. However, the nursing progress note failed to identify if R12 was placed into contact precautions. 5/28/26 at 6:20 a.m., writer received lab results this morning indicating R12 was positive for C-Difficile - Norovirus strain. Staff were updated immediately and isolation precautions implemented. Writer spoke to R12 and strongly encouraged him to stay in his room today so as not to spread the illness. Provider was updated. Communication sent out to facility staff. However, the nursing progress note failed to identify R12 cohorting with a roommate. 5/28/26 at 6:27 a.m., LAB RESULTS Clostridium Difficile: Positive Norovirus GI/GII: Detected 5/28/26 at 8:48 a.m., writer contacted R12's doctor regarding positive stool results. Orders received as follows: 1. Oral Vancomycin (an antibiotic that kills C. diff) 125 milligrams (mg) 4 times a day for 10 days. 5/28/26 10:02 a.m., discussed at IDT: R12 was diagnosed with C-Diff and norovirus. Isolation precautions in place. Notifications made. However,	F0880		07/08/2026

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F0880 SS = F	Continued from page 16 the nursing progress note failed to identify R12 cohorting with a roommate. 5/28/26 at 10:05 a.m., Antibiotic(s) prescribed:: Vancomycin Start Date:: 05/29/2026 Dose:: 125 mg Route:: Oral Duration:: 10 days Stop Date:: 06/07/2026 Reason Antibiotic(s) Prescribed:: Other (List) C-Diff/Norovirus Review Event: Did resident meet McGeer's Criteria to treat?: Yes Review Event: Did culture or imaging tests confirm infection?: Yes Risk Factors/Concerns:: No Risk Factors/Concerns Does resident still have symptoms?: Yes Are signs and symptoms improving?: Yes Red Flags:: Antibiotic is ordered for more than 7 days Actions to Take:: Notify nurse manager or facility supervisor, Update provider Has attending provider been updated?: Yes 5/28/26 at 6:32 p.m., no concerns or complaints noted. R12 was on contact precautions due to c-diff. 5/29/26 at 11:30 a.m., Annual Nutrition Review: R12 had just been diagnosed with norovirus and C diff. R12 may benefit from the addition of a probiotic. Nutritional care plan reviewed. Goal for weight maintenance is 230-250 pounds (lbs). Nutritional needs were being met by weight trend. No changes were needed. Encourage fluids related to kidney disease. 5/30/26 at 6:02 p.m., No concerns or complaints	F0880		07/08/2026

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F0880 SS = F	Continued from page 17 noted. Continued to be in contact isolation due to C-diff, no loose stools noted, antibiotic continued with no adverse effect noted. 6/3/26 at 12:26 p.m., regarding active Loperamide prescription (PRN), writer received orders as follows: 1. Hold Loperamide for duration of C-Diff infection 6/7/26 at 5:42 a.m., R12 at baseline, no concerns. Continued with contact precautions. R12 stated was ready to come out of that. 6/7/26 at 7:09 p.m., continued contact precautions for C-diff. R12 was noncompliant. R12 came from his room to dining room at times, staff continued to redirect. 6/8/26 at 3:47 a.m., R12 self-transferred to bathroom twice during the night. R12 was reeducated on the need to use his call light for assistance. During a continuous observation on 6/8/26 at 7:46 a.m., R12 had a 3-drawer plastic cart outside his room. A Contact Precautions sign, bleach disposable wipes and red biohazard bags were sitting on top. The top drawer contained gloves and surgical masks, the second drawer had eye and face protection, and the bottom drawer was empty. Inside the doorway, there was a 13-gallon trash bin. R12 was sitting on the edge of his bed. R12's roommate, R7, was in bed with the privacy curtain pulled. At 8:26 a.m., R12 continued sitting on the side of his bed. R12 was dressed and had his wheelchair and overbed table in front of him in reach. 8:41 a.m., LPN-A stated she did know who the facility's infection prevention nurse was. There have been too many changes. R12 began hollering at LPN-A. LPN-A asked dietary aide (DA)-A if R12 had eaten breakfast. DA-A stated no, half the residents in the unit had not eaten breakfast and stated "after 9:00 a.m., you have to deliver it." DA-A continued to the dining room. At 8:48 a.m., R12 continued to sit on the side of his	F0880		07/08/2026

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F0880 SS = F	Continued from page 18 bed. R12 did not have his breakfast. At 9:04 a.m., the health unit coordinator (HUC) delivered gowns and placed them in R12's cart in the bottom drawer. At 9:14 a.m., NA-B entered R12's without any personal protective equipment (PPE). R12 began yelling "what the hell is going on? I haven't had my breakfast yet." NA-B stated she would go check. Left room and went to the dining room. NA-B did not use hand sanitizer. At 9:19 a.m., NA-B returned with R12's breakfast tray. NA-B put on a gown, gloves and a surgical mask then brought the tray to R12. NA-B placed R12's tray on the overbed table and set up R12's meal, touching items on his overbed table. NA-B removed her gloves and made to leave the room when R12 stopped her and stated, "no coffee?" NA-B stated R12 had already had some coffee that morning. R12 stated yes, he had, but that was a while ago. "Ok, that's fine. I'll get some later". NA-B removed her washable gown and placed it into the trash can at the door, then used hand sanitizer. At 9:24 a.m., NA-B stated staff only needed to wear a gown and gloves when doing anything with R12 and did not need to wear anything if they were caring for R7. NA-B then reentered the room to care for R7 without a gown or gloves. At 10:42 a.m., the wellness activity director (WAD)-A and culinary manager (CM)-A entered R12's room without gown or gloves. WAD-A and CM-A are touching R12's personal items such as his overbed table, wheelchair, closet and bedding. The bedding was brushing WAD-A's clothing. WAD-A told R12 they were going to help R12 with his bath. CM-A removed clothing from R12's closet for R12 to pick out. WAD-A put a gait belt on R12 and assisted R12 to transfer to his wheelchair. At 10:47 a.m., CM-A stated R12 had been removed from contact precautions that morning. They knew this because it was discussed in the IDT that morning and staff just had not gotten around to removing the cart. However, CM-A did not know if R12's room had been cleaned.	F0880		07/08/2026

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F0880 SS = F	Continued from page 19 At 11:10 a.m., housekeeping manager (HM)-A was in R12's room wearing gloves but without a gown. HM-A was pulling linens from R12's bed and cleaning his room. At 12:11 p.m., the cart was removed from R12's doorway. During an interview on 6/8/26 at 12:15 p.m., trained medication aide (TMA)-A stated when a resident needed contact precautions, the charge nurse came around and told all the staff. The cart was placed outside the room, and a trash container was put inside the doorway to remove your gown and gloves. Staff were expected to put on a gown and gloves every time you entered the room. When the contact precautions were done, the charge nurse came around again to tell all the staff. The room needs to be "broken down" and everything needed to be cleaned. Housekeeping had to sanitize the room as well as the cart. The cart was then stocked and put back in the supply closet for another use. When a resident had 3 or more loose stools, TMA-A brought it to the attention of the charge nurse; especially if the stool was foul smelling. "When that happens, I put the cart out because it's like lice, nobody wants it." During an interview on 6/8/26 at 12:25 p.m., HM-A stated R12 had come off of contact that morning so HM-A sanitized R12's room and bathroom with a bleach disposable wipe and then waited 30 minutes before R12 could go back into his room to make sure everything was dry. HM-A stated she wore gloves when she used the disposable wipe. "Well, everybody was in there without a gown, so I didn't think I needed to do that if I was cleaning it. That's just standard precautions." R7 R7's annual Minimum Data Set (MDS) dated 4/5/26, identified R5 had severe cognitive impairment and diagnosis included obesity, diabetes, and dementia. R7's care plan dated 5/22/26, identified the care plan lacked any guidance regarding a possible exposure to C. diff. R24 R24's admission Minimum Data Set (MDS) dated 5/6/26, identified R24 had a mild cognitive	F0880		07/08/2026

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F0880 SS = F	Continued from page 20 impairment and had diagnoses that included non-traumatic spinal cord dysfunction, diabetes, and dementia. R24 was dependent on staff for toileting and transfers and was frequently incontinent with bowel and bladder. R24's Activities of Daily Living (ADLs) Functional/Rehabilitation Potential Care Area Assessment (CAA) dated 5/11/26, identified R24 was a recent admit from another care center and had diagnoses of dementia, depression, heart failure and asthma. R24 had clear speech and was understood and usually understood. R24 denied shortness of breath. R24 stated she had pain per medication administration record (MAR) review. R24 had a history of refusing medications per staff. R24 was frequently incontinent of bowel and bladder and had some moisture-associated skin damage (MASD) noted with ointment/cream to apply. R24 required assistance for transfers. Care area was triggered due to ADL review. R24 would be assisted per need and per request. R24 was to be encouraged to be as independent as able and observed for changes in her abilities. Peri care completed with incontinence episodes. R24's Urinary Incontinence and Indwelling Catheter Care Area Assessment dated 5/11/26, identified R24 required assistance for transfers. Care area was triggered due to prescribed medication, impaired mobility, health history and ADL review. She was to be observed for changes in her elimination pattern and peri care to be completed with incontinent episodes. R24's care plan revised 5/27/26, identified the following: R24 was frequently incontinent of urine. Staff were directed to document incontinent episodes. Bladder assessment at least quarterly. Monthly 24-hour (hr) bladder/bowel record. Provide with appropriate incontinence products. R24 required an extensive partial assistance of one (PAO1) using a gait belt (GB) and a wheeled walker to transfer, wipe, adjust clothing and manage incontinence. R24 was to receive peri cares twice daily and as needed after any incontinent episode. Protective ointment to skin as needed. Observe for signs/symptoms of urinary tract infection (UTI): pain or burning with urination, fever, increased incontinence, cloudy/odorous urine in small amounts, increased confusion/lethargy. Encourage adequate fluids. However, the care plan failed to direct staff regarding precautions related to R24's loose stools.	F0880		07/08/2026

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F0880 SS = F	Continued from page 21 R24's nursing progress notes identified the following: On 5/13/26 at 8:30 p.m., R24 was complaining of pain. As needed (PRN) Ibuprofen given per orders and effective. R24 was given Imodium (an anti-diarrhea medication) per order after 2 loose stools. So far effective. On 5/15/26 at 1:33 p.m., R24 complained of some pain especially during transfers. R24 some diarrhea. Ibuprofen and Imodium given per orders. On 5/17/26 at 12:48 p.m., R24 had loose stools. PRN Imodium given per order. R24 verbalizing pain but refuses all interventions. On 5/24/25 at 1:49 p.m., R24 refused some of her medications this morning. Loperamide given at 1015 for loose stools, medication was effective. On 5/27/26 at 1:20 p.m., R24 had a loose stool before lunch and was given 4 mg of PRN loperamide at 11:09 a.m. No further loose stools noted. On 5/28/26 at 1:33 p.m., R24 has loose stools. PRN Imodium given and effective. R24 also complaining of pain. Scheduled Tylenol was given a little early due to condition. No other concerns. On 5/29/26 at 9:31 a.m., IDT review: R24 having loose stools, will contact provider for stool sample. On 5/29/26 at 1:33 p.m., R24 had PRN Imodium per order. No other concerns. On 5/29/26 at 2:26 p.m., writer contacted R24's doctor regarding concerns of loose stools. Received order as follows: 1. Stool C-diff 2. Stool culture. On 6/2/26 at 10:43 a.m., stool sample was collected. On 6/3/26 at 11:25 p.m., stool tests were negative,	F0880		07/08/2026

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F0880 SS = F	Continued from page 22 and results were sent to R24's doctor. R24's medical record failed to identify if R24's loose stools required contact precautions. R24 R4's Enteric Pathogens by Molecular Detection resulted 6/2/26, identified R24 as negative. R24's Clostridium difficile by Molecular Detection resulted 6/2/26, identified R24 was negative. During an observation on 6/7/26 at 11:30 a.m., R24's doorway had no signage and/or cart. R24 was lying in bed with her head of bed (HOB) at 30 degrees. R24 was wearing a dusky purple sweatshirt and no pants. There was a fleece blanket across the foot of R24's bed but it was not covering R24. R24 was wearing an incontinent brief with no pants and had her knees bent with her feet resting on the bed. R24 had been incontinent of bowel and bladder. At 12:10 p.m., NA-B entered R24's room and told R24 she was wet, so she needed to be cleaned up. NA-B put on gloves but no gown, then told R24 she didn't need to cry because she was there. R24 stated "I want to get up". At 12:11 p.m. NA-B unfastened R24's incontinent brief and used disposable wipes to clean R24's skin of feces and urine. R24 had a loose, watery stool. R24 stated that her skin was itchy, NA-B told R24 that R24 had "pooped" and NA-B would clean R24's skin well. At 12:22 p.m., NA-A and NA-B entered the room and used the ceiling lift to transfer R24 from her bed to her wheelchair. NA-B then brought R24 to the dining room for her noon meal. NA-B did not offer to wash R24's hands in the sink and NA-B used hand sanitizer when leaving the room. During an interview on 6/7/26 at 12:28 p.m., NA-B stated she had removed her gloves and did not clean her soiled gloves with a disposable wipe. "No. I removed my gloves." NA-B then stated staff had to remove their gloves after cleaning feces to prevent the spread of germs everywhere. NA-B stated hand sanitizer was ok. During an observation on 6/8/26 at 1:09 p.m., TMA-A entered R24's room without gown or gloves.	F0880		07/08/2026

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F0880 SS = F	Continued from page 23 TMA-A used hand sanitizer when exiting R24's room. During an interview on 6/9/26 at 2:49 p.m., the DON stated whenever staff are requesting a stool panel for a resident that has loose stools, precautions should be started. Even if the provider did not believe a stool panel was warranted and the loose stools were ongoing, precautions should be started to ensure a stool panel was needed in the future and became positive. This should continue until the loose stools resolve. Staff were expected to follow precautions and precautions should be care planned to direct staff to do so. The facility policy Contact Precautions revised 9/2023, identified Contact Precautions are used when diseases are transmitted by contact with the resident or the resident's environment. Residents with disease caused by organisms that have been demonstrated to cause heavy environmental contamination will be placed on Contact Precautions. The policy included the following: A. Resident Placement: Decisions regarding resident placement during an acute infection will be made on a case-by-case basis. Consideration will be given to risk of transmission to roommate, presence of any factors that will increase the likelihood of transmission, and the psychological impact on the infected resident. B. Procedure for Contact Precautions: 1. Hand Hygiene is done prior to donning PPE. 2. PPE is donned prior to entering room. A gown and gloves are needed upon entering room. 3. Change gown and gloves between residents even if only one resident is on Contact Precautions. 4. Use of masks, eye protection and face shields is not routinely a part of contact precautions, however, just as with Standard Precautions, these items are worn during resident care activities that are likely to create splashes or sprays of blood, body fluid, secretions, and excretions. 5. Hand hygiene is perfom1ed between glove changes and when removing gloves. The facility policy Standing House Orders for Symptoms Management revised February 2025, identified the following: Bowel and Bladder Management Bowel: Diarrhea (Perform steps sequentially) Perform rectal check to determine if impaction is present; If impacted, follow guidelines for constipation; If not impacted, hold all cathartic-related (constipation) meds and observe for 24 hours. If diarrhea is resolved, resume cathartic-related (constipation) med. If diarrhea continues: Notify Provider of the change in condition to determine if sending a stool specimen	F0880		07/08/2026

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F0880 SS = F	Continued from page 24 for C. difficile toxin A and Bis indicated; If testing for C. difficile toxin is ordered, collect only diarrheal (unformed) stool; and Encourage fluids to help maintain hydration. However, the policy failed to direct staff to place the resident into precautions until testing and/or loose stools were resolved. The Center for Disease Control and Prevention (CDC) About C. diff dated 5/13/26, identified Clostridioides difficile [klos–TRID–e–OY-dees dif–uh–SEEL], also known as Clostridium difficile and often called C. difficile or C. diff, is a bacterium (germ) that causes diarrhea and inflammation of the colon. Symptoms include: Diarrhea, Fever, Stomach tenderness or pain, Loss of appetite, and Nausea.C. diff infection (CDI) is more common among patients in healthcare settings, such as hospitals and nursing homes. This is because many people who have C. diff stay or get treated in those facilities. Other risk factors include: Older age (65 or older); A weakened immune system, such as people with cancer or organ transplants taking drugs that suppress the immune system; and Previous infection with C. diff or known exposure to the germs When C. diff germs are outside the body, they become spores. These spores are an inactive form of the germ and have a protective coating allowing them to live for months or years on surfaces and in the soil. Spores become active again after being swallowed and reaching the intestines. Once there, they can cause infection if your immune system is weak or you've recently taken antibiotics. However, most healthy people don't get infected even if spores reach their intestines. If a patient has had three or more stools in 24 hours; Isolate patients with possible C. diff immediately, even if you only suspect CDI; Order a C. diff test if other etiologies of diarrhea such as stool softener or laxative were not used; Wear gloves and a gown when treating patients with potential infectious diarrhea, including C. diff infection, even during short visits. Gloves are important because hand sanitizer doesn't kill C. diff. In addition, handwashing alone may not be sufficient to eliminate all C. diff spores; and Reassess appropriateness of antibiotics in C. diff patients. SURVEILLANCE The facility surveillance log dated 2/25/26 through 6/2/26, identified resident name, room number and unit, admit date, event closed date, infection type, body system of infection, origin of infection, onset date, resolved date, was surveillance met, was there a hospital admission, was the infection reportable, signs and symptoms, was it a device related	F0880		07/08/2026

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F0880 SS = F	Continued from page 25 infection, risk factors, laboratory results, type of tests, test dates, culture source/radiology site, test results, treatment, medication class, dose, route, frequency, treatment start date, treatment end date, total days of therapy, did the infection meet criteria and was transmission-based precautions implemented. The log identified the following infections: 12 Urinary tract infection (UTI) 4 cellulitis (skin infection) 3 “other” 1 lower respiratory tract infection 1 norovirus (a highly contagious virus that causes acute gastroenteritis - inflammation of the stomach and intestines. Commonly referred to as the "stomach flu" or food poisoning, it is completely unrelated to the influenza virus. It triggers sudden, severe vomiting, diarrhea, and stomach cramps) 1 Clostridioides difficile (C. diff) (a highly contagious bacterium that infects the large intestine (colon), causing severe inflammation (colitis) and watery diarrhea. It primarily affects individuals whose normal gut bacteria have been disrupted by recent antibiotic use, making it a common healthcare-associated infection) However, the log did not identify any resident with a sign and/or symptom of an infection that was not treated. During an interview on 6/9/26 at 3:13 p.m., the director of nursing (DON) stated there was an infection tracker built into the electronic medical record. Whenever a resident exhibited signs or symptoms of an infection, staff opened an infection tracker for that resident. The tracker helped identify trends and addressed antibiotic stewardship, room grouping, history of organisms, and a deeper dive into the infections. Outbreak management required an action plan depending on the organism. Also, it helped determine who needed precautions, testing, etc. The surveillance tracking log then pulled data from the electronic medical record system. The	F0880		07/08/2026

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F0880 SS = F	Continued from page 26 facility used the McGreer criteria (standardized definitions used to detect and track infections (such as UTIs, pneumonia, and respiratory illnesses) in long-term care and nursing facilities.) The resident infections were monitored daily to determine if there were trends then, at the end of the month, percentages were calculated, and all the data was brought to the quality improvement meeting for discussion. The DON stated all infections should be documented and put on the surveillance log for tracking. For R24, an event should have started to track R24's diarrhea. It was important to track bowels in general, but diarrhea lets the staff know when intervention was needed. At 3:21 p.m., the DON stated an event tracker should have started for R7 as well. The DON had noticed R7 was rooming with R12 who had tested positive for C. diff and norovirus when she began her role at the facility the week prior. At that point, R12 was fully into treatment, experiencing symptoms and R7 was already exposed. The DON felt to roomR7, at that time, was just going to spread the infection more so R7 continued rooming with R12. The DON stated she was going to have a meeting with the unit managers to discuss the resident care plans and Kardex because that was what instructed the staff on how to provide care for the residents. If the staff were unaware, the staff would not follow precautions as expected. Hand Hygiene R24's admission MDS dated 5/6/26, identified R24 had mild cognitive impairment and was dependent on staff for toileting and transfers and was frequently incontinent with bowel and bladder. Diagnoses included non-traumatic spinal cord dysfunction, diabetes, and dementia. R24's Activities of Daily Living (ADLs) Functional/Rehabilitation Potential Care Area Assessment (CAA) dated 5/11/26, identified R24 was a recent admit from another care center and had diagnoses of dementia, depression, heart failure and asthma. R24 had clear speech and was understood and usually understood. R24 denied shortness of breath. R24 stated she had pain per medication administration record (MAR) review. R24 had a history of refusing medications per staff. R24 was frequently incontinent of bowel and bladder and had some moisture-associated skin damage (MASD) noted with ointment/cream to apply. R24 required assistance for transfers. Care area was triggered due to ADL review. R24 would be assisted per need and per request. R24 was to be encouraged to be as	F0880		07/08/2026

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F0880 SS = F	Continued from page 27 independent as able and observed for changes in her abilities. Peri care completed with incontinence episodes. R24's Urinary Incontinence and Indwelling Catheter Care Area Assessment dated 5/11/26, identified R24 required assistance for transfers. Care area was triggered due to prescribed medication, impaired mobility, health history and ADL review. She was to be observed for changes in her elimination pattern and peri care to be completed with incontinent episodes. R24's care plan revised 5/27/26, identified the following: R24 was frequently incontinent of urine. Staff were directed to document incontinent episodes. R24 was to receive peri cares twice daily and as needed after any incontinent episode. Protective ointment to skin as needed. During an observation on 6/7/26 at 12:11 p.m., NA-B unfastened R24's incontinent brief and used disposable wipes to clean R24's skin of feces and urine. R24 stated that her skin was itchy, NA-B told R24 that R24 had "pooped" and NA-B would clean R24's skin well. At 12:13 p.m., NA-B rolled R24 to the right and R24 began crying and stated, "I can't do this". NA-B told R24 that they were almost done. R24's skin on her upper thighs and buttocks was reddened but had no open areas. NA-B applied barrier cream then a clean brief. NA-B used disposable wipes to clean her gloves. NA-B did not remove her gloves nor use hand sanitizer. During an interview on 6/7/26 at 12:28 p.m., NA-B stated she had removed her gloves and did not clean her soiled gloves with a disposable wipe. "No. I removed my gloves." NA-B then stated staff had to remove their gloves after cleaning feces to prevent the spread of germs everywhere. During an interview on 6/9/26 at 11:29 a.m., trained medication aide (TMA)-A stated staff were always expected to remove gloves and use hand sanitizer whenever removing a soiled brief before putting on the clean brief because you didn't want to get feces on anything. "That's just gross." During an interview on 6/9/26 at 11:42 a.m., NA-C stated she always changed her gloves after taking off a soiled brief or after wiping a resident because it was just better that way.	F0880		07/08/2026

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F0880 SS = F	Continued from page 28 During an interview on 6/9/26 at 2:06 p.m., registered nurse (RN)-A stated staff obviously need education regarding hand hygiene and when to remove gloves. “It’s appalling”. During an interview on 6/9/26 at 2:49 p.m., the DON stated staff were expected to never go from dirty to clean. After providing peri care, staff were expected to remove their gloves, use hand sanitizer, then apply new gloves prior to finishing the task to prevent the spread of organisms or possible infection. The facility policy Hand Hygiene dated 2024, identified Infection Prevention begins with the basic hand hygiene. By following proper hand hygiene practices, associates will reduce the spread of potentially deadly ge1ms, as well as reduce the risk of healthcare provider colonization caused by gem1s acquired from the residents. Hand hygiene simply means cleaning hands using either handwashing (washing hands with soap and water), or antiseptic hand rub (i.e. alcohol-based hand sanitizer, including foam or gel). Times to Perform Hand Hygiene arc, but not limited to: When arriving for work; When hands are visibly soiled, wash hands with soap and water; Before and after direct resident contact; Before and after performing any invasive procedure (e.g. fingerstick blood sample); Before and after entering isolation precaution setting; Before and after eating or handling food -wash hands with soap and water; Before and after assisting a resident with meals -wash hands with soap and water; Before and after assisting a resident with personal care; Before and after handling peripheral vascular catheters and other invasive devices; Before and aft.er inse11ing indwelling catheters; Before and after changing a wound dressing; Upon and after coming in contact with a resident's intact skin, such as when taking vitals or after assisting with lifting; After personal use of the restroom -wash hands with soap and water; Before and after assisting a resident with toileting -wash hands with soap and water; After blowing or wiping nose; After contact with a resident's mucous membranes and body fluids or excretions; After handling soiled or used linens, dressing, bedpans, catheters and urinals; After handling soiled equipment or utensils; After performing your personal hygiene -wash hands with soap and water; After removing gloves or aprons; When workday is completed. ENHANCED BARRIER PRECAUTIONS	F0880		07/08/2026

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F0880 SS = F	Continued from page 29 R6: R6's annual Minimum Data Set (MDS) dated 5/29/26, identified R6 had intact cognition and required moderate assistance with bathing. R6 had an abdominal feeding tube (G-tube). Diagnoses included Parkinson's disease, narcolepsy, anxiety, and dysphagia (difficulty swallowing). R6's care plan dated 6/1/26, identified R8 was frequently incontinent of bladder. Approaches included for staff to provide peri care two times per day and as needed (PRN) when incontinent. R8's care plan also identified R8 has special treatment/procedures related to the presence of a G-tube. Approaches included to provide daily care and observance of R8's G-tube to ensure patency and usefulness. The care plan failed to include instructions for enhanced barrier precautions (EBP) related to when staff provided personal cares. R6's undated Active Order Report identified numerous medication orders, all with instruction to crush and administer the medication through her feeding tube. On 6/8/26, at 6:34 a.m. a plastic cart was observed outside of R6's room. The cart contained disposable gloves and masks. A sign on top of the cart identified R6 was on enhanced barrier precautions and directed staff to wear a gown and gloves when performing direct care, including G-tube care. During observation and interview on 6/8/26, at 6:34 a.m. licensed practical nurse (LPN)-A entered R6's room to start R6's enteral feeding. LPN-A donned gloves but failed to don a gown. LPN-A poured a small amount of water into a 60 cc syringe, opened the cap on R6's G-tube and attached the syringe. LPN-A attempted to allow the water to drain into the G-tube but had to manually milk the G-tube to get the water to go in. LPN-A primed the feeding tube with formula and attached the feeding to to R6's G-tube. LPN-A removed her gloves and used hand sanitizer on her hands and left R6's room to obtain a dressing. LPN-A returned to R6's room with a split 4x4 dressing. LPN-A put on gloves, leaned over R6 on the bed and placed the dressing on R6's abdomen, around the G-tube. LPN-A removed her gloves, secured the dressing with tape, used hand sanitizer on her hands and exited the room. LPN-A stated she always wore gloves when she worked with R6's G-tube but did not always put on a	F0880		07/08/2026

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F0880 SS = F	Continued from page 30 protective gown. LPN-A stated she had not received specific instruction for the use of EBP's related to R6's G-tube care. R6 did have an EBP cart outside of her room with instructions on top of the cart regarding what and when certain PPE was required. The instructions identified gown and gloves were required when providing G-tube care. LPN-A stated sometimes she put on a gown and other times she did not. There were no gowns in the cart and so she had not worn one, when gowns were in the PPE carts outside of resident rooms, she put them on. There were masks in R6's PPE cart, but she had not worn a mask. LPN-A did not understand the PPE setup and thought maybe the facility did want the staff to wear masks as well. When the facility had a resident on contact precautions, they had been given clear instructions on what PPE was needed but she did not remember getting any instructions on what PPE was required for G-tube care or for EBP. During interview on 6/8/26, at 10:38 a.m. the DON stated providing G-tube care would be one instance when EBP should be used. EBP should be on resident's plan of care when it was required to be used. The DON stated it was important for staff to put on a gown when indicated for direct care to prevent transmission of multidrug-resistant organisms (MDRO), protect other residents and to keep the staff uniform clean from splashes. R7: R7's annual Minimum Data Set (MDS) dated 4/5/26, identified R5 had severe cognitive impairment and diagnosis included obesity. R7 had an unstageable pressure ulcer and moisture associated skin damage (MASD). R7's care plan dated 5/22/26, lacked any guidance of use for enhanced barrier precautions (EBP). R7's wound assessment dated 6/8/26, identified the coccyx ulcer was stable and measured 1.5 centimeters (cm) x 0.3 cm x 0.3 cm deep. During observations on 6/8/26 at 7:46 a.m., there was an isolation cart outside of R7's room with a contact precaution sign for R7's roommate and did not address if R7 was on enhanced barrier precautions (EBP). The cart had gloves and masks in the first drawer, eye/face protection in second	F0880		07/08/2026

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F0880 SS = F	Continued from page 31 drawer, and the third drawer was empty. There were no gowns on the cart. On 6/8/26 at 9:19 a.m., NA-A stated they did not need to wear a gown or gloves when caring for R7, and they only needed to wear it for R7's roommate. NA-A then entered R7's room and proceeded to get R7 ready for the day. NA-A was not wearing a gown or gloves. During observation on 6/8/26 at 12:11 p.m., the isolation cart was removed from in front of R7's door. During an interview on 6/9/26 at 3:21 p.m., the DON stated R7 should have been on EBP due to chronic wounds. The DON stated she noticed it last Monday when she started working at the facility. The DON stated she need to have a meeting with the unit managers to discuss updating care plans, and Kardex (quick reference for providing care to a specific resident) related to use of EBP. If staff do not know about it, they will not follow precautions as expected. The facility's undated Enhanced Barrier Precautions policy identified EBP were used with resident with chronic wound and required the use of gown and gloves when performing high contact activities with the resident. These activities included dressing, bathing, transferring, providing hygiene, changing linens, assisting with toileting and changing briefs, residents with chronic wounds and for residents with indwelling medical devices.	F0880		07/08/2026
F0656 SS = E	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or	F0656	CMS Plan of Correction – F656 Develop/Implement Comprehensive Care Plan Completion Date: July 8th, 2026 Director of Nursing: Eliza Messerschmidt, RN, DNS-CT Administrator: Jason Carlson, LNHA Changes Implemented: July 1, 2026 1. Corrective Action for Residents Found to be Affected	07/08/2026

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F0656 SS = E	Continued from page 32 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 document review the facility failed to develop comprehensive, person-centered care plan to include enhanced barrier precautions (EBP) for 3 of 5 residents (R6, R7, R1) reviewed who were identified to be on EBP. Findings include: R6 R6's annual Minimum Data Set (MDS) dated 5/29/26, identified R6 had intact cognition and required moderate assistance with bathing. R6 had an	F0656	Continued from page 32 Residents identified during survey review, including residents requiring Enhanced Barrier Precautions (EBP) due to chronic wounds, indwelling devices, and G-tube utilization, were immediately reviewed by the interdisciplinary team. Care plans were updated to accurately reflect EBP requirements, including when gowns and gloves are required during high-contact resident care activities. Orders were entered for EBP for the affected residents. Resident R6 EBP sign updated to identify bed A. Care plan completed for EBP use while performing cares and accessing g-tube. Resident R7 EBP sign updated to identify bed A. Care plan was completed for EBP use while performing cares. R1 EBP sign updated to identify bed A. Care plan completed for EBP use while performing cares. Nursing staff were educated regarding the requirement that care plans accurately reflect resident-specific infection prevention interventions, physician orders, and identified care needs. Residents identified during survey review had care plans revised to include individualized EBP interventions and instructions for staff, orders were entered for EBP. 2. Identification of Other Residents with the Potential to be Affected All residents residing in the facility had the potential to be affected by the deficient practice. The Director of Nursing, Infection Preventionist, Clinical Manager, MDS Coordinator, and interdisciplinary team conducted a facility-wide audit of residents requiring Enhanced Barrier Precautions, transmission-based precautions, chronic wound management, indwelling devices, feeding tubes, and other infection prevention interventions. All resident care plans were reviewed to ensure care planning accurately reflected physician orders, assessed needs, infection prevention interventions, and current resident conditions. Any identified deficiencies were immediately corrected. 3. Systemic Changes Implemented Effective July 1, 2026, the facility implemented the	07/08/2026

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F0656 SS = E	Continued from page 33 abdominal feeding tube (G-tube). Diagnoses included Parkinson's disease, narcolepsy, anxiety, and dysphagia (difficulty swallowing). R6's care plan with review date 6/1/26, identified R8 was frequently incontinent of bladder. Approaches included for staff to provide peri care two times per day and as needed (PRN) when incontinent. R8's care plan also identified R8 has special treatment/procedures related to the presence of a G-tube. Approaches included to provide daily care and observance of R8's G-tube to ensure patency and usefulness. The care plan failed to include instructions for EBP related to when staff provided G-tube and/or personal cares. R6's undated Active Order Report reviewed 6/9/26, identified numerous medication orders, all with instruction to crush and administer the medication through her feeding tube. On 6/8/26, at 6:34 a.m. a plastic cart was observed outside of R6's room. The cart contained disposable gloves and masks. A sign on top of the cart identified R6 was on enhanced barrier precautions and directed staff to wear a gown and gloves when performing direct care, including G-tube care. During interview on 6/8/26, at 10:38 a.m. the director of nursing (DON) stated providing G-tube care would be one instance when EBP should be used. EBP should be on resident's plan of care when it was required to be used. The DON stated it was important for staff to put on a gown when indicated for direct care to prevent transmission of multidrug-resistant organisms (MDRO), protect other residents and to keep the staff uniform clean from splashes. The required use of EBP's should be care planned on the resident's plan of care because it did affect the resident's care. The DON thought it used to be on the resident's care plan as well as in the physician orders, but she had not gotten all resident's charts audited and so it may not be on every resident's chart as needed. R7 R7's annual Minimum Data Set (MDS) dated 4/5/26, identified R5 had severe cognitive impairment and diagnosis included obesity. R7 had an unstageable pressure ulcer and moisture associated skin damage (MASD). R7's wound assessment dated 6/8/26, identified the coccyx ulcer was stable and measured 1.5	F0656	Continued from page 33 following systemic corrective actions: • Completed a facility-wide audit of resident care plans requiring infection prevention interventions. • Revised care planning processes to ensure physician orders, infection prevention requirements, and resident-specific interventions are accurately reflected in care plans. • Educated licensed nurses, MDS staff, unit managers, and interdisciplinary team members regarding: - Comprehensive care plan requirements - Person-centered care planning - Enhanced Barrier Precautions requirements - Incorporation of physician orders into care plans - Timely care plan review and updates - Documentation expectations - Interdisciplinary care plan responsibilities • Implemented additional review of newly admitted residents and residents with significant changes to ensure care plans are updated timely. • Implemented leadership review of residents requiring Enhanced Barrier Precautions to verify care plans accurately reflect infection prevention interventions. • Education was initiated July 1, 2026, and will continue through orientation and annual competency validation. 4. Monitoring and Quality Assurance The Director of Nursing, MDS Coordinator, Infection Preventionist, Clinical Manager, or designee will conduct the following audits: Care Plan Audits • Five resident care plan audits weekly for four weeks.	07/08/2026

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F0656 SS = E	Continued from page 34 centimeters (cm) x 0.3 cm x 0.3 cm deep. R7's care plan dated 5/22/26, lacked any guidance of use for EBP. During observations on 6/8/26 at 7:46 a.m., there was an isolation cart outside of R7's room with a contact precaution sign for R7's roommate and did not address if R7 was on EBP. The cart had gloves and masks in the first drawer, eye/face protection in second drawer, and the third drawer was empty. There were no gowns on the cart. During an interview and observation on 6/8/26 at 9:19 a.m., nursing assistant (NA)-A stated they did not need to wear a gown or gloves when caring for R7, we only needed to wear that for R7's roommate. NA-A then entered R7's room and proceeded to get R7 ready for the day. NA-A was not wearing a gown or gloves. R1 R1’s quarterly MDS dated 4/30/26, identified R1 had moderate cognition and had an indwelling catheter. Diagnoses included renal insufficiency, urinary retention. R1’s care plan dated 5/22/26, included instructions to change catheter monthly, complete catheter care daily, and monitor for signs and symptoms of infection. The care plan failed to include instructions for EBP related to catheter. During observation on 6/9/26 at 7:23 a.m., a plastic cart was outside R1’s room. The cart contained disposable gowns and gloves, and a sign identifying R1 was on enhanced barrier precautions. The sign included instructions for staff to wear gowns and gloves when performing direct care, including catheter care. During interview on 6/10/26 at 5:16 p.m., DON stated EBP was used to prevent the spread of infections between staff/residents and helped to reduce the spread of multidrug-resistant organisms (MDRO’s) whether they are known, suspected or potential. The DON stated staff were expected to follow resident care plans and the facility policy regarding wearing PPE for EBP. The Enhanced Barrier Precautions policy, revised 3/28/24, identified the purpose was to decrease transmission of CDC-targeted and other epidemiologically important MDRO’s, and EBP	F0656	Continued from page 34 • Five resident care plan audits biweekly for an additional eight weeks. Enhanced Barrier Precaution Audits • Weekly audit of all residents requiring EBP for twelve weeks to verify care plans accurately reflect required interventions. Admission and Significant Change Audits • Weekly review of new admissions and significant change assessments for twelve weeks to ensure care plans are updated timely. QAPI Oversight • Audit findings will be reviewed monthly through the QAPI Committee. • Any identified concerns will result in immediate corrective action, re-education, increased monitoring, and follow-up auditing until sustained compliance is achieved. The facility alleges compliance on July 8th, 2026, when all corrective actions were completed and systems were established to ensure ongoing compliance with F656 Develop/Implement Comprehensive Care Plans.	07/08/2026

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F0656 SS = E	Continued from page 35 would be used for residents actively infected or colonized with CDC-targeted and other epidemiologically important MDRO's. Additionally, residents at risk for MDRO's, specifically those with an indwelling medical device and/or chronic wounds requiring a dressing would be required to use EBP. The Comprehensive Assessments and Care Planning policy revised 2/26/26, identified a comprehensive person-centered care assessment of the resident's condition was completed in order to develop consistent quality care that would attain or maintain the highest practicable physical, mental and psychological functioning possible.	F0656		07/08/2026
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.	F0550	CMS Plan of Correction – F550 Resident Rights/Dignity Completion Date: July 8th, 2026 Director of Nursing: Eliza Messerschmidt, RN, DNS-CT Administrator: Jason Carlson, LNHA Changes Implemented: July 1, 2026 1. Corrective Action for Residents Found to be Affected Resident R24 was immediately assessed by the interdisciplinary team following identification of the deficient practice. The resident's care plan, toileting program, transfer needs, incontinence management interventions, and dignity-related preferences were reviewed and revised as necessary. Staff involved received immediate education regarding resident rights, dignity, prompt response to resident requests, toileting assistance expectations, and person-centered care practices. Staff were instructed that residents are never to be encouraged to remain incontinent or be instructed to void in incontinence products when toileting assistance is requested and can be provided. Resident care assignments and staffing processes were reviewed to ensure resident care needs can be met timely and respectfully. 2. Identification of Other Residents with the Potential	07/08/2026

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F0550 SS = D	Continued from page 36 §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and record review, the facility failed to ensure dignified care was provided for 1 of 1 resident (R24) reviewed for dignity. Staff encouraged R24 to remain incontinent rather than assisting her to the toilet when requested, resulting in embarrassment, and loss of dignity. Findings include: R24's admission Minimum Data Set (MDS) dated 5/6/26, identified R24 had a mild cognitive impairment and had diagnoses that included non-traumatic spinal cord dysfunction, diabetes, and dementia. R24 was dependent on staff for toileting and transfers and was frequently incontinent with bowel and bladder. R24's Activities of Daily Living (ADLs) Functional/Rehabilitation Potential Care Area Assessment (CAA) dated 5/11/26, identified R24 was a recent admit from another care center and had diagnoses of dementia, depression, heart failure and asthma. R24 had clear speech and was understood and usually understood. R24 denied shortness of breath. R24 stated she had pain per medication administration record (MAR) review. R24 had a history of refusing medications per staff. R24 was frequently incontinent of bowel and bladder and had some moisture-associated skin damage (MASD) noted with ointment/cream to apply. R24 required assistance for transfers. Care area was triggered due to ADL review. R24 would be assisted per need and per request. R24 was to be encouraged to be as independent as able and observed for changes in her abilities. Peri care completed with incontinence episodes. R24's Urinary Incontinence and Indwelling Catheter Care Area Assessment dated 5/11/26, identified R24 required assistance for transfers. Care area was triggered due to prescribed medication, impaired mobility, health history and ADL review. She was to be observed for changes in her elimination pattern and peri care to be completed with incontinent episodes.	F0550	Continued from page 36 to be Affected All residents residing in the facility had the potential to be affected by the deficient practice. The Director of Nursing, Clinical Manager, Unit Managers, and interdisciplinary team conducted a facility-wide review of residents requiring assistance with toileting, transfers, incontinence care, and activities of daily living. Care plans, toileting programs, call light response practices, transfer assistance requirements, and dignity-related interventions were reviewed. Residents requiring extensive assistance, mechanical lift transfers, or frequent toileting assistance were specifically reviewed to ensure services were provided consistent with resident rights and dignity expectations. Any identified concerns were immediately addressed. 3. Systemic Changes Implemented Effective July 1, 2026, the facility implemented the following systemic corrective actions: • Educated all licensed nurses, nursing assistants, trained medication aides, agency staff, and ancillary personnel regarding: - Resident Rights and Dignity requirements - Person-centered care expectations - Timely response to resident requests - Toileting assistance expectations - Incontinence care practices - Respectful communication - Maintaining resident privacy and dignity - Call light response expectations - Resident choice and self-determination	07/08/2026

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F0550 SS = D	Continued from page 37 R24's care plan revised 5/27/26, identified the following: R24 was frequently incontinent of urine. Staff were directed to document incontinent episodes. Bladder assessment at least quarterly. Monthly 24-hour (hr) bladder/bowel record. Provide with appropriate incontinence products. R24 required an extensive partial assistance of one (PAO1) using a gait belt (GB) and a wheeled walker to transfer, wipe, adjust clothing and manage incontinence. R24 was to receive peri cares twice daily and as needed after any incontinent episode. Protective ointment to skin as needed. Observe for signs/symptoms of urinary tract infection (UTI): pain or burning with urination, fever, increased incontinence, cloudy/odorous urine in small amounts, increased confusion/lethargy. Encourage adequate fluids. R24 had self-deficit with the following activities of daily living: bathing, personal hygiene, ambulation, transferring, toileting, dressing, bed mobility, eating, ambulating and medication administration. Staff were directed R24 required assist of two (AO2) assistance with all transfers to and from bed, wheelchair and toilet. R24 used a full body mechanical lift. R24 could verbally ask for assistance with toileting. R24 required assistance from two to get R24's toileting needs addressed. R24 used the toilet for my current toileting needs and was both continent/incontinent. R24 was to be offered toileting every 3 hours to help R24 to remain free of skin breakdown and respect R24's dignity. During an observation on 6/7/26 at 11:30 a.m., R24 was lying in bed with her head of bed (HOB) at 30 degrees. R24 was wearing a dusky purple sweatshirt and no pants. There was a fleece blanket across the foot of R24's bed but it was not covering R24. R24 was wearing an incontinent brief with no pants and had her knees bent with her feet resting on the bed. R24 was crying and stated staff told R24 she had to stay in bed and couldn't get up. "I don't know why." R24 then stated, "they told me to pee my pants, and they'd clean me up here." R24 stated this happened "all the time". At that time, nursing assistant (NA)-B stepped into the room and told R24 NA-B needed to help another resident and would be back. NA-B turned off R24's call light and left the room. R24 continued to cry and stated nursing assistants said that and shut off R24's call light "just about every day" and "they say they're short". R24 sobbed and stated "I hate it here. It's awful. I hate peeing in my pants."	F0550	Continued from page 37 • Reinforced expectations that residents are never to be encouraged to remain incontinent due to staffing challenges or workload concerns. • Implemented leadership rounds to monitor resident dignity, call light response, and resident satisfaction. • Reviewed staffing assignments and workflows to improve timely response to resident care needs. • Implemented additional monitoring of residents requiring frequent toileting assistance and extensive transfer assistance. • Education was initiated July 1, 2026 and will continue through orientation and annual competency validation. 4. Monitoring and Quality Assurance The Director of Nursing, Clinical Manager, Unit Managers, or designee will conduct the following audits: Resident Dignity Audits • Five resident observations weekly for four weeks. • Five resident observations biweekly for an additional eight weeks. Call Light Response Audits • Weekly call light response observations for twelve weeks. Toileting and ADL Audits • Five resident care observations weekly for twelve weeks to evaluate timely toileting assistance and dignity during care. Resident Interview Audits • Five resident interviews weekly for twelve weeks regarding dignity, respect, and responsiveness of staff. QAPI Oversight	07/08/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245502	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/10/2026

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F0550 SS = D	Continued from page 38 At 12:10 p.m., NA-B entered R24's room and told R24 she was wet and needed to be cleaned up. While putting on gloves, NA-B told R24 she didn't need to cry because NA-B was there. NA-B proceeded to provide incontinent care. Afterwards, NA-A and NA-B transferred R24 into her wheelchair using the full body mechanical lift. During an interview on 6/7/26 at 12:28 p.m., NA-B stated the facility was working "short" that day. "You just do the best you can." NA-B stated R24 did get up into her chair for breakfast that morning, but staff laid R24 down to do incontinent care after breakfast. NA-B stated R24 was "encouraged" to stay in bed because NA-B had other residents to care for. R24 did turn on her call light and asked to get up, but R24 was assistance of 2 and NA-B was providing care to another resident. During an interview on 6/9/26 at 11:29 a.m., trained medication aide (TMA)-A stated R24 should never wait when she had to go to the bathroom because R24 would then be incontinent. R24 should never be encouraged to go to the bathroom in her pants because that's not what R24 or any resident deserved. Staff are expected to either request help from another staff member or to prioritize work to the best of their ability. During an interview on 6/9/26 at 11:42 a.m., NA-C stated R24 cannot wait when R24 asked to use the bathroom. When R24 turned on her call light, NA-C tried to get her to the bathroom right away because R24 would have an "accident." R24 or any other resident should never be told to go in their pants because of dignity. During an interview on 6/9/26 at 1:36 p.m., licensed practical nurse (LPN)-A stated a resident should never be told to just go in their pants because the residents have the right to receive their care. During an interview on 6/9/26 at 2:06 p.m., registered nurse (RN)-A stated a resident should never be told to be incontinent. It was a dignity issue as well as an ADL issue. "It's just wrong." During an interview on 6/9/26 at 2:49 p.m., the director of nursing (DON) stated staff were expected to provide care when requested and to ensure all residents are safe. Staff were also expected to never tell a resident to be incontinent because it was a dignity issue for the residents. The facility policy Activities of Daily Living (ADL)	F0550	Continued from page 38 • Audit findings will be reviewed monthly through the QAPI Committee. • Negative findings will result in immediate corrective action, additional education, increased monitoring, and follow-up auditing until sustained compliance is achieved. The facility alleges compliance on July 8th, 2026, when all corrective actions were completed and systems were established to ensure ongoing compliance with F550 Resident Rights and Dignity.	07/08/2026

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F0550 SS = D	Continued from page 39 dated 2021, identified staff were directed to provide residents with care, treatment and services appropriate to maintain or improve their ability to carry out activities of daily living (ADLs).	F0550		07/08/2026
F0585 SS = D	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system;	F0585	CMS Plan of Correction – F585 Grievances Completion Date: July 8th, 2026 Director of Nursing: Eliza Messerschmidt, RN, DNS-CT Administrator: Jason Carlson, LNHA Changes Implemented: July 1, 2026 1. Corrective Action for Residents Found to be Affected The grievance identified during survey review regarding a missing hearing aid was immediately reviewed by facility leadership. A comprehensive investigation was completed, documentation was reviewed, and follow-up communication was conducted with the resident and/or resident representative as appropriate. The facility reviewed grievance documentation requirements, investigation processes, communication expectations, and resolution procedures to ensure grievances are fully investigated, documented, resolved, and communicated in accordance with facility policy and regulatory requirements. Staff responsible for receiving, investigating, documenting, and resolving grievances received immediate education regarding grievance management requirements. 2. Identification of Other Residents with the Potential to be Affected All residents residing in the facility had the potential to be affected by the deficient practice. The Administrator, Director of Nursing, Social Services, and interdisciplinary team conducted a review of grievance documentation, investigations,	07/08/2026

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F0585 SS = D	Continued from page 40 (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations; (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to ensure a resident grievance regarding a missing hearing aid was fully investigated, documented, resolved, and communicated to the resident representative in accordance with facility	F0585	Continued from page 40 resolutions, and communication practices. A facility-wide audit of grievances submitted within the previous thirty days was conducted to ensure investigations, follow-up actions, communication, written responses, and documentation were completed according to facility policy. Any identified concerns were immediately corrected. 3. Systemic Changes Implemented Effective July 1, 2026, the facility implemented the following systemic corrective actions: • Reviewed and reinforced the facility grievance policy and procedures. • Educated leadership staff, department managers, social services personnel, licensed nurses, and other designated grievance officials regarding: - Resident rights related to grievances - Grievance investigation requirements - Documentation expectations - Timely communication with complainants - Written grievance response requirements - Tracking and follow-up processes - Regulatory requirements related to F585 • Reinforce use of the Benedictine centralized grievance tracking log to monitor receipt, investigation, follow-up, communication, resolution, and closure of all grievances. • Implemented leadership review of all open grievances at least weekly until resolution. • Established oversight processes to ensure complainants receive timely updates regarding grievance status and outcomes. • Education was initiated July 1, 2026 and will continue during orientation and annual competency validation as applicable. 4. Monitoring and Quality Assurance	07/08/2026

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F0585 SS = D	Continued from page 41 policy for 1 of 1 resident (R5) reviewed for grievances. Findings include: R5's Customer Concern/Grievance dated 5/20/26, identified family member (FM)-A reported R5's hearing aid was missing. The facility documented an initial search of the room, bedding, and laundry; however, no further investigation, follow-up, or resolution was documented. R5's progress notes from 5/20/26 through 6/6/26 contained no documentation regarding the missing hearing aid or grievance follow-up. During an interview on 6/9/26 at 2:33 p.m., the social services designee (SSD) acknowledged receiving the grievance but stated it had been assigned to another person and no outcome had been communicated. During an interview on 6/9/26 at 3:48 p.m., FM-A reported she had not received any updates or information regarding the grievance after filing the concern. During an interview on 6/9/26 at 4:43 p.m., the director of nursing (DON) confirmed there was no documented follow-up and stated the expectation was that grievances would be resolved within five days and the complainant updated on progress and outcome. The facility's Concerns and Grievances policy required investigation, resolution, communication with the complainant within five business days, ongoing updates when resolution was delayed, and documentation of actions taken.	F0585	Continued from page 41 The Administrator, Director of Nursing, Social Services Designee, or designee will conduct the following audits: Grievance Audits • Audit 100% of grievances weekly for four weeks. • Audit 100% of grievances biweekly for an additional eight weeks. Documentation Audits • Weekly review of grievance investigations, communication records, and written responses for twelve weeks. Leadership Review • Weekly review of all open grievances until closure. Resident/Family Follow-Up Audits • Weekly verification of resident or representative communication regarding grievance outcomes for twelve weeks. QAPI Oversight • Audit findings will be reviewed monthly through the QAPI Committee. • Negative findings will result in immediate corrective action, re-education, increased monitoring, and follow-up auditing until sustained compliance is achieved. The facility alleges compliance on July 8th, 2026, when all corrective actions were completed and systems were established to ensure ongoing compliance with F585 Grievances.	07/08/2026
F0605 SS = D	Right to be Free from Chemical Restraints CFR(s): 483.10(e)(1),483.12(a)(2),483.45(c)(3)(d)(e) §483.10(e) Respect and Dignity.	F0605	CMS Plan of Correction – F605 Right to be Free from Chemical Restraints Completion Date: July 8th, 2026	07/08/2026

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F0605 SS = D	Continued from page 42 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 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	F0605	Continued from page 42 Director of Nursing: Eliza Messerschmidt, RN, DNS-CT Administrator: Jason Carlson, LNHA Changes Implemented: July 1, 2026 1. Corrective Action for Residents Found to be Affected The resident identified during survey review (R8) was immediately reviewed by the attending provider, hospice provider, consultant pharmacist, Director of Nursing, and interdisciplinary team. The resident's psychotropic medication regimen, PRN antipsychotic order, physician documentation, pharmacist recommendations, and behavioral documentation were reviewed. The facility ensured the resident's PRN psychotropic medication orders were reviewed for regulatory compliance, clinical indication, duration limits, physician evaluation requirements, and documentation standards. Any identified concerns were immediately addressed and corrected. Licensed nursing staff received immediate education regarding psychotropic medication requirements, PRN psychotropic limitations, physician review requirements, consultant pharmacist recommendations, and documentation expectations. 2. Identification of Other Residents with the Potential to be Affected All residents receiving psychotropic medications had the potential to be affected by the deficient practice. The Director of Nursing, Medical Director, Consultant Pharmacist, Clinical Manager, and interdisciplinary team completed a facility-wide audit of all residents receiving psychotropic medications, including antipsychotics, antidepressants, anxiolytics, hypnotics, and PRN psychotropic medications. The audit included review of physician documentation, behavioral monitoring, gradual dose reduction requirements, pharmacist recommendations, PRN review requirements,	07/08/2026

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F0605 SS = D	Continued from page 43 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 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.	F0605	Continued from page 43 physician evaluations, and medication effectiveness documentation. Any identified concerns were immediately corrected. 3. Systemic Changes Implemented Effective July 1, 2026, the facility implemented the following systemic corrective actions: • Completed a facility-wide review of all psychotropic medications and PRN psychotropic orders. • Implemented a psychotropic medication tracking process to monitor review dates, physician evaluations, pharmacist recommendations, and required follow-up. • Educated licensed nurses, providers, department managers, and interdisciplinary team members regarding: - F605 requirements - PRN psychotropic medication limitations - Fourteen-day review requirements - Physician evaluation requirements - Consultant pharmacist recommendation follow-up - Behavioral monitoring and documentation - Gradual dose reduction requirements - Chemical restraint regulations • Implemented monthly psychotropic medication review meetings. • Implemented enhanced pharmacy recommendation tracking to ensure physician responses and facility follow-up are completed timely. • Education was initiated July 1, 2026 and will continue through orientation and annual competency validation. 4. Monitoring and Quality Assurance The Director of Nursing, Clinical Manager, Consultant	07/08/2026

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F0605 SS = D	Continued from page 44 §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to review and justify continued use of an as needed (PRN) psychotropic medication for 1 of 5 residents (R8) who were reviewed for unnecessary medications. Findings include: R8's quarterly Minimum Data Set dated 6/9/26, identified R8 had moderate cognitive deficit and required moderate assistance with most activities of daily living (ADLs). R8 had not exhibited any behavior during the observation period and did not have hallucinations or delusions. R8 received antianxiety and antidepressant medications during the observation period. Diagnoses included congestive heart failure, dementia, diabetes, and depression. R8's undated Active Physician Orders, identified numerous medication orders for R8, which included haloperidol (antipsychotic) 1 milligram (MG) for agitation and restlessness every four hours PRN with start date 3/1/26 and end date was listed as open ended. R8's care plan dated 3/23/26, identified R8 was under hospice care for end-of-life status due to heart failure. Approaches included to follow the hospice plan of care, communicate with hospice physician and nurses to discuss medication concerns and what was effective. Hospice services with standing orders, scheduled and as needed (PRN) medications for pain, shortness of breath, restlessness and secretions. The care plan identified R8 received psychotropic medications for depression and anxiety with a goal to not experience any adverse reactions. Approaches listed included to administer medications as ordered. Administer the antianxiety medication for increased anxiety and restless. Staff were to document three interventions trialed before administering the PRN medication. MD review per guidelines for a gradual dose reduction and monthly pharmacist review. R8's Consultant Pharmacist Recommendation to Physician reports identified the following: 3/9/26, identified the pharmacist recommended to discontinue the PRN use of Haldol 1 mg every four hours PRN for anxiety/agitation on or before 3/14/26, following federal guidelines that PNR orders for anti-psychotic drugs were limited to fourteen days and could not be renewed unless the attending physician evaluated the resident for the	F0605	Continued from page 44 Pharmacist, or designee will conduct the following audits: Psychotropic Medication Audits • Audit 100% of residents receiving PRN psychotropic medications weekly for four weeks. • Audit 100% of residents receiving PRN psychotropic medications biweekly for an additional eight weeks. Pharmacy Recommendation Audits • Weekly review of consultant pharmacist recommendations for twelve weeks. Behavioral Documentation Audits • Five psychotropic medication documentation audits weekly for twelve weeks. Physician Review Audits • Weekly verification of required physician reviews and evaluations for twelve weeks. QAPI Oversight • Audit findings will be reviewed monthly through the QAPI Committee. • Negative findings will result in immediate corrective action, additional education, increased monitoring, and follow-up auditing until sustained compliance is achieved. The facility alleges compliance on July 8th, 2026, when all corrective actions were completed and systems were established to ensure ongoing compliance with F605 Right to be Free from Chemical Restraints.	07/08/2026

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F0605 SS = D	Continued from page 45 appropriateness of the renewal. R8's physician commented that R8 was a hospice patient and signed the recommendation with no further response or action on 3/24/26. 4/3/26, identified the pharmacist recommended to discontinue the PRN use of Haldol 1 mg every four hours PRN for anxiety/agitation on or before 3/14/26, following federal guidelines that PNR orders for anti-psychotic drugs were limited to fourteen days and could not be renewed unless the attending physician evaluated the resident for the appropriateness of the renewal. No physician response was documented. R8's PRN Medication Administration Record (MAR) dated 5/1/26 to 5/31/26, identified an order for Haldol 1 mg every four hours PRN for agitation and restless. start date of 3/1/26 and open-ended end date. The MAR documented the medication had been administered to R8 on 5/19/26 and 5/26/26. R8's medical record lacked evidence a face-to-face visit was performed by a medical provider and identified the justification for continued used of the antipsychotic. During observation on 6/7/26, R8 was noted be hollering she had to use the bathroom from her room. An unidentified nursing assistant (NA) assisted the resident to use the bathroom and then assisted her into a recliner in the facility's commons area. R8 closed her eyes and went to sleep. The NA stated R8 was tired as she had been up till 3:00 a.m. the night before. During interview on 6/8/26, at 1:23 p.m. licensed practical nurse (LPN)-A stated R8 had a PRN Haldol ordered that was used once in a while. The medication made R8 sleepy, so LPN-A did not typically give her the medication during the day. R8 was diabetic and LPN-A wanted to be sure R8 was alert enough to eat her meals. If R8 was sleepy she would not eat. The PRN Haldol order came from hospice, so hospice would be the ones to review the order. LPN-A knew a pharmacist also came once in a while and reviewed resident medications. LPN-A did know PRN anti-psychotic medications were limited to a specific time, and she had asked the hospice nurse about that, however, she did not get any results. During interview on 6/9/26, at 10:27 a.m. the director of nursing (DON) stated all PRN psychotropic medications should have a fourteen-day review. She had thought the regulation had changed for hospice patients, and it could go longer than fourteen days, but she always had them reviewed every fourteen days. The facility's process was to have hospice follow their patient's medications and notify the facility if there was any need for review or update. The facility's	F0605		07/08/2026

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F0605 SS = D	Continued from page 46 consultant's pharmacist was telephoned on 6/9/26, at 5:56 p.m. and message left to return call. During telephone interview on 6/10/26, at 9:29 a.m. the facility's consultant pharmacist (CP)-G stated he only reviewed medications for the facility for new admissions or hospital returns and was not the pharmacist that had done the monthly medication reviews for R8. CP-G stated it was his understanding the Center for Medicaid and Medicare (CMS) guidelines were that any PRN antipsychotic medication needed to be addressed by the physician The medication needed to be limited to fourteen days and re-evaluated by the provider. If the provider chose to continue the PRN antipsychotic medication, it would need to be evaluated with a face-to-face visit from the provider. CP-G stated hospice was not an exception. The facility's policy Psychotropic Medication Use with review date 9/7/23, identified PRN orders for psychotropic drugs were limited to fourteen days and could not be renewed unless the attending provider evaluated the resident for the appropriateness of the medication.	F0605		07/08/2026
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 activities of daily living (ADL) care and services necessary to maintain residents' abilities by failing to provide timely toileting assistance for 1 of 6 residents (R24) reviewed who required staff assistance with toileting and transfers; and failed to provide timely supervision and assistance with eating for 1 of 6 residents (R23) reviewed who required staff assistance during meals. Findings include: R24: R24’s admission Minimum Data Set (MDS) dated 5/6/26, identified R24 had mild cognitive impairment and was dependent on staff for toileting and transfers and was frequently incontinent with bowel and bladder. Diagnoses included non-traumatic spinal cord dysfunction, diabetes, and dementia.	F0677	CMS Plan of Correction – F677 ADL Care Provided for Dependent Residents Completion Date: July 8th, 2026 Director of Nursing: Eliza Messerschmidt, RN, DNS-CT Administrator: Jason Carlson, LNHA Changes Implemented: July 1, 2026 1. Corrective Action for Residents Found to be Affected Residents identified during survey review (R24 and R23) were immediately assessed by the interdisciplinary team. Care plans, ADL assistance needs, toileting schedules, transfer requirements, dining assistance needs, and staffing assignments were reviewed and updated as indicated. Staff involved received immediate education regarding timely toileting assistance, prompt response to resident requests, resident dignity, transfer assistance requirements, dining supervision, and meal assistance expectations.	07/08/2026

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F0677 SS = D	Continued from page 47 R24's Activities of Daily Living (ADLs) Functional/Rehabilitation Potential Care Area Assessment (CAA) dated 5/11/26, identified R24 was a recent admit from another care center and had diagnoses of dementia, depression, heart failure and asthma. R24 had clear speech and was understood and usually understood. R24 denied shortness of breath. R24 stated she had pain per medication administration record (MAR) review. R24 had a history of refusing medications per staff. R24 was frequently incontinent of bowel and bladder and had some moisture-associated skin damage (MASD) noted with ointment/cream to apply. R24 required assistance for transfers. Care area was triggered due to ADL review. R24 would be assisted per need and per request. R24 was to be encouraged to be as independent as able and observed for changes in her abilities. Peri care completed with incontinence episodes. R24's Urinary Incontinence and Indwelling Catheter Care Area Assessment dated 5/11/26, identified R24 required assistance for transfers. Care area was triggered due to prescribed medication, impaired mobility, health history and ADL review. She was to be observed for changes in her elimination pattern and peri care to be completed with incontinent episodes. R24's care plan revised 5/27/26, identified the following: R24 was frequently incontinent of urine. Staff were directed to document incontinent episodes. Bladder assessment at least quarterly. Monthly 24-hour (hr) bladder/bowel record. Provide with appropriate incontinence products. R24 required an extensive partial assistance of one (PAO1) using a gait belt (GB) and a wheeled walker to transfer, wipe, adjust clothing and manage incontinence. R24 was to receive peri cares twice daily and as needed after any incontinent episode. Protective ointment to skin as needed. Observe for signs/symptoms of urinary tract infection (UTI): pain or burning with urination, fever, increased incontinence, cloudy/odorous urine in small amounts, increased confusion/lethargy. Encourage adequate fluids. R24 had self-deficit with the following activities of daily living: bathing, personal hygiene, ambulation, transferring, toileting, dressing, bed mobility, eating, ambulating and medication administration. Staff were directed R24 required assist of two (AO2) assistance with all transfers to and from bed, wheelchair and	F0677	Continued from page 47 Resident care assignments were reviewed to ensure residents requiring extensive assistance with ADLs, toileting, transfers, and dining receive services in a timely manner consistent with assessed needs and care plans. 2. Identification of Other Residents with the Potential to be Affected All residents residing in the facility had the potential to be affected by the deficient practice. The Director of Nursing, Clinical Manager, Unit Managers, Dietary Manager, and interdisciplinary team completed a facility-wide review of residents requiring assistance with activities of daily living, toileting, transfers, eating, grooming, and personal hygiene. Residents requiring extensive assistance, mechanical lift transfers, scheduled toileting programs, dining assistance, or supervision during meals were specifically reviewed to ensure services were provided according to resident needs, physician orders, and care plans. Any identified concerns were immediately corrected. 3. Systemic Changes Implemented Effective July 1, 2026, the facility implemented the following systemic corrective actions: • Educated licensed nurses, nursing assistants, trained medication aides, agency staff, and ancillary personnel regarding: - F677 requirements - Timely toileting assistance - Dining assistance expectations - ADL care requirements - Resident dignity during care - Prompt response to resident requests - Transfer assistance requirements - Resident-centered care practices	07/08/2026

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F0677 SS = D	Continued from page 48 toilet. R24 used a full body mechanical lift. R24 could verbally ask for assistance with toileting. R24 required assistance from two to get R24's toileting needs addressed. R24 used the toilet for my current toileting needs and was both continent/incontinent. R24 was to be offered toileting every three hours to help R24 to remain free of skin breakdown and respect R24's dignity. During an observation on 6/7/26 at 11:30 a.m., R24 was lying in bed with her head of bed (HOB) at 30 degrees. R24 was wearing a dusky purple sweatshirt and no pants. There was a fleece blanket across the foot of R24's bed but it was not covering R24. R24 was wearing an incontinent brief with no pants and had her knees bent with her feet resting on the bed. R24 was crying and stated staff told R24 she had to stay in bed and couldn't get up. "I don't know why." R24 then stated, "they told me to pee my pants, and they'd clean me up here." R24 stated this happened "all the time". At that time, nursing assistant (NA)-B stepped into the room and told R24 NA-B needed to help another resident and would be back. NA-B turned off R24's call light and left the room. R24 continued to cry and stated nursing assistants said that and shut off R24's call light "just about every day" and "they say they're short". R24 sobbed and stated "I hate it here. It's awful. I hate peeing in my pants." At 12:10 p.m., NA-B entered R24's room and told R24 she was wet, so she needed to be cleaned up. NA-B put on gloves then told R24 she didn't need to cry because she was there. R24 stated "I want to get up". At 12:11 p.m. NA-B unfastened R24's incontinent brief and used disposable wipes to clean R24's skin of feces and urine. R24 stated that her skin was itchy, NA-B told R24 that R24 had "pooped" and NA-B would clean R24's skin well. At 12:13 p.m., NA-B rolled R24 to the right and R24 began crying and stated, "I can't do this". NA-B told R24 that they were almost done. R24's skin on her upper thighs and buttocks was reddened but had no open areas. NA-B applied barrier cream then a clean brief.	F0677	Continued from page 48 - Call light response expectations • Implemented enhanced leadership rounds to monitor resident care delivery. • Reviewed staffing assignments to improve coverage for residents requiring extensive ADL assistance. • Implemented monitoring of dining room staffing and meal assistance processes. • Reinforced expectations that residents requesting toileting assistance will receive timely assistance to prevent incontinence episodes and preserve dignity. • Continued agency staffing utilization as needed to ensure adequate staffing resources are available. • Education was initiated July 1, 2026 and will continue through orientation and annual competency validation. 4. Monitoring and Quality Assurance The Director of Nursing, Clinical Manager, Unit Managers, or designee will conduct the following audits: ADL Care Audits • Five resident observations weekly for four weeks. • Five resident observations biweekly for an additional eight weeks. Toileting Assistance Audits • Five toileting assistance observations weekly for twelve weeks. Dining Assistance Audits • Observation of at least two meal services weekly for twelve weeks. Transfer Assistance Audits • Five transfer observations weekly for twelve	07/08/2026

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F0677 SS = D	Continued from page 49 At 12:16 p.m., NA-B put on R24's pants. NA-B then removed her gloves and removed the trash from the trash containers and asked for assistance with R24's transfer over the walkie. NA-B exited the room. At 12:19 p.m., NA-B returned with a full body mechanical lift sling and placed it under R24. NA-B told R24 that she needed another staff person to assist with the transfer and left the room. At 12:22 p.m., NA-A and NA-B entered the room and used the ceiling lift to transfer R24 from her bed to her wheelchair. NA-B then brought R24 to the dining room for her noon meal. During an interview on 6/7/26 at 12:28 p.m., NA-B stated the facility was working "short" that day. "You just do the best you can." NA-B stated R24 did get up into her chair for breakfast that morning, but staff laid R24 down to do incontinent care after breakfast. NA-B stated R24 was "encouraged" to stay in bed because NA-B had other residents to care for. R24 did turn on her call light and asked to get up, but R24 was assistance of 2 and NA-B was providing care to another resident. During an interview on 6/9/26 at 11:29 a.m., trained medication aide (TMA)-A stated R24 should never wait when she had to go to the bathroom because R24 would then be incontinent and R24 deserved to receive the care she needed. Staff were expected to either request help from another staff member or to prioritize work to the best of their ability. During an interview on 6/9/26 at 11:42 a.m., NA-C stated R24 cannot wait when R24 asked to use the bathroom. When R24 turned on her call light, NA-C tried to get her to the bathroom right away because R24 would have an "accident." During an interview on 6/9/26 at 1:36 p.m., licensed practical nurse (LPN)-A stated staff were expected to provide timely toileting assistance to prevent incontinence and skin breakdown. During an interview on 6/9/26 at 2:06 p.m., registered nurse (RN)-A stated a resident should be provided with timely toileting assistance to prevent incontinence and skin breakdown. During an interview on 6/9/26 at 2:49 p.m., the director of nursing (DON) stated staff were expected	F0677	Continued from page 49 weeks. Resident Interview Audits • Five resident interviews weekly regarding responsiveness of staff and timeliness of care. QAPI Oversight • Audit findings will be reviewed monthly through the QAPI Committee. • Negative findings will result in immediate corrective action, additional education, increased monitoring, and follow-up auditing until sustained compliance is achieved. The facility alleges compliance on July 8th, 2026, when all corrective actions were completed and systems were established to ensure ongoing compliance with F677 ADL Care Provided for Dependent Residents.	07/08/2026

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F0677 SS = D	Continued from page 50 to provide care when requested and to ensure all residents were safe. R23: R23's quarterly MDS dated 5/8/26, identified R23 was cognitively intact and independent with eating. R23 had diagnoses of obesity and mass/lump on abdomen. The MDS did not identify any a significant weight loss or gain. R23's mini nutritional assessment dated 5/9/26, identified R23 normally ate 51-75% of most meals. R23 was assisted with meals for optimal intake. R23's care plan dated 5/26/26 identified R23 was independent with eating. During observations on 6/7/26 at 1:04 p.m., there was not enough staff in the dining room to assist residents with eating. A t 1:05 p.m., there were at least 2 residents who were sitting there with food in front of them and were not eating nor was staff helping them. A t 1:09 p.m., R23 was identified as one of the residents sitting at the table where staff are supposed to assist residents with eating. At 1:12 p.m., R23 still had her plate of food in front of her, and she had not attempted to eat. R23's potatoes and meat had formed a crust on them. R23 waited 45 minutes before staff assisted her to eat. At 1:15 p.m., R23 ate well with staff assistance. During an interview on 6/9/26 at 7:36 a.m., nursing assistant (NA)-D stated R23 needed to be supervised while eating. R23 ate slowly and it would take her a while to eat, and we encourage her at that time. When R23 stopped using the silverware while eating, staff assisted R23. During an interview on 6/9/26 at 2:02 p.m., NA-A	F0677		07/08/2026

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F0677 SS = D	Continued from page 51 stated R23 had changed over the weekend, previously she just required supervision with eating. R23 had seemed to decline and had started to pocket food and had moved to a different table to assist with eating because R23 needed more help with meals. During lunch on Sunday 6/7/26, the facility was short staffed and the residents in the dining room had to wait for assistance to eat and some had to wait an extended period of time before they received help. During an interview on 6/9/26 at 4:43 p.m., the director of nursing (DON) stated residents who required supervision with eating would be watched and if the residents had stopped eating or had not started for about five minutes staff are expected to cue residents to continue to eat. If after ten minutes staff should approach resident and assist with eating. I would be expected if R23 was not eating it would be realized quickly and assisted in a timely fashion. It is not dignified to sit there with a plate of food in front of you and not being able to eat it. Staff should wait until someone is available to assist with eating before bringing out the plate. The facility policy Activities of Daily Living (ADL) dated 2021, identified staff were directed to provide residents with care, treatment and services appropriate to maintain or improve their ability to carry out activities of daily living (ADLs).	F0677		07/08/2026
F0686 SS = D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing.	F0686	CMS Plan of Correction – F686 Treatment/Services to Prevent and Heal Pressure Ulcers Completion Date: July 8th, 2026 Director of Nursing: Eliza Messerschmidt, RN, DNS-CT Administrator: Jason Carlson, LNHA Changes Implemented: July 1, 2026 1. Corrective Action for Residents Found to be Affected The resident identified during survey review (R5) was immediately assessed by the wound care team, Director of Nursing, Infection Preventionist, and attending provider. Wound treatment orders, infection prevention interventions, dressing change	07/08/2026

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F0686 SS = D	Continued from page 52 This REQUIREMENT is NOT MET as evidenced by: During observation, interview, and document review, the facility failed to perform hand hygiene between glove changes during pressure ulcer wound care for 1 of 2 residents (R5) reviewed for pressure ulcers, creating the potential for contamination of pressure ulcer wounds and development of infection. Findings include: R5's admission Minimum Data Set (MDS) dated 5/5/26, identified R5 was cognitively intact. R5 was substantial/maximal assist with transfers, and supervision with bed mobility. R5's diagnosis includes fracture of thoracic (mid back) vertebrae, muscle weakness, and amputation of right lower leg. It identified the resident was at risk for pressure ulcers but did not have one. R5's pressure ulcer/injury Care Area Assessment (CAA) dated 5/8/26, identified R5 was at risk for pressure ulcers due to recent injury with a fracture of thoracic vertebra. Plan of care updated for prevention of pressure related skin impairments. R5's provider's orders identified the following: 6/1/26, identified for left heel, cleanse heel gently with saline wipe. Pat dry. place a Mepilex (a specialized silicone foam dressing). over the area. 6/8/26, identified to cleanse the right buttock with saline wipes and pat dry, then pack with Aquacel AG (an advanced antimicrobial primary wound dressing) and cover with a sacral Mepilex. In gluteal crease (between the buttocks) cleanse wound with saline wipes and cover with a 4-inch by 4-inch Mepilex. R5's wound assessment dated 6/8/26, identified they had a pressure ulcer on right upper buttock. The wound measured 5 centimeters (cm) wide x 6.5 cm long x 2 cm deep. The wound was odorous, and heavy drainage of purulent dark brown drainage which saturated the dressings. R5 also had an unstageable pressure ulcer on their coccyx measuring 2.2 cm x 2.8 and identified scab was completely attached. R5 also had a deep tissue injury on his left heel with drained blister and intact epidermal (skin) layer in place which measured 4 cm x 5 cm. The resident was seen the previous week and had wound debrided and had not much change and ordered a follow up appt for wound debridement. During observation on 6/9/26 at 8:08 a.m., licensed practical nurse (LPN)-A gathered the supplies she would need and asked nursing	F0686	Continued from page 52 procedures, and skin integrity monitoring processes were reviewed. The licensed nurse involved received immediate education regarding hand hygiene requirements, glove changes, wound care infection prevention standards, standard precautions, and proper dressing change technique. Immediate observation and competency validation of wound care procedures were completed. The facility reviewed all current residents receiving wound treatments to ensure wound care procedures were completed according to professional standards of practice and infection prevention requirements. 2. Identification of Other Residents with the Potential to be Affected All residents receiving wound care services had the potential to be affected by the deficient practice. The Director of Nursing, Infection Preventionist, Wound Nurse, and Clinical Manager completed a facility-wide audit of residents receiving wound treatments, skin treatments, dressing changes, pressure ulcer care, and other invasive treatment procedures. The audit included review of wound treatment orders, dressing change practices, infection prevention interventions, hand hygiene compliance, wound documentation, and treatment records. Any identified concerns were immediately corrected. 3. Systemic Changes Implemented Effective July 1, 2026, the facility implemented the following systemic corrective actions: • Educated licensed nurses, agency nurses, and treatment nurses regarding: - F686 requirements - Hand hygiene standards - Glove change requirements	07/08/2026

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F0686 SS = D	Continued from page 53 assistant (NA)-A to help position R5. LPN-A and NA-A both sanitized hands and then put on personal protective equipment (PPE) for wound dressing change. Once in the room they positioned R5, and NA-A helped to stabilize him. LPN-A placed a barrier down and then proceeded to remove the old dressing. The dressing was saturated with purulent dark brown drainage and was very odorous. The wound bed was full of slough (dead, non-viable tissue that accumulated on the surface of the wound bed). The gluteal fold dressing was also removed due to starting to come off. Once the dressings were removed, LPN-A removed the dirty gloves and did not do hand hygiene and then placed another pair of gloves on. LPN-A then proceeded to clean both wounds using saline spray and wipes. LPN-A then removed her dirty gloves and did not perform hand hygiene before putting a pair of new gloves on. LPN-A opened the Aquacel AG and placed it in the wound bed then opened the sacral Mepilex on the wound on the right buttock and then placed a 4-inch x 4-inch Mepilex in gluteal crease. LPN-A then started to clean up and when completed she removed her gloves then seen the left heel dressing was coming off. Without doing hand hygiene LPN-A placed a pair of gloves on and then removed the old dressing. There was no drainage or odor coming from wound and it was covered with a layer of old skin. LPN-A removed gloves and put a different pair on without doing hand hygiene and then, then proceeded to clean the heel with saline wipes. Then changed gloves again without doing hand hygiene and placed the 4-inch x 4-inch Mepilex dressing on R5's heel. Upon completing the dressing changes, she washed her hands with soap and water and then removed her gown and sanitized her hands on exiting the room. During an interview on 6/9/26 at 8:51 a.m., LPN-A stated she washed her hands prior to starting and once the dressing change was done. She did not think to do hand hygiene when changing gloves. During an interview on 6/9/26 at 8:51 a.m., the director of nursing (DON) stated nurses were to follow wound procedures when doing dressing changes. That would include hand hygiene each time gloves were changed. Hand hygiene was done to ensure the wound does not become decontaminated when placing clean dressings. The facility's Contact Precautions policy dated 9/2023, identified hand hygiene is performed between glove changes and when removing gloves. A policy regarding pressure ulcers was requested,	F0686	Continued from page 53 - Wound care infection prevention practices - Standard precautions - Treatment procedure expectations - Pressure ulcer prevention and treatment requirements - Professional standards of nursing practice • Implemented wound care competency validation for licensed nursing staff. • Reinforced hand hygiene requirements between glove changes and during treatment procedures. • Implemented enhanced treatment observation rounds by nursing leadership. • Reviewed and reinforced infection prevention policies related to wound care and treatment procedures. • Education was initiated July 1, 2026 and will continue through orientation and annual competency validation. • Weekly skin and wound meetings were implemented to review wound progression, treatment compliance, infection prevention practices, and documentation requirements. 4. Monitoring and Quality Assurance The Director of Nursing, Infection Preventionist, Wound Nurse, or designee will conduct the following audits: Treatment Observation Audits • Five wound care observations weekly for four weeks. • Five wound care observations biweekly for an additional eight weeks. Hand Hygiene Audits • Ten hand hygiene observations weekly during treatment procedures for twelve weeks.	07/08/2026

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F0686 SS = D	Continued from page 54 but one was not received.	F0686	Continued from page 54 Wound Documentation Audits • Five wound treatment record audits weekly for twelve weeks. Competency Validation Audits • Verification of wound care competency validation for all licensed nursing staff. QAPI Oversight • Audit findings will be reviewed monthly through the QAPI Committee. • Negative findings will result in immediate corrective action, additional education, increased monitoring, and follow-up auditing until sustained compliance is achieved. The facility alleges compliance on July 8th, 2026, when all corrective actions were completed and systems were established to ensure ongoing compliance with F686 Treatment/Services to Prevent and Heal Pressure Ulcers.	07/08/2026
F0689 SS = D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to ensure transfers were performed in accordance with assessed needs, care plan interventions, and facility policy for 1 of 3 residents (R24) reviewed for accidents. Staff performed transfers using a full-body mechanical lift with one staff member rather than the required two staff	F0689	CMS Plan of Correction – F689 Free of Accident Hazards/Supervision/Devices Completion Date: July 8th, 2026 Director of Nursing: Eliza Messerschmidt, RN, DNS-CT Administrator: Jason Carlson, LNHA Changes Implemented: July 1, 2026 1. Corrective Action for Residents Found to be Affected Resident R24 was immediately assessed by the interdisciplinary team following identification of the deficient practice. The resident's transfer status, care plan interventions, mechanical lift requirements, safety precautions, and staffing assignments were reviewed.	07/08/2026

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F0689 SS = D	Continued from page 55 members, creating the potential for falls, entrapment, and transfer-related injury. Findings include: R24's admission Minimum Data Set (MDS) dated 5/6/26, identified R24 had a mild cognitive impairment and had diagnoses that included non-traumatic spinal cord dysfunction, diabetes, and dementia. R24 was dependent on staff for toileting and transfers and was frequently incontinent with bowel and bladder. R24's Activities of Daily Living (ADLs) Functional/Rehabilitation Potential Care Area Assessment (CAA) dated 5/11/26, identified R24 was a recent admit from another care center and had diagnoses of dementia, depression, heart failure and asthma. R24 had clear speech and was understood and usually understood. R24 denied shortness of breath. R24 stated she had pain per medication administration record (MAR) review. R24 had a history of refusing medications per staff. R24 was frequently incontinent of bowel and bladder and had some moisture-associated skin damage (MASD) noted with ointment/cream to apply. R24 required assistance for transfers. Care area was triggered due to ADL review. R24 would be assisted per need and per request. R24 was to be encouraged to be as independent as able and observed for changes in her abilities. Peri care completed with incontinence episodes. R24's Urinary Incontinence and Indwelling Catheter Care Area Assessment dated 5/11/26, identified R24 required assistance for transfers. Care area was triggered due to prescribed medication, impaired mobility, health history and ADL review. She was to be observed for changes in her elimination pattern and peri care to be completed with incontinent episodes. R24's care plan revised 5/27/26, identified R24 had self-deficit with transferring. Staff were directed to provide assistance with two staff with all transfers to and from bed, wheelchair and toilet. R24 used a full body mechanical lift. During an interview on 6/9/26 at 11:29 a.m., trained medication aide (TMA)-A stated staffing was awful. The facility used a lot of agency staff and the schedule frequently got "messed up" which added to the problem. Staff did the best they could with what they had. TMA-A tried her hardest when they had to work short to prioritize work and to help the nursing assistants as much as she was able. R24	F0689	Continued from page 55 Staff involved received immediate education regarding safe transfer practices, mechanical lift procedures, care plan compliance, and facility policy requiring two trained staff members for all full-body mechanical lift transfers. The resident's transfer needs were reviewed with nursing staff and transfer observations were completed to ensure compliance with physician orders, care plan interventions, and facility policy. 2. Identification of Other Residents with the Potential to be Affected All residents requiring mechanical lift transfers had the potential to be affected by the deficient practice. The Director of Nursing, Clinical Manager, Rehabilitation Department, and interdisciplinary team completed a facility-wide audit of residents requiring full-body mechanical lifts, ceiling lifts, sit-to-stand lifts, and other transfer assistance devices. Care plans, transfer assessments, Kardexes, transfer status documentation, and staffing assignments were reviewed to ensure transfer requirements accurately reflected resident needs and were communicated to staff. Any identified concerns were immediately corrected. 3. Systemic Changes Implemented Effective July 1, 2026, the facility implemented the following systemic corrective actions: • Educated licensed nurses, nursing assistants, trained medication aides, agency staff, and ancillary personnel regarding: - F689 requirements - Safe resident handling procedures - Mechanical lift transfer requirements - Two-person transfer expectations - Care plan compliance	07/08/2026

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F0689 SS = D	Continued from page 56 could not wait when R24 asked to use the bathroom because she would be incontinent. TMA-A stated she wasn't going to lie and transferred R24 using the full body mechanical lift by herself. TMA-A did this because R24 had a right to get up and use the bathroom. It was also harmful to R24 skin to void in her pants. TMA-A stated she felt the transfer was safe doing that. During an interview on 6/9/26 at 11:42 a.m., NA-C stated she never transferred R24 with assistance of one and the full body mechanical lift. It was unsafe to do that. During an interview on 6/9/26 at 11:57 a.m., R24 stated sometimes there was not enough staff at the facility, and they transfer her with the lift with only one staff member. R24 stated they say there's not enough staff and it was against the rules, but they do it. R24 never felt unsafe but knew she was not supposed to tell anyone to get anybody in trouble. "I'm just thankful to get to the toilet." During an interview on 6/9/26 at 1:36 p.m., licensed practical nurse (LPN)-A stated she had told the nursing assistants to not transfer any resident with the full body mechanical lift with assistance of one and had never witnessed any staff doing that. During an interview on 6/9/26 at 1:49 p.m., nursing assistant (NA)-A didn't know "for sure" if staff transferred R24 using the full body mechanical lift with only one staff member, but if they're unable to find help NA-A could see them doing it. NA-A stated she has seen staff come out of a room pushing a resident in a wheelchair and NA-A had questioned how the resident was transferred because NA-A had not helped. NA-A stated she had never asked, and the staff member had never said. During an interview on 6/9/26 at 2:06 p.m., registered nurse (RN)-A stated the staff should never be so short staffed they were transferring any resident using the ceiling lift with assistance of one for the safety of the resident. During an interview on 6/9/26 at 2:49 p.m., the director of nursing (DON) stated no resident should be transferred with the full body mechanical lift using assistance of one because it was a safety issue as well as best practice. The facility policy Using a Mechanical Lift dated 2024, identified the purpose of this procedure is to establish the general principles of safe lifting using a mechanical lifting device. It is not a substitute for manufacturer's training or instructions. I. At least two (2) trained	F0689	Continued from page 56 - Accident prevention strategies - Resident safety expectations - Reporting unsafe practices • Reinforced facility policy requiring two trained staff members for all full-body mechanical lift transfers. • Enhanced leadership rounding to observe transfer practices and ensure compliance. • Reviewed staffing assignments to ensure adequate staffing resources are available to safely complete transfers. • Continued agency staffing utilization as needed to maintain safe staffing levels. • Education was initiated July 1, 2026 and will continue through orientation and annual competency validation. 4. Monitoring and Quality Assurance The Director of Nursing, Clinical Manager, Rehabilitation Director, or designee will conduct the following audits: Transfer Observation Audits • Five transfer observations weekly for four weeks. • Five transfer observations biweekly for an additional eight weeks. Mechanical Lift Audits • Weekly audit of residents requiring full-body mechanical lifts for twelve weeks. Competency Validation Audits • Verification of transfer competency validation for all direct care staff. Resident Safety Audits • Weekly review of transfer-related incidents, near misses, and safety concerns for twelve weeks.	07/08/2026

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F0689 SS = D	Continued from page 57 associates are needed to safely move a resident with a mechanical full body floor based mechanical lift or a ceiling/overhead full body lift.	F0689	Continued from page 57 QAPI Oversight • Audit findings will be reviewed monthly through the QAPI Committee. • Negative findings will result in immediate corrective action, additional education, increased monitoring, and follow-up auditing until sustained compliance is achieved. The facility alleges compliance on July 8th, 2026, when all corrective actions were completed and systems were established to ensure ongoing compliance with F689 Free of Accident Hazards/Supervision/Devices.	07/08/2026
F0755 SS = D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(f). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in	F0755	CMS Plan of Correction – F755 Pharmacy Services/Procedures/Pharmacist/Records Completion Date: July 8th, 2026 Director of Nursing: Eliza Messerschmidt, RN, DNS-CT Administrator: Jason Carlson, LNHA Changes Implemented: July 1, 2026 1. Corrective Action for Residents Found to be Affected Resident R37's reported medication error involving Zepbound was immediately reviewed by the Director of Nursing, attending provider, consultant pharmacist, and interdisciplinary team. A retrospective investigation was completed to determine the circumstances surrounding the reported event, evaluate potential resident impact, and identify opportunities for system improvement. The resident was reviewed for adverse effects, physician notification was verified, and documentation requirements were reinforced with licensed nursing staff. Staff involved received education regarding medication error reporting, investigation requirements, root cause analysis, documentation standards, and implementation of corrective actions to prevent recurrence.	07/08/2026

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F0755 SS = D	Continued from page 58 order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to ensure a reported medication error was investigated, documented, and addressed in accordance with facility policy for 1 of 5 residents (R37) reviewed for unnecessary medications. This deficient practice resulted in the facility's inability to determine the circumstances surrounding a reported Zepbound medication error, assess resident impact, and implement interventions to prevent recurrence. Findings include: R37's quarterly Minimum Data Set (MDS) dated 4/17/26, identified R37 had a moderate cognitive impairment and had diagnoses that included morbid obesity, cerebral palsy and obstructive sleep apnea. R37's Event Report dated 4/23/26 at 9:37 a.m., identified Zepbound (an FDA-approved, once-weekly injectable medication containing tripeptide. It is prescribed alongside a reduced-calorie diet and increased exercise for chronic weight management in adults with obesity or those who are overweight with weight-related conditions) wrong dose on 4/22/26. The report failed to identify any investigation into the event or actions taken to prevent further events. R37's medical record failed to identify any further information regarding the 4/22/26 Zepbound wrong dose. During an interview on 6/8/26 at 10:44 a.m., the director of nursing (DON) stated she had reviewed R37's medical record and R37's medication error investigation. The DON stated there was a lapse in the process and an investigation was not completed. The DON spoke with facility staff who explained the medication did not come from the pharmacy and R37 did not receive his dose of medication. However, the event report stated wrong dose. The DON stated investigation needed to be done to ensure what had occurred. The staff were expected to complete an event report, then complete an investigation into what had happened. This needed to be documented as well as interventions to prevent further medication errors. During an interview on 6/9/26 at 2:15 p.m., registered nurse (RN)-A stated she vaguely remembered the event and attempted to review	F0755	Continued from page 58 2. Identification of Other Residents with the Potential to be Affected All residents receiving medications had the potential to be affected by the deficient practice. The Director of Nursing, Clinical Manager, Consultant Pharmacist, and interdisciplinary team completed a facility-wide review of medication errors reported within the previous twelve months. The audit included review of medication error reports, investigations, physician notifications, resident assessments, documentation, follow-up actions, root cause analyses, and quality improvement interventions. Any identified concerns were immediately corrected. 3. Systemic Changes Implemented Effective July 1, 2026, the facility implemented the following systemic corrective actions: • Reviewed and reinforced the Medication Error/Occurrence policy. • Implemented a standardized medication error investigation process requiring: - Resident assessment - Physician notification when indicated - Documentation of resident outcome - Root cause analysis - Corrective action planning - Follow-up monitoring - Quality improvement review • Educated licensed nurses, nurse managers, and leadership staff regarding: - F755 requirements - Medication error reporting expectations	07/08/2026

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F0755 SS = D	Continued from page 59 R37's medical record for further information. RN-A stated there was no documentation to explain what had occurred or actions taken. RN-A stated there should be a progress note, an event report, and a documented investigation into what happened. Afterwards, it would be brought to IDT to discuss what had occurred and/or if further actions needed to be taken. An emailed response from the consultant pharmacist dated 6/10/26, identified the pharmacist expected facility staff to complete a thorough root cause investigation and analysis, appropriate follow-up, and detailed documentation for any medication error identified. This should include assessment of the resident, physician notification when indicated, monitoring for adverse effects, and implementation of measures to help prevent recurrence. In the case of a resident receiving a one-time higher dose of tirzepatide (Zepbound), potential adverse effects may include gastrointestinal intolerance such as nausea, vomiting, diarrhea, abdominal discomfort, and decreased appetite. Conversely, if a resident receives a lower-than-ordered dose, potential concerns may include less effective appetite suppression, and possible elevations in blood glucose for residents using the medication for glycemic control. The facility policy Medication Error/Occurrence dated 2021, identified When an error is made in the preparation or administration of a drug or biological, the licensed nurse provides any necessary immediate care and notifies the attending provider and resident or resident representative when nursing or medical intervention, observation or treatment is indicated. Medication errors are tracked and trended for quality improvement purposes.	F0755	Continued from page 59 - Investigation requirements - Documentation standards - Root cause analysis methodology - Resident monitoring requirements - Corrective action implementation - Quality assurance expectations • Implemented leadership review of all medication errors within 24 hours of occurrence. • Enhanced consultant pharmacist involvement in medication error review and trending. • Education was initiated July 1, 2026 and will continue through orientation and annual competency validation. 4. Monitoring and Quality Assurance The Director of Nursing, Clinical Manager, Consultant Pharmacist, or designee will conduct the following audits: Medication Error Audits • Audit 100% of medication errors weekly for four weeks. • Audit 100% of medication errors biweekly for an additional eight weeks. Investigation Audits • Weekly review of medication error investigations for twelve weeks. Documentation Audits • Weekly verification of physician notification, resident assessment, follow-up actions, and corrective interventions. Pharmacy Review Audits • Monthly review of medication error trends with the	07/08/2026

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F0755 SS = D		F0755	Continued from page 60 consultant pharmacist. QAPI Oversight • Audit findings will be reviewed monthly through the QAPI Committee. • Medication error trends, corrective actions, and system improvements will be discussed and tracked. • Negative findings will result in immediate corrective action, re-education, increased monitoring, and follow-up auditing until sustained compliance is achieved. The facility alleges compliance on July 8th, 2026, when all corrective actions were completed and systems were established to ensure ongoing compliance with F755 Pharmacy Services/Procedures/Pharmacist/Records.	07/08/2026
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	F0756	CMS Plan of Correction – F756 Drug Regimen Review, Report Irregular, Act On Completion Date: July 8th, 2026 Director of Nursing: Eliza Messerschmidt, RN, DNS-CT Administrator: Jason Carlson, LNHA Changes Implemented: July 1, 2026 1. Corrective Action for Residents Found to be Affected Resident R8 was immediately reviewed by the attending provider, hospice provider, consultant pharmacist, Director of Nursing, and interdisciplinary team. The resident's psychotropic medication regimen, PRN antipsychotic orders, consultant pharmacist recommendations, physician responses, and documentation were reviewed. Haldol was discontinued for the resident related to non-use. The PRN antipsychotic medication order was reviewed for compliance with CMS requirements. Consultant pharmacist recommendations were addressed, physician follow-up was completed, and documentation requirements were reinforced.	07/08/2026

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F0756 SS = D	Continued from page 61 resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to ensure consultant pharmacist recommendations regarding an irregularity in psychotropic medication use were addressed and resolved for 1 of 5 residents (R8) reviewed for unnecessary medications. The facility failed to ensure a required face-to-face practitioner evaluation occurred and allowed a PRN antipsychotic medication order to remain active and be administered despite repeated consultant pharmacist recommendations for review and discontinuation. Findings include: R8's quarterly Minimum Data Set dated 6/9/26, identified R8 had moderate cognitive deficit and required moderate assistance with most activities of daily living (ADLs). R8 had not exhibited any behavior during the observation period and did not have hallucinations or delusions. R8 consumed antianxiety and antidepressant medications during the observation period. Diagnoses included congestive heart failure, dementia, diabetes, and depression. R8's care plan dated 3/23/26, identified R8 was under hospice care for end-of-life status due to heart failure. Approaches included to follow the hospice plan of care, communicate with hospice physician and nurses to discuss medication concerns and what was effective. Hospice services with standing orders, scheduled and as needed (PRN) medications for pain, shortness of breath, restlessness and secretions. The care plan identified R8 received psychotropic medications for depression and anxiety with a goal to not experience any adverse reactions. Approaches listed included to administer medications as ordered. Administer the antianxiety medication for increased anxiety and restless. Staff were to document three interventions trialed before administering the PRN medication. MD review per guidelines for a gradual dose reduction	F0756	Continued from page 61 Licensed nursing staff and leadership received immediate education regarding pharmacist recommendation review, physician follow-up, PRN psychotropic requirements, and documentation expectations. 2. Identification of Other Residents with the Potential to be Affected All residents receiving psychotropic medications or having consultant pharmacist recommendations had the potential to be affected by the deficient practice. The Director of Nursing, Medical Director, Consultant Pharmacist, Clinical Manager, and interdisciplinary team completed a facility-wide audit of consultant pharmacist recommendations from the previous six months. The audit included review of pharmacist recommendations, physician responses, implementation status, psychotropic medication reviews, PRN psychotropic orders, face-to-face evaluations, and documentation requirements. Any identified concerns were immediately corrected. 3. Systemic Changes Implemented Effective July 1, 2026, the facility implemented the following systemic corrective actions: • Implemented a consultant pharmacist recommendation tracking log. • Established a process to ensure all pharmacist recommendations are reviewed, addressed, documented, and resolved timely. • Educated licensed nurses, providers, nurse managers, MDS personnel, and leadership staff regarding: - F756 requirements - Consultant pharmacist recommendation requirements - Physician response requirements - Documentation expectations	07/08/2026

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Benedictine Care Community	**201 9TH STREET WEST , ADA, Minnesota, 56510**

(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
F0756 SS = D	Continued from page 62 and monthly pharmacist review. R8's undated Active Physician Orders identified numerous medication orders for R8, which included haloperidol 1 milligram (MG) for agitation and restlessness every four hours PRN with start date 3/1/26 and end date was listed as open ended. R8's PRN Medication Administration Record (MAR) dated 5/1/26 to 5/31/26, identified an order for Haldol 1 mg every four hours PRN for agitation and restless. start date of 3/1/26 and open-ended end date. The MAR documented the medication had been administered to R8 on 5/19/26 and 5/26/26. Consultant Pharmacist Recommendation to Physician forms identified the following: 3/9/26, identified the pharmacist recommended to discontinue the PRN use of Haldol 1 mg every four hours PRN for anxiety/agitation on or before 3/14/26, following federal guidelines that PNR orders for anti-psychotic drugs were limited to fourteen days and could not be renewed unless the attending physician evaluated the resident for the appropriateness of the renewal. R8's physician commented that R8 was a hospice patient and signed the recommendation with no further response or action on 3/24/26. 4/3/26, identified the pharmacist recommended to discontinue the PRN use of Haldol 1 mg every four hours PRN for anxiety/agitation on or before 3/14/26, following federal guidelines that PNR orders for anti-psychotic drugs were limited to fourteen days and could not be renewed unless the attending physician evaluated the resident for the appropriateness of the renewal. No physician response was documented. R8's medical record lacked a face-to-face assessment by the medical provider to justify continued use of the Haldol. During interview on 6/9/26, at 10:27 a.m. the director of nursing (DON) stated all PRN psychotropic medications should have a fourteen-day review. She had thought the regulation had changed for hospice patients, and it could go longer than fourteen days, but she always had them reviewed every fourteen days. The facility's process was to have hospice follow their patient's medications and notify the facility if there was any need for review or update. The facility's consultant's pharmacist was telephoned on 6/9/26, at 5:56 p.m. and message left to return call. During telephone interview on 6/10/26, at 9:29 a.m. the facility's consultant pharmacist (CP)-G stated he only reviewed medications for the facility for new admissions or hospital returns and was not the pharmacist that had done the monthly medication	F0756	Continued from page 62 - PRN psychotropic medication regulations - Fourteen-day PRN psychotropic review requirements - Face-to-face evaluation requirements - Follow-up and resolution processes • Implemented monthly interdisciplinary psychotropic medication review meetings. • Implemented leadership oversight of open pharmacist recommendations until resolution is documented. • Education was initiated July 1, 2026 and will continue through orientation and annual competency validation. 4. Monitoring and Quality Assurance The Director of Nursing, Clinical Manager, Consultant Pharmacist, or designee will conduct the following audits: Consultant Pharmacist Recommendation Audits • Audit 100% of pharmacist recommendations weekly for four weeks. • Audit 100% of pharmacist recommendations biweekly for an additional eight weeks. Psychotropic Medication Audits • Weekly review of psychotropic medications and PRN psychotropic orders for twelve weeks. Physician Response Audits • Weekly verification of physician review and documented response to pharmacist recommendations. Tracking Log Audits • Weekly review of pharmacist recommendation tracking logs to ensure timely follow-up and resolution.	07/08/2026

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F0756 SS = D	Continued from page 63 reviews for R8. CP-G stated it was his understanding the Center for Medicaid and Medicare (CMS) guidelines were that any PRN antipsychotic medication needed to be addressed by the physician The medication needed to be limited to fourteen days and re-evaluated by the provider. If the provider chose to continue the PRN antipsychotic medication, it would need to be evaluated with a face-to-face visit from the provider. CP-G stated hospice was not an exception. In an electronic mail (email) response received on 6/10/26, at 4:30 p.m. CP-H wrote she had made recommendations to R8's primary provider both in March and April of 2026. R8's physician had signed each recommendation, acknowledging he had reviewed them. In addition, CP-H had emailed the DON and the facility's medical director to reiterate that all PRN antipsychotic medications were subject to an initial 14 day stop date requirement unless a documented face to face evaluation was completed. The order for the PNR haloperidol was discontinued on 6/9/26, However, the discontinuation of the medication was after interviews were completed regarding the continued use of the PRN medication. The facility's policy Psychotropic Medication Use with review date 9/7/23, identified PRN orders for psychotropic drugs were limited to fourteen days and could not be renewed unless the attending provider evaluated the resident for the appropriateness of the medication.	F0756	Continued from page 63 QAPI Oversight • Audit findings will be reviewed monthly through the QAPI Committee. • Negative findings will result in immediate corrective action, re-education, increased monitoring, and follow-up auditing until sustained compliance is achieved. The facility alleges compliance on July 8th, 2026, when all corrective actions were completed and systems were established to ensure ongoing compliance with F756 Drug Regimen Review, Report Irregular, Act On.	07/08/2026

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

June 26, 2026

Administrator
Benedictine Care Community
201 9TH STREET WEST
ADA, MN 56510

RE: CCN:245502
Cycle Start Date: June 10, 2026

Dear Administrator:

On June 10, 2026, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Jen Bahr, RN, Regional Operations Supervisor
Bemidji District Office
Health Regulation Division
Minnesota Department of Health
705 5th Street NW, Suite A
Bemidji, Minnesota 56601-2933
Email: Jennifer.bahr@state.mn.us
Office: (218) 308-2104

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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

If substantial compliance with the regulations is not verified by September 10, 2026 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by December 10, 2026 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

INFORMAL DISPUTE RESOLUTION (IDR)

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

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

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

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

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

to:

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

Feel free to contact me if you have questions.

Sincerely,



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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245502	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/10/2026

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E0000	Initial Comments On 6/7/26 through 6/10/26, 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		06/26/2026
F0000	INITIAL COMMENTS On 6/7/26 through 6/10/26, a standard recertification survey (S5502040-0) was conducted at your facility. Complaint investigations were 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: H55022751C (2792538), H55022752C (2784421), H55022754C (2717252), H55022755C (2700268), H55022756C (2700208), H55022757C (2700214), H55022758C (2700263), H55022759C (2700191), H55022753C (3031510). 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		06/26/2026
F0725 SS = F	Sufficient Nursing Staff CFR(s): §483.35(a)(1)(2) §483.35 Nursing Services.	F0725	CMS Plan of Correction – F725 (S/S F) Compliance Date: July 8th, 2026	07/08/2026

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: 245502	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/10/2026

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F0725 SS = F	Continued from page 1 The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity, and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.71. §483.35(a) Sufficient Staff. §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to provide sufficient nursing staff to meet residents' assessed needs and provide required care and services. The facility's staffing shortages resulted in delayed toileting assistance, delayed eating assistance, loss of dignity, and transfers performed contrary to assessed needs and facility policy for 2 of 6 residents (R23, R24) reviewed in the sample requiring staff assistance with quality-of-care needs. The facility's ongoing staffing shortages had the potential to affect all 36 residents residing in the facility. Findings include: The Centers for Medicare and Medicaid Services (CMS) PBJ Staffing Data Report CASPER Report 1705	F0725	Continued from page 1 Director of Nursing: Eliza Messerschmidt, RN, DNS-CT Administrator: Jason Carlson, LNHA Changes Implemented: July 1, 2026 1. Corrective Action for Residents Found to be Affected Resident R24 was immediately assessed by the interdisciplinary team. Care plans, transfer requirements, toileting schedules, dignity interventions, and staffing assignments were reviewed and updated as indicated. Staff received immediate education regarding timely toileting assistance, resident dignity, call light response, and compliance with two-person mechanical lift transfer requirements. Resident R23 was assessed regarding dining assistance needs. Care plans, nutritional interventions, dining supervision requirements, and meal assistance needs were reviewed. Staff received immediate education regarding timely meal assistance and monitoring of residents requiring assistance during meals. Any additional residents identified as requiring extensive assistance with transfers, toileting, dining, or activities of daily living were reviewed to ensure current staffing assignments adequately supported resident needs. 2. Identification of Other Residents with the Potential to be Affected All residents residing in the facility had the potential to be affected by the deficient practice. A facility-wide review was conducted by the Director of Nursing, Clinical Manager, and interdisciplinary team. The review included staffing schedules, resident acuity, transfer requirements, toileting programs, dining assistance needs, call light response practices, and care plan interventions. Residents requiring extensive assistance, mechanical lift transfers, dining assistance, frequent toileting	07/08/2026

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F0725 SS = F	Continued from page 2 D identified the following: FY [fiscal year] Quarter 3 2025 (April 1 - June 30) identified the metric for excessively low weekend staffing was triggered. The trigger is defined as submitted staffing data that was excessively low. FY Quarter 4 2025 (July1 -September 30) identified the metric for excessively low weekend staffing was triggered. The trigger is defined as submitted staffing data that was excessively low. FY Quarter 1 2026 (October 1 - December 31) identified the metric for excessively low weekend staffing was triggered. The trigger is defined as submitted staffing data that was excessively low. On 6/7/26 at 11:40 a.m., the survey team approached the facility at the entrance door, and it was locked. The phone on the wall was used to call to gain entry into the building. The call was answered and then immediately hung up. the survey team knocked on the glass door and licensed practical nurse (LPN)-A could be seen standing at the medication cart. LPN-A looked at the team but did not respond. The team attempted to call again and was immediately given an entry code for the lock, and the call was disconnected. The team attempted several times to enter the code, but eventually nursing assistant (NA)-A let the team in. At that time, LPN-A stated the facility was working “short”, as a day shift nurse did not show up that morning to work. The night nurse stayed until 10:30 a.m. but then left the facility. LPN-A stated she attempted to call staff in to work but had been answering call lights, assisting the nursing assistants (NA) as much as possible and trying to complete her own duties as well. LPN-A stated she had two nursing assistants in the facility. LPN-A showed a binder that contained a phone tree but stated she just hadn’t had time to call anyone. LPN-A was visibly frustrated with facial grimacing, and she was rubbing her forehead. The nursing assistants were busy in rooms. Many resident room doors were shut. FACILITY ASSESSMENT and SCHEUDLE REVIEW: The Facility Assessment updated 1/22/26, identified the following staffing needs with an average daily census of 42: Licensed nurses providing direct care, every day of the week for AM and evening shift had two staff and night shift had one staff. Unlicensed staff (nursing assistant/trained medication assistant), every day of the week for AM and evening shift had four staff and night shift had 2 staff.	F0725	Continued from page 2 assistance, or complex nursing services were specifically reviewed to ensure staffing resources and assignments were adequate to meet assessed needs. 3. Systemic Changes Implemented Effective July 1, 2026, the facility implemented the following systemic corrective actions: • Reviewed and revised staffing schedules to align with the Facility Assessment and current resident acuity. • Continued utilization of agency staffing resources as needed to maintain safe staffing levels. • Implemented an enhanced staffing escalation process including notification of the DON and Administrator when staffing concerns are identified. • Expanded call-in procedures and staffing contingency plans. • Implemented twice weekly staffing review meetings to evaluate census, acuity, staffing coverage, and anticipated staffing concerns. • Revised float staff assignments to include assigned resident groups for improved accountability. • Educated licensed nurses, nursing assistants, trained medication aides regarding: - Timely call light response - Toileting assistance expectations - Dining assistance requirements - Resident dignity and resident rights - Transfer safety requirements - Compliance with care plans and assessed needs - Reporting staffing concerns through the chain of command • Implemented leadership rounds to monitor call light response, dining room coverage, transfer assistance, resident care completion, and resident satisfaction.	07/08/2026

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F0725 SS = F	Continued from page 3 The facility provided a working schedule for the week of survey and identified the Sunday 6/7/26, AM shift 6:00 a.m. to 2:30 p.m., had one nurse working and two nursing assistants (NA) working. The nurse staff posting dated 6/7/26 identified the resident census was 36. The working nursing schedules from FY Quarter 1 2026 (October 1 - December 31) were reviewed for weekend staffing patterns and identified the following: Saturday 10/4/25, AM shift 6:00 a.m. to 10:00 a.m. and PM shift 2:00 p.m. to 10:30 p.m., only 3 NAs scheduled on each of the identified shifts. Sunday 10/5/25, AM shift 6:00 a.m. to 10:00 a.m. and PM shift 2:00 p.m. to 11:30 p.m., only 3 NAs scheduled on each of the identified shifts. Saturday 10/11/25, AM shift 6:00 a.m. to 10:00 a.m. and PM shift 2:00 p.m. to 10:30 p.m., only 3 NAs working on each of the identified shifts. Sunday 10/12/25, AM shift 6:00 a.m. to 2:30 p.m., only 2 NAs were scheduled. On PM shift 2:00 p.m. to 10:30 p.m., only 3 NAs were scheduled on the identified shifts. Saturday 10/18/25, AM shift 6:00 a.m. to 2:30 p.m., only 3 NAs were scheduled on the identified shift. Sunday 10/19/25, AM shifts from 11:00 a.m. to 2:30 p.m., and PM shift 2:00 p.m. to 6:00 p.m., only 3 NAs were scheduled on the identified shifts. Saturday 10/25/25, PM shift 2:00 p.m. to 10:30 p.m., only 3 NAs were scheduled on the identified shift. Sunday 10/26/25, AM shift 6:00 a.m. to 10:00 a.m., only 2 NAs were scheduled . At 11:00 a.m. to 2:30 p.m. and PM shift 2:00 p.m. to 10:30 p.m., only 3 NAs were scheduled on the identified shifts. Saturday 11/1/25, AM shift 11:00 a.m. to 2:30 p.m. and 2:00 p.m. to 6:00 p.m., only 3 NAs were scheduled on the identified shifts. Sunday 11/2/25, AM shift 6:00 a.m. to 10:00 a.m. and PM shift 2:00 p.m. to 6:00 p.m., only 3 NAs were scheduled on the identified shifts. Saturday 12/6/25, AM shift 10:00 a.m. to 2:30 p.m. and PM shift 2:00 p.m. to 10:30 p.m., only 3 NAs were scheduled on the identified shifts.	F0725	Continued from page 3 Education was initiated and completed for current staff, with ongoing education provided during orientation and annual competency validation. 4. Monitoring and Quality Assurance The Director of Nursing, Clinical Manager, or designee will monitor compliance through the following audit process: Staffing Audits • Daily staffing schedule review for all shifts x 4 weeks. • Weekly staffing review thereafter x 3 months. Resident Care Audits • Five resident observations weekly x 12 weeks to evaluate: - Timeliness of toileting assistance - Timeliness of call light response - Compliance with transfer requirements - Resident dignity during care Dining Audits • Observation of at least two meal services per week x 12 weeks to ensure residents requiring assistance receive timely meal support. QAPI Oversight • Audit findings will be reviewed monthly through the QAPI Committee. • Negative findings will result in immediate corrective action, additional staff education, increased monitoring, and follow-up auditing until sustained compliance is achieved. The facility alleges compliance on July 8th, 2026, when all corrective actions were completed and	07/08/2026

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F0725 SS = F	Continued from page 4 Sunday 12/7/25, AM shift 6:00 a.m. to 10:00 a.m. and PM shift 2:00 p.m. to 10:30 p.m., only 3 NAs were scheduled on the identified shifts. Saturday 12/13/25, AM shift 6:00 a.m. to 10:00 a.m., only 3 NAs were scheduled on the identified shift. Sunday 12/14/25, AM shift 6:00 a.m. to 10:00 a.m., only 3 NAs were scheduled on the identified shift. Saturday 12/20/25, AM shift 6:00 a.m. to 2:30 p.m., only 3 NAs were scheduled on the identified shift. Sunday 12/21/25, AM shift 6:00 a.m. to 2:30 p.m., only 2 NAs were scheduled and PM shift 6:00 p.m. to 10:30 p.m., only 3 NAs were scheduled on the identified shifts. See also F677: Based on observation, interview, and document review, the facility failed to provide activities of daily living (ADL) care and services necessary to maintain residents' abilities by failing to provide timely toileting assistance for 1 of 6 residents (R24) reviewed who required staff assistance with toileting and transfers; and failed to provide timely supervision and assistance with eating for 1 of 6 residents (R23) reviewed who required staff assistance during meals. R24: R24’s admission Minimum Data Set (MDS) dated 5/6/26, identified R24 had mild cognitive impairment and was dependent on staff for toileting and transfers and was frequently incontinent with bowel and bladder. Diagnoses included non-traumatic spinal cord dysfunction, diabetes, and dementia. R24’s care plan revised 5/27/26, R24's care plan dated 5/27/26 identified she was dependent on staff for transfers and toileting, required a full-body mechanical lift with assistance of two staff for transfers, and was to be offered toileting every three hours and upon request to maintain skin integrity and dignity. During an observation on 6/7/26 at 11:30 a.m., R24 was lying in bed with her head of bed (HOB) at 30 degrees. R24 was wearing a dusky purple sweatshirt and no pants. There was a fleece blanket across the foot of R24’s bed but it was not covering R24. R24 was wearing an incontinent brief with no pants and had her knees bent with her feet resting on the bed. R24 was crying and stated staff told R24 she had to stay in bed and couldn’t get up. “I don’t know why.” R24 then stated, “they told me to pee my	F0725	Continued from page 4 systems were established to ensure ongoing compliance with F725.	07/08/2026

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F0725 SS = F	Continued from page 5 pants, and they'd clean me up here." R24 stated this happened "all the time". At that time, nursing assistant (NA)-B stepped into the room and told R24 NA-B needed to help another resident and would be back. NA-B turned off R24's call light and left the room. R24 continued to cry and stated nursing assistants said that and shut off R24's call light "just about every day" and "they say they're short". R24 sobbed and stated "I hate it here. It's awful. I hate peeing in my pants." At 12:10 p.m., NA-B entered R24's room and told R24 she was wet, so she needed to be cleaned up. NA-B put on gloves then told R24 she didn't need to cry because she was there. R24 stated "I want to get up". At 12:11 p.m. NA-B unfastened R24's incontinent brief and used disposable wipes to clean R24's skin of feces and urine. R24 stated that her skin was itchy, NA-B told R24 that R24 had "pooped" and NA-B would clean R24's skin well. At 12:13 p.m., NA-B rolled R24 to the right and R24 began crying and stated, "I can't do this". NA-B told R24 that they were almost done. R24's skin on her upper thighs and buttocks was reddened but had no open areas. NA-B applied barrier cream then a clean brief. At 12:16 p.m., NA-B put on R24's pants. NA-B then removed her gloves and removed the trash from the trash containers and asked for assistance with R24's transfer over the walkie. NA-B exited the room. At 12:19 p.m., NA-B returned with a full body mechanical lift sling and placed it under R24. NA-B told R24 that she needed another staff person to assist with the transfer and left the room. At 12:22 p.m., NA-A and NA-B entered the room and used the ceiling lift to transfer R24 from her bed to her wheelchair. NA-B then brought R24 to the dining room for her noon meal. During an interview on 6/7/26 at 12:28 p.m., NA-B stated the facility was working "short" that day. "You just do the best you can." NA-B stated R24 did get up into her chair for breakfast that morning, but staff laid R24 down to do incontinent care after breakfast. NA-B stated R24 was "encouraged" to stay in bed because NA-B had other residents to care for. R24 did turn on her call light and asked to get up, but R24 was assistance of two and NA-B was providing care to another resident.	F0725		07/08/2026

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F0725 SS = F	Continued from page 6 R23: R23's quarterly MDS dated 5/8/26, identified R23 was cognitively intact and independent with eating. R23 had diagnoses of obesity and mass/lump on abdomen. R23's care plan dated 5/26/26 identified R23 was independent with eating. However, R23's mini nutritional assessment dated 5/9/26, identified R23 normally ate 51-75% of most meals. R23 was assisted with meals for optimal intake. During observations on 6/7/26 at 1:04 p.m., there were not enough staff in the dining room to assist residents with eating. At 1:05 p.m., there were at least two residents who were sitting there with food in front of them and were not eating nor were staff helping them. At 1:09 p.m., R23 was identified as one of the residents sitting at the table where staff are supposed to assist residents with eating. At 1:12 p.m., R23 still had her plate of food in front of her, and she had not attempted to eat. R23's potatoes and meat had formed a crust on them. R23 waited 45 minutes before staff assisted her to eat. At 1:15 p.m., R23 ate well with staff assistance. During an interview on 6/9/26 at 2:02 p.m., NA-A stated R23 had changed over the weekend, previously she just required supervision with eating. R23 had seemed to decline and had started to pocket food and had moved to a different table to assist with eating because R23 needed more help with meals. During lunch on Sunday 6/7/26, the facility was short staffed and the residents in the dining room had to wait for assistance to eat and some had to wait an extended period of time before they received help. See also F550: Based on observation, interview, and record review, the facility failed to ensure dignified care was provided for 1 of 1 resident (R24) reviewed for dignity. Staff encouraged R24 to remain incontinent rather than assisting her to the toilet when requested, resulting in embarrassment, and loss of dignity. R24’s admission Minimum Data Set (MDS) dated 5/6/26, identified R24 had mild cognitive impairment and was dependent on staff for toileting and transfers and was frequently incontinent with bowel and bladder. Diagnoses included non-traumatic	F0725		07/08/2026

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F0725 SS = F	Continued from page 7 spinal cord dysfunction, diabetes, and dementia. R24's care plan revised 5/27/26, R24's care plan dated 5/27/26 identified she was dependent on staff for transfers and toileting, required a full-body mechanical lift with assistance of two staff for transfers, and was to be offered toileting every three hours and upon request to maintain skin integrity and dignity. During an observation on 6/7/26 at 11:30 a.m., R24 was lying in bed with her head of bed (HOB) at 30 degrees. R24 was wearing a dusky purple sweatshirt and no pants. There was a fleece blanket across the foot of R24's bed but it was not covering R24. R24 was wearing an incontinent brief with no pants and had her knees bent with her feet resting on the bed. R24 was crying and stated staff told R24 she had to stay in bed and couldn't get up. "I don't know why." R24 then stated, "they told me to pee my pants, and they'd clean me up here." R24 stated this happened "all the time". At that time, nursing assistant (NA)-B stepped into the room and told R24 NA-B needed to help another resident and would be back. NA-B turned off R24's call light and left the room. R24 continued to cry and stated nursing assistants said that and shut off R24's call light "just about every day" and "they say they're short". R24 sobbed and stated "I hate it here. It's awful. I hate peeing in my pants." During an interview on 6/7/26 at 12:28 p.m., NA-B stated the facility was working "short" that day. "You just do the best you can." NA-B stated R24 did get up into her chair for breakfast that morning, but staff laid R24 down to do incontinent care after breakfast. NA-B stated R24 was "encouraged" to stay in bed because NA-B had other residents to care for. R24 did turn on her call light and asked to get up, but R24 was assistance of two, and NA-B was providing care to another resident. See also F689: Based on interview and document review, the facility failed to ensure transfers were performed in accordance with assessed needs, care plan interventions, and facility policy for 1 of 3 residents (R24) reviewed for accidents. Staff performed transfers using a full-body mechanical lift with one staff member rather than the required two staff members, creating the potential for falls, entrapment, and transfer-related injury. R24's admission Minimum Data Set (MDS) dated 5/6/26, identified R24 had a mild cognitive impairment and had diagnoses that included non-traumatic spinal cord dysfunction, diabetes, and dementia. R24 was dependent on staff for toileting	F0725		07/08/2026

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F0725 SS = F	Continued from page 8 and transfers and was frequently incontinent with bowel and bladder. R24's care plan revised 5/27/26, identified R24 had self-deficit with transferring. Staff were directed to provide assistance with two staff with all transfers to and from bed, wheelchair and toilet. R24 used a full body mechanical lift. During an interview on 6/9/26 at 11:29 a.m., trained medication aide (TMA)-A stated staffing was awful. The facility used a lot of agency staff and the schedule frequently got "messed up" which added to the problem. Staff did the best they could with what they had. TMA-A tried her hardest when they had to work short to prioritize work and to help the nursing assistants as much as she was able. R24 could not wait when R24 asked to use the bathroom because she would be incontinent. TMA-A stated she wasn't going to lie and transferred R24 using the full body mechanical lift by herself. TMA-A did this because R24 had a right to get up and use the bathroom. It was also harmful to R24 skin to void in her pants. TMA-A stated she felt the transfer was safe doing that. During an interview on 6/9/26 at 11:57 a.m., R24 stated sometimes there was not enough staff at the facility, and they transfer her with the lift with only one staff member. R24 stated they say there's not enough staff and it was against the rules, but they do it. R24 never felt unsafe but knew she was not supposed to tell anyone to get anybody in trouble. "I'm just thankful to get to the toilet." STAFF INTERVIEWS: During an interview on 6/8/26 at 4:44 a.m., RN-A stated she was the unit manager and was covering night shift because the facility was short on staff. During an interview on 6/9/26 at 11:29 a.m., TMA-A stated staffing was awful. The facility used a lot of agency staffing and the schedule would get "screwed up". On 6/9/26, TMA-A had to work a double shift because her relief was scheduled on the electronic module but not on the printed schedule. The Pioneer unit needed at least 2 aides because the cares were heavier over there. There should be a float that goes between the Pioneer unit and the Wild Rose unit, but they don't like to do it and refuse to help on Wild Rose. They just don't do it. The agency staff don't know what to do when a staff member calls in for their shift. The agency staff don't have access to the texting app but they have the staff list and the have the phone tree. TMA-A was not called to work on Sunday. TMA-A had heard nothing about the staff being short staffed on	F0725		07/08/2026

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F0725 SS = F	Continued from page 9 6/7/26. Staff working the medication cart were expected to assist the nursing assistants with answering call lights and resident care, but some of the agency staff would not do it. During an interview on 6/9/26 at 11:42 a.m., NA-C stated she worked as needed, but didn't work "much". Stated the facility did call her at approximately 1:00 p.m. on 6/7/26 but NA-C could not work that day. NA-C worked 6/8/26, 6/9/26 and was scheduled to work 6/10/26 because "state" was there. "Usually when I'm working, we have everybody here because I'm the one who picked up." During an interview on 6/9/26 at 1:36 p.m., LPN-A stated she was an agency staff person so "that right there should tell you what staffing is like." Stated the facility worked "short" like they were on 6/7/26 a lot. "Every week". LPN-A stated the nurse who was supposed to work on 6/7/26 comes to work late often. The night nurse stayed to cover, but the nurse never arrived. That's when LPN-A realized she wasn't coming. LPN-A was trying to call staff to come in to work but was getting pulled in every direction because the nursing assistants needed help, plus she had nursing duties she had to attend to. During an interview on 6/9/26 at 1:49 p.m., NA-A stated the facility worked short staffed all the time and even if NA-A had a float, the float wasn't much help, so she was working alone anyway. Some of the floats just didn't want to work. They liked the social aspect of the role, but they didn't want to listen to direction, or they were slow in their tasks. Some didn't answer call lights. For example, one float wanted to sit with the residents and drink coffee and visit. The float routinely didn't look at the bath list and didn't want to answer call light. When NA-A would tell this person what to do, NA-A would get ignored. NA-A stated she had reported this to administration many times and not had a response. During an interview on 6/9/26 at 2:06 p.m., RN-A stated she had been told there were float staff ho were resistant to working on the Wild Rose unit. The floats had worked at the facility for "years" and believed they didn't have to. RN-A had spoken to the float staff individually and informed administration but had never documented this. During an interview on 6/9/26 at 2:49 p.m., the DON stated she expected staff to answer call lights when they can safely leave the person they are caring for to check on the call light to ensure it's not a safety	F0725		07/08/2026

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F0725 SS = F	Continued from page 10 concern. The DON also stated she had recognized the float staff didn't have accountability because the float didn't have an assigned resident group. The DON planned to change assignments so each nursing assistant, including the float, would have an assigned group of residents. This would include the float assigned residents from each unit. That way, the float would be assisting on each unit and there would be a way to hold the float accountable for their work.	F0725		07/08/2026
F0880 SS = F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections;	F0880	CMS Plan of Correction – F880 Infection Prevention & Control Completion Date: July 8th, 2026 Director of Nursing: Eliza Messerschmidt, RN, DNS-CT Administrator: Jason Carlson, LNHA Changes Implemented: July 1, 2026 1. Corrective Action for Residents Found to be Affected Residents identified during survey observations were immediately assessed for any potential impact related to the deficient infection prevention and control practices. Immediate corrective action included re-education of involved staff regarding hand hygiene requirements, standard precautions, transmission-based precautions, PPE utilization, environmental cleaning, and infection prevention practices. Isolation precautions were reviewed, PPE supplies and signage verified, and any deficient infection control practices immediately corrected. Residents residing on transmission-based precautions, including contact precautions, were reviewed to ensure interventions were implemented according to physician orders, facility policy, CDC guidance, and CMS requirements. 2. Identification of Other Residents with the Potential to be Affected All residents residing in the facility had the potential	07/08/2026

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F0880 SS = F	Continued from page 11 (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 prevention and control program that included a system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases. Specifically, the facility failed to timely initiate and consistently implement transmission-based precautions for 2 of 2 residents (R12. R24) reviewed who exhibited signs and symptoms of potentially infectious diarrhea; failed to consistently identify and monitor residents exhibiting signs and symptoms of potential infection through the facility's surveillance system for 2 of 2 residents (R7, R24) reviewed for infection surveillance; failed to ensure staff adhered to infection prevention practices related to hand hygiene for 1 of 3 residents (R24) reviewed for activities of daily living; and	F0880	Continued from page 11 to be affected by the deficient practice. The Director of Nursing, Infection Preventionist, Clinical Manager, and interdisciplinary team conducted a facility-wide review of hand hygiene practices, PPE utilization, isolation precautions, environmental cleaning processes, equipment disinfection, infection surveillance activities, and resident care practices. Residents with active infections, isolation precautions, wounds, indwelling devices, recent antibiotic use, multidrug-resistant organisms, and Clostridioides difficile histories were specifically reviewed for compliance with infection prevention interventions. 3. Systemic Changes Implemented Effective July 1, 2026, the facility implemented the following systemic corrective actions: • Reviewed and reinforced the Infection Prevention and Control Program. • Enhanced infection surveillance processes and reporting. • Reinforced Infection Preventionist responsibilities. • Educated all licensed nurses, nursing assistants, TMAs, ancillary staff, contract personnel, and agency staff regarding: - Hand hygiene requirements - Standard precautions - Transmission-based precautions - Proper PPE selection and utilization - Donning and doffing procedures - Environmental cleaning standards - Equipment cleaning and disinfection - C. difficile prevention and control practices - Isolation precaution requirements	07/08/2026

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F0880 SS = F	Continued from page 12 failed to implement enhanced barrier precautions for 2 of 5 residents (R6, R7) reviewed who met criteria for enhanced barrier precautions. These deficient practices had the potential to affect all 36 residents residing in the facility. Findings include: TRANSMISSION BASED PRECAUTIONS R12 R12's annual Minimum Data Set (MDS) dated 5/22/26, identified R12 had severe cognitive impairment, and included a diagnosis of chronic kidney disease. R12 required partial/moderate assistance with toileting and was always incontinent with bowel and bladder. R12's care plan revised 5/28/26, identified R12 had acute gastroenteritis (inflammation that spreads from your stomach into your intestines, causing pain, vomiting and diarrhea) as evidenced by diarrhea and/or vomiting. Placing R12 at risk for dehydration, electrolyte imbalance, impaired skin integrity, and infection transmission. Staff were directed to: Administer antiemetics, antidiarrheals, or antibiotics as ordered by provider. Monitor for medication effectiveness and side effects. Assess for abdominal pain, cramping, nausea, fever, or discomfort; report concerns to the resident's provider and treat as ordered. Assist with toileting as needed, provide perineal care after diarrhea, and apply barrier cream/protective ointments as indicated. Initiate appropriate isolation precautions per facility policy, minimize resident movement outside of room, and clean and disinfect high-touch surfaces and shared equipment. Monitor frequency, consistency, and volume of stools and/or emesis. R12's Clostridium difficile (C. diff) by Molecular Detection dated 5/27/26, identified R12 was was positive for C. diff (a highly contagious bacterium	F0880	Continued from page 12 - Reporting infection prevention concerns • Leadership rounds were implemented to monitor infection prevention compliance. • Weekly infection prevention meetings were implemented to review infection trends, outbreaks, antibiotic utilization, and compliance concerns. • All new employees and agency staff will receive infection prevention education during orientation before providing resident care. 4. Monitoring and Quality Assurance The Director of Nursing, Infection Preventionist, Clinical Manager, or designee will conduct the following audits: Hand Hygiene Audits • Ten observations weekly for four weeks. • Five observations weekly for an additional eight weeks. Isolation and PPE Audits • Five audits weekly for twelve weeks. Environmental Cleaning Audits • Five audits weekly for twelve weeks. Infection Surveillance Audits • Weekly review of infection surveillance data for twelve weeks. Leadership Rounds • Weekly infection prevention leadership rounds for twelve weeks. QAPI Oversight • Audit findings will be reviewed monthly through the QAPI Committee.	07/08/2026

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F0880 SS = F	Continued from page 13 that causes diarrhea and colitis. It often infects people who've recently taken antibiotics. Antibiotics that kill other bacteria in your gut but don't kill C. diff allow it to quickly grow out of control, (Cleveland Clinic dated 11/19/24)). R12's Enteric Pathogens by Molecular Detection dated 5/27/26, identified R12 was positive for norovirus. (Norovirus is a highly contagious virus that causes acute gastroenteritis (inflammation of the stomach and intestines). Often mistaken for the "stomach flu" or food poisoning, it results in explosive vomiting, watery diarrhea, and stomach cramps. It is notoriously difficult to kill and spreads rapidly through contaminated food, surfaces, or close contact, Cleveland Clinic dated 2/3/23) R12's nurse progress notes identified the following: 5/18/25 at 5:05 p.m., social work designee (SWD) met with resident on 5/18/26 and completed PHQ-9 Assessments (a screening tool for depression). PHQ-9 score was 3/27 indicating minimal depression. R12 answered yes to feeling down, depressed, and hopeless. R12 stated he doesn't know why he feels this way at times, but stated he was glad that his legs were getting better and was working with therapy. R12 also stated yes for poor appetite, he stated he wasn't eating much when he was feeling sick and stated he had been having loose stools these last couple of days. R12 stated he ate better today. Case manager notified about loose stools, no other concerns for R12 at this time. 5/19/26 at 9:15 a.m., Discussed at Interdisciplinary Team (IDT): weight variance. Will be followed up with provider today during rounds. 5/19/26 at 4:52 p.m., PROVIDER UPDATE: Regarding concerns with loose stools. Reviewed by provider with orders received as follows: comprehensive metabolic panel (CMP) (measures 14 different substances in your blood and is primarily used to evaluate organ function and metabolism), magnesium (Magnesium is a vital electrolyte that your nerves, muscles, and heart need to function properly), complete blood count (CBC), C-reactive protein (CRP) (CRP is a protein made by your liver that increases when there is inflammation in your body). Orders updated. However, the nursing progress note failed to identify if R12 was placed into contact precautions.	F0880	Continued from page 13 • Negative findings will result in immediate corrective action, additional education, increased monitoring, and follow-up audits until sustained compliance is achieved. The facility alleges compliance on July 8th, 2026, when all corrective actions were completed and systems were established to ensure ongoing compliance with F880 Infection Prevention and Control.	07/08/2026

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F0880 SS = F	Continued from page 14 5/20/26 at 5:15 a.m., R12 at baseline. No complaints. Incontinent of stool one time. 5/20/26 at 10:30 a.m., LAB RESULTS CRP: 2.6 RBC: 3.82 HGB: 12.2 MCV: 102.1 MCHC: 31.3 RDW: 16.3 BUN: 37 Creatinine: 1.58 GFR: 40 Glucose: 128 Albumin: 3.0 Alkaline Phosphatase: 224 Alanine Aminotransferase: 7 Provider updated. No further orders at this time. 5/20/26 at 12:30 p.m., per provider, CRP was elevated but substantially improved compared to a few weeks ago in the hospital. Electrolytes and kidney functions look okay for R12. Alkaline Phosphatase was elevated but had been elevated over the last year. Add a Gamma-glutamyl transferase (GGT) to see if the Alkaline Phosphatase elevation was likely from the liver or bone. GGT lab order added. Writer called lab to inform of add-on lab. However, the nursing progress note failed to identify if R12 was placed into contact precautions. 5/21/26 at 7:15 a.m., staff interviewed for Assessment Reference Date (ARD) ending 05/22/2026: Staff reported continence level for bladder as incontinent and bowel as incontinent. R12 was incontinent in briefs at this time and required check and change in bed or on toilet. Staff reported R12 had frequent loose stools daily since hospital	F0880		07/08/2026

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F0880 SS = F	Continued from page 15 stay. Provider aware. Imodium (anti-diarrhea medication) is in use as needed. 5/26/26 at 5:12 a.m., loose stools twice. Imodium given. However, the nursing progress note failed to identify if R12 was placed into contact precautions. 5/26/26 at 9:06 a.m., some difficulty with therapies due to loose stools per therapy. Will see about stool sample today. 5/27/26 at 11:12 a.m., spoke to R12's doctor about ongoing problems with loose stools and incontinence since hospitalization. Received order for stool culture and C-diff labs. Howe 5/27/26 5:53 p.m., R12 at baseline. No concerns noted. Obtained stool specimen and dropped off to lab as ordered for occult parasite and C-diff. However, the nursing progress note failed to identify if R12 was placed into contact precautions. 5/28/26 at 6:20 a.m., writer received lab results this morning indicating R12 was positive for C-Difficile - Norovirus strain. Staff were updated immediately and isolation precautions implemented. Writer spoke to R12 and strongly encouraged him to stay in his room today so as not to spread the illness. Provider was updated. Communication sent out to facility staff. However, the nursing progress note failed to identify R12 cohorting with a roommate. 5/28/26 at 6:27 a.m., LAB RESULTS Clostridium Difficile: Positive Norovirus GI/GII: Detected 5/28/26 at 8:48 a.m., writer contacted R12's doctor regarding positive stool results. Orders received as follows: 1. Oral Vancomycin (an antibiotic that kills C. diff) 125 milligrams (mg) 4 times a day for 10 days. 5/28/26 10:02 a.m., discussed at IDT: R12 was diagnosed with C-Diff and norovirus. Isolation precautions in place. Notifications made. However,	F0880		07/08/2026

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F0880 SS = F	Continued from page 16 the nursing progress note failed to identify R12 cohorting with a roommate. 5/28/26 at 10:05 a.m., Antibiotic(s) prescribed:: Vancomycin Start Date:: 05/29/2026 Dose:: 125 mg Route:: Oral Duration:: 10 days Stop Date:: 06/07/2026 Reason Antibiotic(s) Prescribed:: Other (List) C-Diff/Norovirus Review Event: Did resident meet McGeer's Criteria to treat?: Yes Review Event: Did culture or imaging tests confirm infection?: Yes Risk Factors/Concerns:: No Risk Factors/Concerns Does resident still have symptoms?: Yes Are signs and symptoms improving?: Yes Red Flags:: Antibiotic is ordered for more than 7 days Actions to Take:: Notify nurse manager or facility supervisor, Update provider Has attending provider been updated?: Yes 5/28/26 at 6:32 p.m., no concerns or complaints noted. R12 was on contact precautions due to c-diff. 5/29/26 at 11:30 a.m., Annual Nutrition Review: R12 had just been diagnosed with norovirus and C diff. R12 may benefit from the addition of a probiotic. Nutritional care plan reviewed. Goal for weight maintenance is 230-250 pounds (lbs). Nutritional needs were being met by weight trend. No changes were needed. Encourage fluids related to kidney disease. 5/30/26 at 6:02 p.m., No concerns or complaints	F0880		07/08/2026

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F0880 SS = F	Continued from page 17 noted. Continued to be in contact isolation due to C-diff, no loose stools noted, antibiotic continued with no adverse effect noted. 6/3/26 at 12:26 p.m., regarding active Loperamide prescription (PRN), writer received orders as follows: 1. Hold Loperamide for duration of C-Diff infection 6/7/26 at 5:42 a.m., R12 at baseline, no concerns. Continued with contact precautions. R12 stated was ready to come out of that. 6/7/26 at 7:09 p.m., continued contact precautions for C-diff. R12 was noncompliant. R12 came from his room to dining room at times, staff continued to redirect. 6/8/26 at 3:47 a.m., R12 self-transferred to bathroom twice during the night. R12 was reeducated on the need to use his call light for assistance. During a continuous observation on 6/8/26 at 7:46 a.m., R12 had a 3-drawer plastic cart outside his room. A Contact Precautions sign, bleach disposable wipes and red biohazard bags were sitting on top. The top drawer contained gloves and surgical masks, the second drawer had eye and face protection, and the bottom drawer was empty. Inside the doorway, there was a 13-gallon trash bin. R12 was sitting on the edge of his bed. R12's roommate, R7, was in bed with the privacy curtain pulled. At 8:26 a.m., R12 continued sitting on the side of his bed. R12 was dressed and had his wheelchair and overbed table in front of him in reach. 8:41 a.m., LPN-A stated she did know who the facility's infection prevention nurse was. There have been too many changes. R12 began hollering at LPN-A. LPN-A asked dietary aide (DA)-A if R12 had eaten breakfast. DA-A stated no, half the residents in the unit had not eaten breakfast and stated "after 9:00 a.m., you have to deliver it." DA-A continued to the dining room. At 8:48 a.m., R12 continued to sit on the side of his	F0880		07/08/2026

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F0880 SS = F	Continued from page 18 bed. R12 did not have his breakfast. At 9:04 a.m., the health unit coordinator (HUC) delivered gowns and placed them in R12's cart in the bottom drawer. At 9:14 a.m., NA-B entered R12's without any personal protective equipment (PPE). R12 began yelling "what the hell is going on? I haven't had my breakfast yet." NA-B stated she would go check. Left room and went to the dining room. NA-B did not use hand sanitizer. At 9:19 a.m., NA-B returned with R12's breakfast tray. NA-B put on a gown, gloves and a surgical mask then brought the tray to R12. NA-B placed R12's tray on the overbed table and set up R12's meal, touching items on his overbed table. NA-B removed her gloves and made to leave the room when R12 stopped her and stated, "no coffee?" NA-B stated R12 had already had some coffee that morning. R12 stated yes, he had, but that was a while ago. "Ok, that's fine. I'll get some later". NA-B removed her washable gown and placed it into the trash can at the door, then used hand sanitizer. At 9:24 a.m., NA-B stated staff only needed to wear a gown and gloves when doing anything with R12 and did not need to wear anything if they were caring for R7. NA-B then reentered the room to care for R7 without a gown or gloves. At 10:42 a.m., the wellness activity director (WAD)-A and culinary manager (CM)-A entered R12's room without gown or gloves. WAD-A and CM-A are touching R12's personal items such as his overbed table, wheelchair, closet and bedding. The bedding was brushing WAD-A's clothing. WAD-A told R12 they were going to help R12 with his bath. CM-A removed clothing from R12's closet for R12 to pick out. WAD-A put a gait belt on R12 and assisted R12 to transfer to his wheelchair. At 10:47 a.m., CM-A stated R12 had been removed from contact precautions that morning. They knew this because it was discussed in the IDT that morning and staff just had not gotten around to removing the cart. However, CM-A did not know if R12's room had been cleaned.	F0880		07/08/2026

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F0880 SS = F	Continued from page 19 At 11:10 a.m., housekeeping manager (HM)-A was in R12's room wearing gloves but without a gown. HM-A was pulling linens from R12's bed and cleaning his room. At 12:11 p.m., the cart was removed from R12's doorway. During an interview on 6/8/26 at 12:15 p.m., trained medication aide (TMA)-A stated when a resident needed contact precautions, the charge nurse came around and told all the staff. The cart was placed outside the room, and a trash container was put inside the doorway to remove your gown and gloves. Staff were expected to put on a gown and gloves every time you entered the room. When the contact precautions were done, the charge nurse came around again to tell all the staff. The room needs to be "broken down" and everything needed to be cleaned. Housekeeping had to sanitize the room as well as the cart. The cart was then stocked and put back in the supply closet for another use. When a resident had 3 or more loose stools, TMA-A brought it to the attention of the charge nurse; especially if the stool was foul smelling. "When that happens, I put the cart out because it's like lice, nobody wants it." During an interview on 6/8/26 at 12:25 p.m., HM-A stated R12 had come off of contact that morning so HM-A sanitized R12's room and bathroom with a bleach disposable wipe and then waited 30 minutes before R12 could go back into his room to make sure everything was dry. HM-A stated she wore gloves when she used the disposable wipe. "Well, everybody was in there without a gown, so I didn't think I needed to do that if I was cleaning it. That's just standard precautions." R7 R7's annual Minimum Data Set (MDS) dated 4/5/26, identified R5 had severe cognitive impairment and diagnosis included obesity, diabetes, and dementia. R7's care plan dated 5/22/26, identified the care plan lacked any guidance regarding a possible exposure to C. diff. R24 R24's admission Minimum Data Set (MDS) dated 5/6/26, identified R24 had a mild cognitive	F0880		07/08/2026

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F0880 SS = F	Continued from page 20 impairment and had diagnoses that included non-traumatic spinal cord dysfunction, diabetes, and dementia. R24 was dependent on staff for toileting and transfers and was frequently incontinent with bowel and bladder. R24's Activities of Daily Living (ADLs) Functional/Rehabilitation Potential Care Area Assessment (CAA) dated 5/11/26, identified R24 was a recent admit from another care center and had diagnoses of dementia, depression, heart failure and asthma. R24 had clear speech and was understood and usually understood. R24 denied shortness of breath. R24 stated she had pain per medication administration record (MAR) review. R24 had a history of refusing medications per staff. R24 was frequently incontinent of bowel and bladder and had some moisture-associated skin damage (MASD) noted with ointment/cream to apply. R24 required assistance for transfers. Care area was triggered due to ADL review. R24 would be assisted per need and per request. R24 was to be encouraged to be as independent as able and observed for changes in her abilities. Peri care completed with incontinence episodes. R24's Urinary Incontinence and Indwelling Catheter Care Area Assessment dated 5/11/26, identified R24 required assistance for transfers. Care area was triggered due to prescribed medication, impaired mobility, health history and ADL review. She was to be observed for changes in her elimination pattern and peri care to be completed with incontinent episodes. R24's care plan revised 5/27/26, identified the following: R24 was frequently incontinent of urine. Staff were directed to document incontinent episodes. Bladder assessment at least quarterly. Monthly 24-hour (hr) bladder/bowel record. Provide with appropriate incontinence products. R24 required an extensive partial assistance of one (PAO1) using a gait belt (GB) and a wheeled walker to transfer, wipe, adjust clothing and manage incontinence. R24 was to receive peri cares twice daily and as needed after any incontinent episode. Protective ointment to skin as needed. Observe for signs/symptoms of urinary tract infection (UTI): pain or burning with urination, fever, increased incontinence, cloudy/odorous urine in small amounts, increased confusion/lethargy. Encourage adequate fluids. However, the care plan failed to direct staff regarding precautions related to R24's loose stools.	F0880		07/08/2026

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F0880 SS = F	Continued from page 21 R24's nursing progress notes identified the following: On 5/13/26 at 8:30 p.m., R24 was complaining of pain. As needed (PRN) Ibuprofen given per orders and effective. R24 was given Imodium (an anti-diarrhea medication) per order after 2 loose stools. So far effective. On 5/15/26 at 1:33 p.m., R24 complained of some pain especially during transfers. R24 some diarrhea. Ibuprofen and Imodium given per orders. On 5/17/26 at 12:48 p.m., R24 had loose stools. PRN Imodium given per order. R24 verbalizing pain but refuses all interventions. On 5/24/25 at 1:49 p.m., R24 refused some of her medications this morning. Loperamide given at 1015 for loose stools, medication was effective. On 5/27/26 at 1:20 p.m., R24 had a loose stool before lunch and was given 4 mg of PRN loperamide at 11:09 a.m. No further loose stools noted. On 5/28/26 at 1:33 p.m., R24 has loose stools. PRN Imodium given and effective. R24 also complaining of pain. Scheduled Tylenol was given a little early due to condition. No other concerns. On 5/29/26 at 9:31 a.m., IDT review: R24 having loose stools, will contact provider for stool sample. On 5/29/26 at 1:33 p.m., R24 had PRN Imodium per order. No other concerns. On 5/29/26 at 2:26 p.m., writer contacted R24's doctor regarding concerns of loose stools. Received order as follows: 1. Stool C-diff 2. Stool culture. On 6/2/26 at 10:43 a.m., stool sample was collected. On 6/3/26 at 11:25 p.m., stool tests were negative,	F0880		07/08/2026

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F0880 SS = F	Continued from page 22 and results were sent to R24's doctor. R24's medical record failed to identify if R24's loose stools required contact precautions. R24 R4's Enteric Pathogens by Molecular Detection resulted 6/2/26, identified R24 as negative. R24's Clostridium difficile by Molecular Detection resulted 6/2/26, identified R24 was negative. During an observation on 6/7/26 at 11:30 a.m., R24's doorway had no signage and/or cart. R24 was lying in bed with her head of bed (HOB) at 30 degrees. R24 was wearing a dusky purple sweatshirt and no pants. There was a fleece blanket across the foot of R24's bed but it was not covering R24. R24 was wearing an incontinent brief with no pants and had her knees bent with her feet resting on the bed. R24 had been incontinent of bowel and bladder. At 12:10 p.m., NA-B entered R24's room and told R24 she was wet, so she needed to be cleaned up. NA-B put on gloves but no gown, then told R24 she didn't need to cry because she was there. R24 stated "I want to get up". At 12:11 p.m. NA-B unfastened R24's incontinent brief and used disposable wipes to clean R24's skin of feces and urine. R24 had a loose, watery stool. R24 stated that her skin was itchy, NA-B told R24 that R24 had "pooped" and NA-B would clean R24's skin well. At 12:22 p.m., NA-A and NA-B entered the room and used the ceiling lift to transfer R24 from her bed to her wheelchair. NA-B then brought R24 to the dining room for her noon meal. NA-B did not offer to wash R24's hands in the sink and NA-B used hand sanitizer when leaving the room. During an interview on 6/7/26 at 12:28 p.m., NA-B stated she had removed her gloves and did not clean her soiled gloves with a disposable wipe. "No. I removed my gloves." NA-B then stated staff had to remove their gloves after cleaning feces to prevent the spread of germs everywhere. NA-B stated hand sanitizer was ok. During an observation on 6/8/26 at 1:09 p.m., TMA-A entered R24's room without gown or gloves.	F0880		07/08/2026

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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
F0880 SS = F	Continued from page 23 TMA-A used hand sanitizer when exiting R24's room. During an interview on 6/9/26 at 2:49 p.m., the DON stated whenever staff are requesting a stool panel for a resident that has loose stools, precautions should be started. Even if the provider did not believe a stool panel was warranted and the loose stools were ongoing, precautions should be started to ensure a stool panel was needed in the future and became positive. This should continue until the loose stools resolve. Staff were expected to follow precautions and precautions should be care planned to direct staff to do so. The facility policy Contact Precautions revised 9/2023, identified Contact Precautions are used when diseases are transmitted by contact with the resident or the resident's environment. Residents with disease caused by organisms that have been demonstrated to cause heavy environmental contamination will be placed on Contact Precautions. The policy included the following: A. Resident Placement: Decisions regarding resident placement during an acute infection will be made on a case-by-case basis. Consideration will be given to risk of transmission to roommate, presence of any factors that will increase the likelihood of transmission, and the psychological impact on the infected resident. B. Procedure for Contact Precautions: 1. Hand Hygiene is done prior to donning PPE. 2. PPE is donned prior to entering room. A gown and gloves are needed upon entering room. 3. Change gown and gloves between residents even if only one resident is on Contact Precautions. 4. Use of masks, eye protection and face shields is not routinely a part of contact precautions, however, just as with Standard Precautions, these items are worn during resident care activities that are likely to create splashes or sprays of blood, body fluid, secretions, and excretions. 5. Hand hygiene is perfom1ed between glove changes and when removing gloves. The facility policy Standing House Orders for Symptoms Management revised February 2025, identified the following: Bowel and Bladder Management Bowel: Diarrhea (Perform steps sequentially) Perform rectal check to determine if impaction is present; If impacted, follow guidelines for constipation; If not impacted, hold all cathartic-related (constipation) meds and observe for 24 hours. If diarrhea is resolved, resume cathartic-related (constipation) med. If diarrhea continues: Notify Provider of the change in condition to determine if sending a stool specimen	F0880		07/08/2026

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F0880 SS = F	Continued from page 24 for C. difficile toxin A and Bis indicated; If testing for C. difficile toxin is ordered, collect only diarrheal (unformed) stool; and Encourage fluids to help maintain hydration. However, the policy failed to direct staff to place the resident into precautions until testing and/or loose stools were resolved. The Center for Disease Control and Prevention (CDC) About C. diff dated 5/13/26, identified Clostridioides difficile [klos–TRID–e–OY-dees dif–uh–SEEL], also known as Clostridium difficile and often called C. difficile or C. diff, is a bacterium (germ) that causes diarrhea and inflammation of the colon. Symptoms include: Diarrhea, Fever, Stomach tenderness or pain, Loss of appetite, and Nausea.C. diff infection (CDI) is more common among patients in healthcare settings, such as hospitals and nursing homes. This is because many people who have C. diff stay or get treated in those facilities. Other risk factors include: Older age (65 or older); A weakened immune system, such as people with cancer or organ transplants taking drugs that suppress the immune system; and Previous infection with C. diff or known exposure to the germs When C. diff germs are outside the body, they become spores. These spores are an inactive form of the germ and have a protective coating allowing them to live for months or years on surfaces and in the soil. Spores become active again after being swallowed and reaching the intestines. Once there, they can cause infection if your immune system is weak or you've recently taken antibiotics. However, most healthy people don't get infected even if spores reach their intestines. If a patient has had three or more stools in 24 hours; Isolate patients with possible C. diff immediately, even if you only suspect CDI; Order a C. diff test if other etiologies of diarrhea such as stool softener or laxative were not used; Wear gloves and a gown when treating patients with potential infectious diarrhea, including C. diff infection, even during short visits. Gloves are important because hand sanitizer doesn't kill C. diff. In addition, handwashing alone may not be sufficient to eliminate all C. diff spores; and Reassess appropriateness of antibiotics in C. diff patients. SURVEILLANCE The facility surveillance log dated 2/25/26 through 6/2/26, identified resident name, room number and unit, admit date, event closed date, infection type, body system of infection, origin of infection, onset date, resolved date, was surveillance met, was there a hospital admission, was the infection reportable, signs and symptoms, was it a device related	F0880		07/08/2026

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F0880 SS = F	Continued from page 25 infection, risk factors, laboratory results, type of tests, test dates, culture source/radiology site, test results, treatment, medication class, dose, route, frequency, treatment start date, treatment end date, total days of therapy, did the infection meet criteria and was transmission-based precautions implemented. The log identified the following infections: 12 Urinary tract infection (UTI) 4 cellulitis (skin infection) 3 “other” 1 lower respiratory tract infection 1 norovirus (a highly contagious virus that causes acute gastroenteritis - inflammation of the stomach and intestines. Commonly referred to as the "stomach flu" or food poisoning, it is completely unrelated to the influenza virus. It triggers sudden, severe vomiting, diarrhea, and stomach cramps) 1 Clostridioides difficile (C. diff) (a highly contagious bacterium that infects the large intestine (colon), causing severe inflammation (colitis) and watery diarrhea. It primarily affects individuals whose normal gut bacteria have been disrupted by recent antibiotic use, making it a common healthcare-associated infection) However, the log did not identify any resident with a sign and/or symptom of an infection that was not treated. During an interview on 6/9/26 at 3:13 p.m., the director of nursing (DON) stated there was an infection tracker built into the electronic medical record. Whenever a resident exhibited signs or symptoms of an infection, staff opened an infection tracker for that resident. The tracker helped identify trends and addressed antibiotic stewardship, room grouping, history of organisms, and a deeper dive into the infections. Outbreak management required an action plan depending on the organism. Also, it helped determine who needed precautions, testing, etc. The surveillance tracking log then pulled data from the electronic medical record system. The	F0880		07/08/2026

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F0880 SS = F	Continued from page 26 facility used the McGreer criteria (standardized definitions used to detect and track infections (such as UTIs, pneumonia, and respiratory illnesses) in long-term care and nursing facilities.) The resident infections were monitored daily to determine if there were trends then, at the end of the month, percentages were calculated, and all the data was brought to the quality improvement meeting for discussion. The DON stated all infections should be documented and put on the surveillance log for tracking. For R24, an event should have started to track R24's diarrhea. It was important to track bowels in general, but diarrhea lets the staff know when intervention was needed. At 3:21 p.m., the DON stated an event tracker should have started for R7 as well. The DON had noticed R7 was rooming with R12 who had tested positive for C. diff and norovirus when she began her role at the facility the week prior. At that point, R12 was fully into treatment, experiencing symptoms and R7 was already exposed. The DON felt to roomR7, at that time, was just going to spread the infection more so R7 continued rooming with R12. The DON stated she was going to have a meeting with the unit managers to discuss the resident care plans and Kardex because that was what instructed the staff on how to provide care for the residents. If the staff were unaware, the staff would not follow precautions as expected. Hand Hygiene R24's admission MDS dated 5/6/26, identified R24 had mild cognitive impairment and was dependent on staff for toileting and transfers and was frequently incontinent with bowel and bladder. Diagnoses included non-traumatic spinal cord dysfunction, diabetes, and dementia. R24's Activities of Daily Living (ADLs) Functional/Rehabilitation Potential Care Area Assessment (CAA) dated 5/11/26, identified R24 was a recent admit from another care center and had diagnoses of dementia, depression, heart failure and asthma. R24 had clear speech and was understood and usually understood. R24 denied shortness of breath. R24 stated she had pain per medication administration record (MAR) review. R24 had a history of refusing medications per staff. R24 was frequently incontinent of bowel and bladder and had some moisture-associated skin damage (MASD) noted with ointment/cream to apply. R24 required assistance for transfers. Care area was triggered due to ADL review. R24 would be assisted per need and per request. R24 was to be encouraged to be as	F0880		07/08/2026

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F0880 SS = F	Continued from page 27 independent as able and observed for changes in her abilities. Peri care completed with incontinence episodes. R24's Urinary Incontinence and Indwelling Catheter Care Area Assessment dated 5/11/26, identified R24 required assistance for transfers. Care area was triggered due to prescribed medication, impaired mobility, health history and ADL review. She was to be observed for changes in her elimination pattern and peri care to be completed with incontinent episodes. R24's care plan revised 5/27/26, identified the following: R24 was frequently incontinent of urine. Staff were directed to document incontinent episodes. R24 was to receive peri cares twice daily and as needed after any incontinent episode. Protective ointment to skin as needed. During an observation on 6/7/26 at 12:11 p.m., NA-B unfastened R24's incontinent brief and used disposable wipes to clean R24's skin of feces and urine. R24 stated that her skin was itchy, NA-B told R24 that R24 had "pooped" and NA-B would clean R24's skin well. At 12:13 p.m., NA-B rolled R24 to the right and R24 began crying and stated, "I can't do this". NA-B told R24 that they were almost done. R24's skin on her upper thighs and buttocks was reddened but had no open areas. NA-B applied barrier cream then a clean brief. NA-B used disposable wipes to clean her gloves. NA-B did not remove her gloves nor use hand sanitizer. During an interview on 6/7/26 at 12:28 p.m., NA-B stated she had removed her gloves and did not clean her soiled gloves with a disposable wipe. "No. I removed my gloves." NA-B then stated staff had to remove their gloves after cleaning feces to prevent the spread of germs everywhere. During an interview on 6/9/26 at 11:29 a.m., trained medication aide (TMA)-A stated staff were always expected to remove gloves and use hand sanitizer whenever removing a soiled brief before putting on the clean brief because you didn't want to get feces on anything. "That's just gross." During an interview on 6/9/26 at 11:42 a.m., NA-C stated she always changed her gloves after taking off a soiled brief or after wiping a resident because it was just better that way.	F0880		07/08/2026

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F0880 SS = F	Continued from page 28 During an interview on 6/9/26 at 2:06 p.m., registered nurse (RN)-A stated staff obviously need education regarding hand hygiene and when to remove gloves. “It’s appalling”. During an interview on 6/9/26 at 2:49 p.m., the DON stated staff were expected to never go from dirty to clean. After providing peri care, staff were expected to remove their gloves, use hand sanitizer, then apply new gloves prior to finishing the task to prevent the spread of organisms or possible infection. The facility policy Hand Hygiene dated 2024, identified Infection Prevention begins with the basic hand hygiene. By following proper hand hygiene practices, associates will reduce the spread of potentially deadly ge1ms, as well as reduce the risk of healthcare provider colonization caused by gem1s acquired from the residents. Hand hygiene simply means cleaning hands using either handwashing (washing hands with soap and water), or antiseptic hand rub (i.e. alcohol-based hand sanitizer, including foam or gel). Times to Perform Hand Hygiene arc, but not limited to: When arriving for work; When hands are visibly soiled, wash hands with soap and water; Before and after direct resident contact; Before and after performing any invasive procedure (e.g. fingerstick blood sample); Before and after entering isolation precaution setting; Before and after eating or handling food -wash hands with soap and water; Before and after assisting a resident with meals -wash hands with soap and water; Before and after assisting a resident with personal care; Before and after handling peripheral vascular catheters and other invasive devices; Before and aft.er inse11ing indwelling catheters; Before and after changing a wound dressing; Upon and after coming in contact with a resident's intact skin, such as when taking vitals or after assisting with lifting; After personal use of the restroom -wash hands with soap and water; Before and after assisting a resident with toileting -wash hands with soap and water; After blowing or wiping nose; After contact with a resident's mucous membranes and body fluids or excretions; After handling soiled or used linens, dressing, bedpans, catheters and urinals; After handling soiled equipment or utensils; After performing your personal hygiene -wash hands with soap and water; After removing gloves or aprons; When workday is completed. ENHANCED BARRIER PRECAUTIONS	F0880		07/08/2026

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F0880 SS = F	Continued from page 29 R6: R6's annual Minimum Data Set (MDS) dated 5/29/26, identified R6 had intact cognition and required moderate assistance with bathing. R6 had an abdominal feeding tube (G-tube). Diagnoses included Parkinson's disease, narcolepsy, anxiety, and dysphagia (difficulty swallowing). R6's care plan dated 6/1/26, identified R8 was frequently incontinent of bladder. Approaches included for staff to provide peri care two times per day and as needed (PRN) when incontinent. R8's care plan also identified R8 has special treatment/procedures related to the presence of a G-tube. Approaches included to provide daily care and observance of R8's G-tube to ensure patency and usefulness. The care plan failed to include instructions for enhanced barrier precautions (EBP) related to when staff provided personal cares. R6's undated Active Order Report identified numerous medication orders, all with instruction to crush and administer the medication through her feeding tube. On 6/8/26, at 6:34 a.m. a plastic cart was observed outside of R6's room. The cart contained disposable gloves and masks. A sign on top of the cart identified R6 was on enhanced barrier precautions and directed staff to wear a gown and gloves when performing direct care, including G-tube care. During observation and interview on 6/8/26, at 6:34 a.m. licensed practical nurse (LPN)-A entered R6's room to start R6's enteral feeding. LPN-A donned gloves but failed to don a gown. LPN-A poured a small amount of water into a 60 cc syringe, opened the cap on R6's G-tube and attached the syringe. LPN-A attempted to allow the water to drain into the G-tube but had to manually milk the G-tube to get the water to go in. LPN-A primed the feeding tube with formula and attached the feeding to to R6's G-tube. LPN-A removed her gloves and used hand sanitizer on her hands and left R6's room to obtain a dressing. LPN-A returned to R6's room with a split 4x4 dressing. LPN-A put on gloves, leaned over R6 on the bed and placed the dressing on R6's abdomen, around the G-tube. LPN-A removed her gloves, secured the dressing with tape, used hand sanitizer on her hands and exited the room. LPN-A stated she always wore gloves when she worked with R6's G-tube but did not always put on a	F0880		07/08/2026

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F0880 SS = F	Continued from page 30 protective gown. LPN-A stated she had not received specific instruction for the use of EBP's related to R6's G-tube care. R6 did have an EBP cart outside of her room with instructions on top of the cart regarding what and when certain PPE was required. The instructions identified gown and gloves were required when providing G-tube care. LPN-A stated sometimes she put on a gown and other times she did not. There were no gowns in the cart and so she had not worn one, when gowns were in the PPE carts outside of resident rooms, she put them on. There were masks in R6's PPE cart, but she had not worn a mask. LPN-A did not understand the PPE setup and thought maybe the facility did want the staff to wear masks as well. When the facility had a resident on contact precautions, they had been given clear instructions on what PPE was needed but she did not remember getting any instructions on what PPE was required for G-tube care or for EBP. During interview on 6/8/26, at 10:38 a.m. the DON stated providing G-tube care would be one instance when EBP should be used. EBP should be on resident's plan of care when it was required to be used. The DON stated it was important for staff to put on a gown when indicated for direct care to prevent transmission of multidrug-resistant organisms (MDRO), protect other residents and to keep the staff uniform clean from splashes. R7: R7's annual Minimum Data Set (MDS) dated 4/5/26, identified R5 had severe cognitive impairment and diagnosis included obesity. R7 had an unstageable pressure ulcer and moisture associated skin damage (MASD). R7's care plan dated 5/22/26, lacked any guidance of use for enhanced barrier precautions (EBP). R7's wound assessment dated 6/8/26, identified the coccyx ulcer was stable and measured 1.5 centimeters (cm) x 0.3 cm x 0.3 cm deep. During observations on 6/8/26 at 7:46 a.m., there was an isolation cart outside of R7's room with a contact precaution sign for R7's roommate and did not address if R7 was on enhanced barrier precautions (EBP). The cart had gloves and masks in the first drawer, eye/face protection in second	F0880		07/08/2026

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F0880 SS = F	Continued from page 31 drawer, and the third drawer was empty. There were no gowns on the cart. On 6/8/26 at 9:19 a.m., NA-A stated they did not need to wear a gown or gloves when caring for R7, and they only needed to wear it for R7's roommate. NA-A then entered R7's room and proceeded to get R7 ready for the day. NA-A was not wearing a gown or gloves. During observation on 6/8/26 at 12:11 p.m., the isolation cart was removed from in front of R7's door. During an interview on 6/9/26 at 3:21 p.m., the DON stated R7 should have been on EBP due to chronic wounds. The DON stated she noticed it last Monday when she started working at the facility. The DON stated she need to have a meeting with the unit managers to discuss updating care plans, and Kardex (quick reference for providing care to a specific resident) related to use of EBP. If staff do not know about it, they will not follow precautions as expected. The facility's undated Enhanced Barrier Precautions policy identified EBP were used with resident with chronic wound and required the use of gown and gloves when performing high contact activities with the resident. These activities included dressing, bathing, transferring, providing hygiene, changing linens, assisting with toileting and changing briefs, residents with chronic wounds and for residents with indwelling medical devices.	F0880		07/08/2026
F0656 SS = E	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or	F0656	CMS Plan of Correction – F656 Develop/Implement Comprehensive Care Plan Completion Date: July 8th, 2026 Director of Nursing: Eliza Messerschmidt, RN, DNS-CT Administrator: Jason Carlson, LNHA Changes Implemented: July 1, 2026 1. Corrective Action for Residents Found to be Affected	07/08/2026

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F0656 SS = E	Continued from page 32 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 document review the facility failed to develop comprehensive, person-centered care plan to include enhanced barrier precautions (EBP) for 3 of 5 residents (R6, R7, R1) reviewed who were identified to be on EBP. Findings include: R6 R6's annual Minimum Data Set (MDS) dated 5/29/26, identified R6 had intact cognition and required moderate assistance with bathing. R6 had an	F0656	Continued from page 32 Residents identified during survey review, including residents requiring Enhanced Barrier Precautions (EBP) due to chronic wounds, indwelling devices, and G-tube utilization, were immediately reviewed by the interdisciplinary team. Care plans were updated to accurately reflect EBP requirements, including when gowns and gloves are required during high-contact resident care activities. Orders were entered for EBP for the affected residents. Resident R6 EBP sign updated to identify bed A. Care plan completed for EBP use while performing cares and accessing g-tube. Resident R7 EBP sign updated to identify bed A. Care plan was completed for EBP use while performing cares. R1 EBP sign updated to identify bed A. Care plan completed for EBP use while performing cares. Nursing staff were educated regarding the requirement that care plans accurately reflect resident-specific infection prevention interventions, physician orders, and identified care needs. Residents identified during survey review had care plans revised to include individualized EBP interventions and instructions for staff, orders were entered for EBP. 2. Identification of Other Residents with the Potential to be Affected All residents residing in the facility had the potential to be affected by the deficient practice. The Director of Nursing, Infection Preventionist, Clinical Manager, MDS Coordinator, and interdisciplinary team conducted a facility-wide audit of residents requiring Enhanced Barrier Precautions, transmission-based precautions, chronic wound management, indwelling devices, feeding tubes, and other infection prevention interventions. All resident care plans were reviewed to ensure care planning accurately reflected physician orders, assessed needs, infection prevention interventions, and current resident conditions. Any identified deficiencies were immediately corrected. 3. Systemic Changes Implemented Effective July 1, 2026, the facility implemented the	07/08/2026

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F0656 SS = E	Continued from page 33 abdominal feeding tube (G-tube). Diagnoses included Parkinson's disease, narcolepsy, anxiety, and dysphagia (difficulty swallowing). R6's care plan with review date 6/1/26, identified R8 was frequently incontinent of bladder. Approaches included for staff to provide peri care two times per day and as needed (PRN) when incontinent. R8's care plan also identified R8 has special treatment/procedures related to the presence of a G-tube. Approaches included to provide daily care and observance of R8's G-tube to ensure patency and usefulness. The care plan failed to include instructions for EBP related to when staff provided G-tube and/or personal cares. R6's undated Active Order Report reviewed 6/9/26, identified numerous medication orders, all with instruction to crush and administer the medication through her feeding tube. On 6/8/26, at 6:34 a.m. a plastic cart was observed outside of R6's room. The cart contained disposable gloves and masks. A sign on top of the cart identified R6 was on enhanced barrier precautions and directed staff to wear a gown and gloves when performing direct care, including G-tube care. During interview on 6/8/26, at 10:38 a.m. the director of nursing (DON) stated providing G-tube care would be one instance when EBP should be used. EBP should be on resident's plan of care when it was required to be used. The DON stated it was important for staff to put on a gown when indicated for direct care to prevent transmission of multidrug-resistant organisms (MDRO), protect other residents and to keep the staff uniform clean from splashes. The required use of EBP's should be care planned on the resident's plan of care because it did affect the resident's care. The DON thought it used to be on the resident's care plan as well as in the physician orders, but she had not gotten all resident's charts audited and so it may not be on every resident's chart as needed. R7 R7's annual Minimum Data Set (MDS) dated 4/5/26, identified R5 had severe cognitive impairment and diagnosis included obesity. R7 had an unstageable pressure ulcer and moisture associated skin damage (MASD). R7's wound assessment dated 6/8/26, identified the coccyx ulcer was stable and measured 1.5	F0656	Continued from page 33 following systemic corrective actions: • Completed a facility-wide audit of resident care plans requiring infection prevention interventions. • Revised care planning processes to ensure physician orders, infection prevention requirements, and resident-specific interventions are accurately reflected in care plans. • Educated licensed nurses, MDS staff, unit managers, and interdisciplinary team members regarding: - Comprehensive care plan requirements - Person-centered care planning - Enhanced Barrier Precautions requirements - Incorporation of physician orders into care plans - Timely care plan review and updates - Documentation expectations - Interdisciplinary care plan responsibilities • Implemented additional review of newly admitted residents and residents with significant changes to ensure care plans are updated timely. • Implemented leadership review of residents requiring Enhanced Barrier Precautions to verify care plans accurately reflect infection prevention interventions. • Education was initiated July 1, 2026, and will continue through orientation and annual competency validation. 4. Monitoring and Quality Assurance The Director of Nursing, MDS Coordinator, Infection Preventionist, Clinical Manager, or designee will conduct the following audits: Care Plan Audits • Five resident care plan audits weekly for four weeks.	07/08/2026

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F0656 SS = E	Continued from page 34 centimeters (cm) x 0.3 cm x 0.3 cm deep. R7's care plan dated 5/22/26, lacked any guidance of use for EBP. During observations on 6/8/26 at 7:46 a.m., there was an isolation cart outside of R7's room with a contact precaution sign for R7's roommate and did not address if R7 was on EBP. The cart had gloves and masks in the first drawer, eye/face protection in second drawer, and the third drawer was empty. There were no gowns on the cart. During an interview and observation on 6/8/26 at 9:19 a.m., nursing assistant (NA)-A stated they did not need to wear a gown or gloves when caring for R7, we only needed to wear that for R7's roommate. NA-A then entered R7's room and proceeded to get R7 ready for the day. NA-A was not wearing a gown or gloves. R1 R1’s quarterly MDS dated 4/30/26, identified R1 had moderate cognition and had an indwelling catheter. Diagnoses included renal insufficiency, urinary retention. R1’s care plan dated 5/22/26, included instructions to change catheter monthly, complete catheter care daily, and monitor for signs and symptoms of infection. The care plan failed to include instructions for EBP related to catheter. During observation on 6/9/26 at 7:23 a.m., a plastic cart was outside R1’s room. The cart contained disposable gowns and gloves, and a sign identifying R1 was on enhanced barrier precautions. The sign included instructions for staff to wear gowns and gloves when performing direct care, including catheter care. During interview on 6/10/26 at 5:16 p.m., DON stated EBP was used to prevent the spread of infections between staff/residents and helped to reduce the spread of multidrug-resistant organisms (MDRO’s) whether they are known, suspected or potential. The DON stated staff were expected to follow resident care plans and the facility policy regarding wearing PPE for EBP. The Enhanced Barrier Precautions policy, revised 3/28/24, identified the purpose was to decrease transmission of CDC-targeted and other epidemiologically important MDRO’s, and EBP	F0656	Continued from page 34 • Five resident care plan audits biweekly for an additional eight weeks. Enhanced Barrier Precaution Audits • Weekly audit of all residents requiring EBP for twelve weeks to verify care plans accurately reflect required interventions. Admission and Significant Change Audits • Weekly review of new admissions and significant change assessments for twelve weeks to ensure care plans are updated timely. QAPI Oversight • Audit findings will be reviewed monthly through the QAPI Committee. • Any identified concerns will result in immediate corrective action, re-education, increased monitoring, and follow-up auditing until sustained compliance is achieved. The facility alleges compliance on July 8th, 2026, when all corrective actions were completed and systems were established to ensure ongoing compliance with F656 Develop/Implement Comprehensive Care Plans.	07/08/2026

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F0656 SS = E	Continued from page 35 would be used for residents actively infected or colonized with CDC-targeted and other epidemiologically important MDRO's. Additionally, residents at risk for MDRO's, specifically those with an indwelling medical device and/or chronic wounds requiring a dressing would be required to use EBP. The Comprehensive Assessments and Care Planning policy revised 2/26/26, identified a comprehensive person-centered care assessment of the resident's condition was completed in order to develop consistent quality care that would attain or maintain the highest practicable physical, mental and psychological functioning possible.	F0656		07/08/2026
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.	F0550	CMS Plan of Correction – F550 Resident Rights/Dignity Completion Date: July 8th, 2026 Director of Nursing: Eliza Messerschmidt, RN, DNS-CT Administrator: Jason Carlson, LNHA Changes Implemented: July 1, 2026 1. Corrective Action for Residents Found to be Affected Resident R24 was immediately assessed by the interdisciplinary team following identification of the deficient practice. The resident's care plan, toileting program, transfer needs, incontinence management interventions, and dignity-related preferences were reviewed and revised as necessary. Staff involved received immediate education regarding resident rights, dignity, prompt response to resident requests, toileting assistance expectations, and person-centered care practices. Staff were instructed that residents are never to be encouraged to remain incontinent or be instructed to void in incontinence products when toileting assistance is requested and can be provided. Resident care assignments and staffing processes were reviewed to ensure resident care needs can be met timely and respectfully. 2. Identification of Other Residents with the Potential	07/08/2026

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F0550 SS = D	Continued from page 36 §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and record review, the facility failed to ensure dignified care was provided for 1 of 1 resident (R24) reviewed for dignity. Staff encouraged R24 to remain incontinent rather than assisting her to the toilet when requested, resulting in embarrassment, and loss of dignity. Findings include: R24's admission Minimum Data Set (MDS) dated 5/6/26, identified R24 had a mild cognitive impairment and had diagnoses that included non-traumatic spinal cord dysfunction, diabetes, and dementia. R24 was dependent on staff for toileting and transfers and was frequently incontinent with bowel and bladder. R24's Activities of Daily Living (ADLs) Functional/Rehabilitation Potential Care Area Assessment (CAA) dated 5/11/26, identified R24 was a recent admit from another care center and had diagnoses of dementia, depression, heart failure and asthma. R24 had clear speech and was understood and usually understood. R24 denied shortness of breath. R24 stated she had pain per medication administration record (MAR) review. R24 had a history of refusing medications per staff. R24 was frequently incontinent of bowel and bladder and had some moisture-associated skin damage (MASD) noted with ointment/cream to apply. R24 required assistance for transfers. Care area was triggered due to ADL review. R24 would be assisted per need and per request. R24 was to be encouraged to be as independent as able and observed for changes in her abilities. Peri care completed with incontinence episodes. R24's Urinary Incontinence and Indwelling Catheter Care Area Assessment dated 5/11/26, identified R24 required assistance for transfers. Care area was triggered due to prescribed medication, impaired mobility, health history and ADL review. She was to be observed for changes in her elimination pattern and peri care to be completed with incontinent episodes.	F0550	Continued from page 36 to be Affected All residents residing in the facility had the potential to be affected by the deficient practice. The Director of Nursing, Clinical Manager, Unit Managers, and interdisciplinary team conducted a facility-wide review of residents requiring assistance with toileting, transfers, incontinence care, and activities of daily living. Care plans, toileting programs, call light response practices, transfer assistance requirements, and dignity-related interventions were reviewed. Residents requiring extensive assistance, mechanical lift transfers, or frequent toileting assistance were specifically reviewed to ensure services were provided consistent with resident rights and dignity expectations. Any identified concerns were immediately addressed. 3. Systemic Changes Implemented Effective July 1, 2026, the facility implemented the following systemic corrective actions: • Educated all licensed nurses, nursing assistants, trained medication aides, agency staff, and ancillary personnel regarding: - Resident Rights and Dignity requirements - Person-centered care expectations - Timely response to resident requests - Toileting assistance expectations - Incontinence care practices - Respectful communication - Maintaining resident privacy and dignity - Call light response expectations - Resident choice and self-determination	07/08/2026

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F0550 SS = D	Continued from page 37 R24's care plan revised 5/27/26, identified the following: R24 was frequently incontinent of urine. Staff were directed to document incontinent episodes. Bladder assessment at least quarterly. Monthly 24-hour (hr) bladder/bowel record. Provide with appropriate incontinence products. R24 required an extensive partial assistance of one (PAO1) using a gait belt (GB) and a wheeled walker to transfer, wipe, adjust clothing and manage incontinence. R24 was to receive peri cares twice daily and as needed after any incontinent episode. Protective ointment to skin as needed. Observe for signs/symptoms of urinary tract infection (UTI): pain or burning with urination, fever, increased incontinence, cloudy/odorous urine in small amounts, increased confusion/lethargy. Encourage adequate fluids. R24 had self-deficit with the following activities of daily living: bathing, personal hygiene, ambulation, transferring, toileting, dressing, bed mobility, eating, ambulating and medication administration. Staff were directed R24 required assist of two (AO2) assistance with all transfers to and from bed, wheelchair and toilet. R24 used a full body mechanical lift. R24 could verbally ask for assistance with toileting. R24 required assistance from two to get R24's toileting needs addressed. R24 used the toilet for my current toileting needs and was both continent/incontinent. R24 was to be offered toileting every 3 hours to help R24 to remain free of skin breakdown and respect R24's dignity. During an observation on 6/7/26 at 11:30 a.m., R24 was lying in bed with her head of bed (HOB) at 30 degrees. R24 was wearing a dusky purple sweatshirt and no pants. There was a fleece blanket across the foot of R24's bed but it was not covering R24. R24 was wearing an incontinent brief with no pants and had her knees bent with her feet resting on the bed. R24 was crying and stated staff told R24 she had to stay in bed and couldn't get up. "I don't know why." R24 then stated, "they told me to pee my pants, and they'd clean me up here." R24 stated this happened "all the time". At that time, nursing assistant (NA)-B stepped into the room and told R24 NA-B needed to help another resident and would be back. NA-B turned off R24's call light and left the room. R24 continued to cry and stated nursing assistants said that and shut off R24's call light "just about every day" and "they say they're short". R24 sobbed and stated "I hate it here. It's awful. I hate peeing in my pants."	F0550	Continued from page 37 • Reinforced expectations that residents are never to be encouraged to remain incontinent due to staffing challenges or workload concerns. • Implemented leadership rounds to monitor resident dignity, call light response, and resident satisfaction. • Reviewed staffing assignments and workflows to improve timely response to resident care needs. • Implemented additional monitoring of residents requiring frequent toileting assistance and extensive transfer assistance. • Education was initiated July 1, 2026 and will continue through orientation and annual competency validation. 4. Monitoring and Quality Assurance The Director of Nursing, Clinical Manager, Unit Managers, or designee will conduct the following audits: Resident Dignity Audits • Five resident observations weekly for four weeks. • Five resident observations biweekly for an additional eight weeks. Call Light Response Audits • Weekly call light response observations for twelve weeks. Toileting and ADL Audits • Five resident care observations weekly for twelve weeks to evaluate timely toileting assistance and dignity during care. Resident Interview Audits • Five resident interviews weekly for twelve weeks regarding dignity, respect, and responsiveness of staff. QAPI Oversight	07/08/2026

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F0550 SS = D	Continued from page 38 At 12:10 p.m., NA-B entered R24's room and told R24 she was wet and needed to be cleaned up. While putting on gloves, NA-B told R24 she didn't need to cry because NA-B was there. NA-B proceeded to provide incontinent care. Afterwards, NA-A and NA-B transferred R24 into her wheelchair using the full body mechanical lift. During an interview on 6/7/26 at 12:28 p.m., NA-B stated the facility was working "short" that day. "You just do the best you can." NA-B stated R24 did get up into her chair for breakfast that morning, but staff laid R24 down to do incontinent care after breakfast. NA-B stated R24 was "encouraged" to stay in bed because NA-B had other residents to care for. R24 did turn on her call light and asked to get up, but R24 was assistance of 2 and NA-B was providing care to another resident. During an interview on 6/9/26 at 11:29 a.m., trained medication aide (TMA)-A stated R24 should never wait when she had to go to the bathroom because R24 would then be incontinent. R24 should never be encouraged to go to the bathroom in her pants because that's not what R24 or any resident deserved. Staff are expected to either request help from another staff member or to prioritize work to the best of their ability. During an interview on 6/9/26 at 11:42 a.m., NA-C stated R24 cannot wait when R24 asked to use the bathroom. When R24 turned on her call light, NA-C tried to get her to the bathroom right away because R24 would have an "accident." R24 or any other resident should never be told to go in their pants because of dignity. During an interview on 6/9/26 at 1:36 p.m., licensed practical nurse (LPN)-A stated a resident should never be told to just go in their pants because the residents have the right to receive their care. During an interview on 6/9/26 at 2:06 p.m., registered nurse (RN)-A stated a resident should never be told to be incontinent. It was a dignity issue as well as an ADL issue. "It's just wrong." During an interview on 6/9/26 at 2:49 p.m., the director of nursing (DON) stated staff were expected to provide care when requested and to ensure all residents are safe. Staff were also expected to never tell a resident to be incontinent because it was a dignity issue for the residents. The facility policy Activities of Daily Living (ADL)	F0550	Continued from page 38 • Audit findings will be reviewed monthly through the QAPI Committee. • Negative findings will result in immediate corrective action, additional education, increased monitoring, and follow-up auditing until sustained compliance is achieved. The facility alleges compliance on July 8th, 2026, when all corrective actions were completed and systems were established to ensure ongoing compliance with F550 Resident Rights and Dignity.	07/08/2026

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F0550 SS = D	Continued from page 39 dated 2021, identified staff were directed to provide residents with care, treatment and services appropriate to maintain or improve their ability to carry out activities of daily living (ADLs).	F0550		07/08/2026
F0585 SS = D	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system;	F0585	CMS Plan of Correction – F585 Grievances Completion Date: July 8th, 2026 Director of Nursing: Eliza Messerschmidt, RN, DNS-CT Administrator: Jason Carlson, LNHA Changes Implemented: July 1, 2026 1. Corrective Action for Residents Found to be Affected The grievance identified during survey review regarding a missing hearing aid was immediately reviewed by facility leadership. A comprehensive investigation was completed, documentation was reviewed, and follow-up communication was conducted with the resident and/or resident representative as appropriate. The facility reviewed grievance documentation requirements, investigation processes, communication expectations, and resolution procedures to ensure grievances are fully investigated, documented, resolved, and communicated in accordance with facility policy and regulatory requirements. Staff responsible for receiving, investigating, documenting, and resolving grievances received immediate education regarding grievance management requirements. 2. Identification of Other Residents with the Potential to be Affected All residents residing in the facility had the potential to be affected by the deficient practice. The Administrator, Director of Nursing, Social Services, and interdisciplinary team conducted a review of grievance documentation, investigations,	07/08/2026

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F0585 SS = D	Continued from page 40 (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations; (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to ensure a resident grievance regarding a missing hearing aid was fully investigated, documented, resolved, and communicated to the resident representative in accordance with facility	F0585	Continued from page 40 resolutions, and communication practices. A facility-wide audit of grievances submitted within the previous thirty days was conducted to ensure investigations, follow-up actions, communication, written responses, and documentation were completed according to facility policy. Any identified concerns were immediately corrected. 3. Systemic Changes Implemented Effective July 1, 2026, the facility implemented the following systemic corrective actions: • Reviewed and reinforced the facility grievance policy and procedures. • Educated leadership staff, department managers, social services personnel, licensed nurses, and other designated grievance officials regarding: - Resident rights related to grievances - Grievance investigation requirements - Documentation expectations - Timely communication with complainants - Written grievance response requirements - Tracking and follow-up processes - Regulatory requirements related to F585 • Reinforce use of the Benedictine centralized grievance tracking log to monitor receipt, investigation, follow-up, communication, resolution, and closure of all grievances. • Implemented leadership review of all open grievances at least weekly until resolution. • Established oversight processes to ensure complainants receive timely updates regarding grievance status and outcomes. • Education was initiated July 1, 2026 and will continue during orientation and annual competency validation as applicable. 4. Monitoring and Quality Assurance	07/08/2026

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F0585 SS = D	Continued from page 41 policy for 1 of 1 resident (R5) reviewed for grievances. Findings include: R5's Customer Concern/Grievance dated 5/20/26, identified family member (FM)-A reported R5's hearing aid was missing. The facility documented an initial search of the room, bedding, and laundry; however, no further investigation, follow-up, or resolution was documented. R5's progress notes from 5/20/26 through 6/6/26 contained no documentation regarding the missing hearing aid or grievance follow-up. During an interview on 6/9/26 at 2:33 p.m., the social services designee (SSD) acknowledged receiving the grievance but stated it had been assigned to another person and no outcome had been communicated. During an interview on 6/9/26 at 3:48 p.m., FM-A reported she had not received any updates or information regarding the grievance after filing the concern. During an interview on 6/9/26 at 4:43 p.m., the director of nursing (DON) confirmed there was no documented follow-up and stated the expectation was that grievances would be resolved within five days and the complainant updated on progress and outcome. The facility's Concerns and Grievances policy required investigation, resolution, communication with the complainant within five business days, ongoing updates when resolution was delayed, and documentation of actions taken.	F0585	Continued from page 41 The Administrator, Director of Nursing, Social Services Designee, or designee will conduct the following audits: Grievance Audits • Audit 100% of grievances weekly for four weeks. • Audit 100% of grievances biweekly for an additional eight weeks. Documentation Audits • Weekly review of grievance investigations, communication records, and written responses for twelve weeks. Leadership Review • Weekly review of all open grievances until closure. Resident/Family Follow-Up Audits • Weekly verification of resident or representative communication regarding grievance outcomes for twelve weeks. QAPI Oversight • Audit findings will be reviewed monthly through the QAPI Committee. • Negative findings will result in immediate corrective action, re-education, increased monitoring, and follow-up auditing until sustained compliance is achieved. The facility alleges compliance on July 8th, 2026, when all corrective actions were completed and systems were established to ensure ongoing compliance with F585 Grievances.	07/08/2026
F0605 SS = D	Right to be Free from Chemical Restraints CFR(s): 483.10(e)(1),483.12(a)(2),483.45(c)(3)(d)(e) §483.10(e) Respect and Dignity.	F0605	CMS Plan of Correction – F605 Right to be Free from Chemical Restraints Completion Date: July 8th, 2026	07/08/2026

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F0605 SS = D	Continued from page 42 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 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	F0605	Continued from page 42 Director of Nursing: Eliza Messerschmidt, RN, DNS-CT Administrator: Jason Carlson, LNHA Changes Implemented: July 1, 2026 1. Corrective Action for Residents Found to be Affected The resident identified during survey review (R8) was immediately reviewed by the attending provider, hospice provider, consultant pharmacist, Director of Nursing, and interdisciplinary team. The resident's psychotropic medication regimen, PRN antipsychotic order, physician documentation, pharmacist recommendations, and behavioral documentation were reviewed. The facility ensured the resident's PRN psychotropic medication orders were reviewed for regulatory compliance, clinical indication, duration limits, physician evaluation requirements, and documentation standards. Any identified concerns were immediately addressed and corrected. Licensed nursing staff received immediate education regarding psychotropic medication requirements, PRN psychotropic limitations, physician review requirements, consultant pharmacist recommendations, and documentation expectations. 2. Identification of Other Residents with the Potential to be Affected All residents receiving psychotropic medications had the potential to be affected by the deficient practice. The Director of Nursing, Medical Director, Consultant Pharmacist, Clinical Manager, and interdisciplinary team completed a facility-wide audit of all residents receiving psychotropic medications, including antipsychotics, antidepressants, anxiolytics, hypnotics, and PRN psychotropic medications. The audit included review of physician documentation, behavioral monitoring, gradual dose reduction requirements, pharmacist recommendations, PRN review requirements,	07/08/2026

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F0605 SS = D	Continued from page 43 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 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.	F0605	Continued from page 43 physician evaluations, and medication effectiveness documentation. Any identified concerns were immediately corrected. 3. Systemic Changes Implemented Effective July 1, 2026, the facility implemented the following systemic corrective actions: • Completed a facility-wide review of all psychotropic medications and PRN psychotropic orders. • Implemented a psychotropic medication tracking process to monitor review dates, physician evaluations, pharmacist recommendations, and required follow-up. • Educated licensed nurses, providers, department managers, and interdisciplinary team members regarding: - F605 requirements - PRN psychotropic medication limitations - Fourteen-day review requirements - Physician evaluation requirements - Consultant pharmacist recommendation follow-up - Behavioral monitoring and documentation - Gradual dose reduction requirements - Chemical restraint regulations • Implemented monthly psychotropic medication review meetings. • Implemented enhanced pharmacy recommendation tracking to ensure physician responses and facility follow-up are completed timely. • Education was initiated July 1, 2026 and will continue through orientation and annual competency validation. 4. Monitoring and Quality Assurance The Director of Nursing, Clinical Manager, Consultant	07/08/2026

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F0605 SS = D	Continued from page 44 §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to review and justify continued use of an as needed (PRN) psychotropic medication for 1 of 5 residents (R8) who were reviewed for unnecessary medications. Findings include: R8's quarterly Minimum Data Set dated 6/9/26, identified R8 had moderate cognitive deficit and required moderate assistance with most activities of daily living (ADLs). R8 had not exhibited any behavior during the observation period and did not have hallucinations or delusions. R8 received antianxiety and antidepressant medications during the observation period. Diagnoses included congestive heart failure, dementia, diabetes, and depression. R8's undated Active Physician Orders, identified numerous medication orders for R8, which included haloperidol (antipsychotic) 1 milligram (MG) for agitation and restlessness every four hours PRN with start date 3/1/26 and end date was listed as open ended. R8's care plan dated 3/23/26, identified R8 was under hospice care for end-of-life status due to heart failure. Approaches included to follow the hospice plan of care, communicate with hospice physician and nurses to discuss medication concerns and what was effective. Hospice services with standing orders, scheduled and as needed (PRN) medications for pain, shortness of breath, restlessness and secretions. The care plan identified R8 received psychotropic medications for depression and anxiety with a goal to not experience any adverse reactions. Approaches listed included to administer medications as ordered. Administer the antianxiety medication for increased anxiety and restless. Staff were to document three interventions trialed before administering the PRN medication. MD review per guidelines for a gradual dose reduction and monthly pharmacist review. R8's Consultant Pharmacist Recommendation to Physician reports identified the following: 3/9/26, identified the pharmacist recommended to discontinue the PRN use of Haldol 1 mg every four hours PRN for anxiety/agitation on or before 3/14/26, following federal guidelines that PNR orders for anti-psychotic drugs were limited to fourteen days and could not be renewed unless the attending physician evaluated the resident for the	F0605	Continued from page 44 Pharmacist, or designee will conduct the following audits: Psychotropic Medication Audits • Audit 100% of residents receiving PRN psychotropic medications weekly for four weeks. • Audit 100% of residents receiving PRN psychotropic medications biweekly for an additional eight weeks. Pharmacy Recommendation Audits • Weekly review of consultant pharmacist recommendations for twelve weeks. Behavioral Documentation Audits • Five psychotropic medication documentation audits weekly for twelve weeks. Physician Review Audits • Weekly verification of required physician reviews and evaluations for twelve weeks. QAPI Oversight • Audit findings will be reviewed monthly through the QAPI Committee. • Negative findings will result in immediate corrective action, additional education, increased monitoring, and follow-up auditing until sustained compliance is achieved. The facility alleges compliance on July 8th, 2026, when all corrective actions were completed and systems were established to ensure ongoing compliance with F605 Right to be Free from Chemical Restraints.	07/08/2026

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F0605 SS = D	Continued from page 45 appropriateness of the renewal. R8's physician commented that R8 was a hospice patient and signed the recommendation with no further response or action on 3/24/26. 4/3/26, identified the pharmacist recommended to discontinue the PRN use of Haldol 1 mg every four hours PRN for anxiety/agitation on or before 3/14/26, following federal guidelines that PNR orders for anti-psychotic drugs were limited to fourteen days and could not be renewed unless the attending physician evaluated the resident for the appropriateness of the renewal. No physician response was documented. R8's PRN Medication Administration Record (MAR) dated 5/1/26 to 5/31/26, identified an order for Haldol 1 mg every four hours PRN for agitation and restless. start date of 3/1/26 and open-ended end date. The MAR documented the medication had been administered to R8 on 5/19/26 and 5/26/26. R8's medical record lacked evidence a face-to-face visit was performed by a medical provider and identified the justification for continued used of the antipsychotic. During observation on 6/7/26, R8 was noted be hollering she had to use the bathroom from her room. An unidentified nursing assistant (NA) assisted the resident to use the bathroom and then assisted her into a recliner in the facility's commons area. R8 closed her eyes and went to sleep. The NA stated R8 was tired as she had been up till 3:00 a.m. the night before. During interview on 6/8/26, at 1:23 p.m. licensed practical nurse (LPN)-A stated R8 had a PRN Haldol ordered that was used once in a while. The medication made R8 sleepy, so LPN-A did not typically give her the medication during the day. R8 was diabetic and LPN-A wanted to be sure R8 was alert enough to eat her meals. If R8 was sleepy she would not eat. The PRN Haldol order came from hospice, so hospice would be the ones to review the order. LPN-A knew a pharmacist also came once in a while and reviewed resident medications. LPN-A did know PRN anti-psychotic medications were limited to a specific time, and she had asked the hospice nurse about that, however, she did not get any results. During interview on 6/9/26, at 10:27 a.m. the director of nursing (DON) stated all PRN psychotropic medications should have a fourteen-day review. She had thought the regulation had changed for hospice patients, and it could go longer than fourteen days, but she always had them reviewed every fourteen days. The facility's process was to have hospice follow their patient's medications and notify the facility if there was any need for review or update. The facility's	F0605		07/08/2026

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F0605 SS = D	Continued from page 46 consultant's pharmacist was telephoned on 6/9/26, at 5:56 p.m. and message left to return call. During telephone interview on 6/10/26, at 9:29 a.m. the facility's consultant pharmacist (CP)-G stated he only reviewed medications for the facility for new admissions or hospital returns and was not the pharmacist that had done the monthly medication reviews for R8. CP-G stated it was his understanding the Center for Medicaid and Medicare (CMS) guidelines were that any PRN antipsychotic medication needed to be addressed by the physician The medication needed to be limited to fourteen days and re-evaluated by the provider. If the provider chose to continue the PRN antipsychotic medication, it would need to be evaluated with a face-to-face visit from the provider. CP-G stated hospice was not an exception. The facility's policy Psychotropic Medication Use with review date 9/7/23, identified PRN orders for psychotropic drugs were limited to fourteen days and could not be renewed unless the attending provider evaluated the resident for the appropriateness of the medication.	F0605		07/08/2026
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 activities of daily living (ADL) care and services necessary to maintain residents' abilities by failing to provide timely toileting assistance for 1 of 6 residents (R24) reviewed who required staff assistance with toileting and transfers; and failed to provide timely supervision and assistance with eating for 1 of 6 residents (R23) reviewed who required staff assistance during meals. Findings include: R24: R24’s admission Minimum Data Set (MDS) dated 5/6/26, identified R24 had mild cognitive impairment and was dependent on staff for toileting and transfers and was frequently incontinent with bowel and bladder. Diagnoses included non-traumatic spinal cord dysfunction, diabetes, and dementia.	F0677	CMS Plan of Correction – F677 ADL Care Provided for Dependent Residents Completion Date: July 8th, 2026 Director of Nursing: Eliza Messerschmidt, RN, DNS-CT Administrator: Jason Carlson, LNHA Changes Implemented: July 1, 2026 1. Corrective Action for Residents Found to be Affected Residents identified during survey review (R24 and R23) were immediately assessed by the interdisciplinary team. Care plans, ADL assistance needs, toileting schedules, transfer requirements, dining assistance needs, and staffing assignments were reviewed and updated as indicated. Staff involved received immediate education regarding timely toileting assistance, prompt response to resident requests, resident dignity, transfer assistance requirements, dining supervision, and meal assistance expectations.	07/08/2026

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F0677 SS = D	Continued from page 47 R24's Activities of Daily Living (ADLs) Functional/Rehabilitation Potential Care Area Assessment (CAA) dated 5/11/26, identified R24 was a recent admit from another care center and had diagnoses of dementia, depression, heart failure and asthma. R24 had clear speech and was understood and usually understood. R24 denied shortness of breath. R24 stated she had pain per medication administration record (MAR) review. R24 had a history of refusing medications per staff. R24 was frequently incontinent of bowel and bladder and had some moisture-associated skin damage (MASD) noted with ointment/cream to apply. R24 required assistance for transfers. Care area was triggered due to ADL review. R24 would be assisted per need and per request. R24 was to be encouraged to be as independent as able and observed for changes in her abilities. Peri care completed with incontinence episodes. R24's Urinary Incontinence and Indwelling Catheter Care Area Assessment dated 5/11/26, identified R24 required assistance for transfers. Care area was triggered due to prescribed medication, impaired mobility, health history and ADL review. She was to be observed for changes in her elimination pattern and peri care to be completed with incontinent episodes. R24's care plan revised 5/27/26, identified the following: R24 was frequently incontinent of urine. Staff were directed to document incontinent episodes. Bladder assessment at least quarterly. Monthly 24-hour (hr) bladder/bowel record. Provide with appropriate incontinence products. R24 required an extensive partial assistance of one (PAO1) using a gait belt (GB) and a wheeled walker to transfer, wipe, adjust clothing and manage incontinence. R24 was to receive peri cares twice daily and as needed after any incontinent episode. Protective ointment to skin as needed. Observe for signs/symptoms of urinary tract infection (UTI): pain or burning with urination, fever, increased incontinence, cloudy/odorous urine in small amounts, increased confusion/lethargy. Encourage adequate fluids. R24 had self-deficit with the following activities of daily living: bathing, personal hygiene, ambulation, transferring, toileting, dressing, bed mobility, eating, ambulating and medication administration. Staff were directed R24 required assist of two (AO2) assistance with all transfers to and from bed, wheelchair and	F0677	Continued from page 47 Resident care assignments were reviewed to ensure residents requiring extensive assistance with ADLs, toileting, transfers, and dining receive services in a timely manner consistent with assessed needs and care plans. 2. Identification of Other Residents with the Potential to be Affected All residents residing in the facility had the potential to be affected by the deficient practice. The Director of Nursing, Clinical Manager, Unit Managers, Dietary Manager, and interdisciplinary team completed a facility-wide review of residents requiring assistance with activities of daily living, toileting, transfers, eating, grooming, and personal hygiene. Residents requiring extensive assistance, mechanical lift transfers, scheduled toileting programs, dining assistance, or supervision during meals were specifically reviewed to ensure services were provided according to resident needs, physician orders, and care plans. Any identified concerns were immediately corrected. 3. Systemic Changes Implemented Effective July 1, 2026, the facility implemented the following systemic corrective actions: • Educated licensed nurses, nursing assistants, trained medication aides, agency staff, and ancillary personnel regarding: - F677 requirements - Timely toileting assistance - Dining assistance expectations - ADL care requirements - Resident dignity during care - Prompt response to resident requests - Transfer assistance requirements - Resident-centered care practices	07/08/2026

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F0677 SS = D	Continued from page 48 toilet. R24 used a full body mechanical lift. R24 could verbally ask for assistance with toileting. R24 required assistance from two to get R24's toileting needs addressed. R24 used the toilet for my current toileting needs and was both continent/incontinent. R24 was to be offered toileting every three hours to help R24 to remain free of skin breakdown and respect R24's dignity. During an observation on 6/7/26 at 11:30 a.m., R24 was lying in bed with her head of bed (HOB) at 30 degrees. R24 was wearing a dusky purple sweatshirt and no pants. There was a fleece blanket across the foot of R24's bed but it was not covering R24. R24 was wearing an incontinent brief with no pants and had her knees bent with her feet resting on the bed. R24 was crying and stated staff told R24 she had to stay in bed and couldn't get up. "I don't know why." R24 then stated, "they told me to pee my pants, and they'd clean me up here." R24 stated this happened "all the time". At that time, nursing assistant (NA)-B stepped into the room and told R24 NA-B needed to help another resident and would be back. NA-B turned off R24's call light and left the room. R24 continued to cry and stated nursing assistants said that and shut off R24's call light "just about every day" and "they say they're short". R24 sobbed and stated "I hate it here. It's awful. I hate peeing in my pants." At 12:10 p.m., NA-B entered R24's room and told R24 she was wet, so she needed to be cleaned up. NA-B put on gloves then told R24 she didn't need to cry because she was there. R24 stated "I want to get up". At 12:11 p.m. NA-B unfastened R24's incontinent brief and used disposable wipes to clean R24's skin of feces and urine. R24 stated that her skin was itchy, NA-B told R24 that R24 had "pooped" and NA-B would clean R24's skin well. At 12:13 p.m., NA-B rolled R24 to the right and R24 began crying and stated, "I can't do this". NA-B told R24 that they were almost done. R24's skin on her upper thighs and buttocks was reddened but had no open areas. NA-B applied barrier cream then a clean brief.	F0677	Continued from page 48 - Call light response expectations • Implemented enhanced leadership rounds to monitor resident care delivery. • Reviewed staffing assignments to improve coverage for residents requiring extensive ADL assistance. • Implemented monitoring of dining room staffing and meal assistance processes. • Reinforced expectations that residents requesting toileting assistance will receive timely assistance to prevent incontinence episodes and preserve dignity. • Continued agency staffing utilization as needed to ensure adequate staffing resources are available. • Education was initiated July 1, 2026 and will continue through orientation and annual competency validation. 4. Monitoring and Quality Assurance The Director of Nursing, Clinical Manager, Unit Managers, or designee will conduct the following audits: ADL Care Audits • Five resident observations weekly for four weeks. • Five resident observations biweekly for an additional eight weeks. Toileting Assistance Audits • Five toileting assistance observations weekly for twelve weeks. Dining Assistance Audits • Observation of at least two meal services weekly for twelve weeks. Transfer Assistance Audits • Five transfer observations weekly for twelve	07/08/2026

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F0677 SS = D	Continued from page 49 At 12:16 p.m., NA-B put on R24's pants. NA-B then removed her gloves and removed the trash from the trash containers and asked for assistance with R24's transfer over the walkie. NA-B exited the room. At 12:19 p.m., NA-B returned with a full body mechanical lift sling and placed it under R24. NA-B told R24 that she needed another staff person to assist with the transfer and left the room. At 12:22 p.m., NA-A and NA-B entered the room and used the ceiling lift to transfer R24 from her bed to her wheelchair. NA-B then brought R24 to the dining room for her noon meal. During an interview on 6/7/26 at 12:28 p.m., NA-B stated the facility was working "short" that day. "You just do the best you can." NA-B stated R24 did get up into her chair for breakfast that morning, but staff laid R24 down to do incontinent care after breakfast. NA-B stated R24 was "encouraged" to stay in bed because NA-B had other residents to care for. R24 did turn on her call light and asked to get up, but R24 was assistance of 2 and NA-B was providing care to another resident. During an interview on 6/9/26 at 11:29 a.m., trained medication aide (TMA)-A stated R24 should never wait when she had to go to the bathroom because R24 would then be incontinent and R24 deserved to receive the care she needed. Staff were expected to either request help from another staff member or to prioritize work to the best of their ability. During an interview on 6/9/26 at 11:42 a.m., NA-C stated R24 cannot wait when R24 asked to use the bathroom. When R24 turned on her call light, NA-C tried to get her to the bathroom right away because R24 would have an "accident." During an interview on 6/9/26 at 1:36 p.m., licensed practical nurse (LPN)-A stated staff were expected to provide timely toileting assistance to prevent incontinence and skin breakdown. During an interview on 6/9/26 at 2:06 p.m., registered nurse (RN)-A stated a resident should be provided with timely toileting assistance to prevent incontinence and skin breakdown. During an interview on 6/9/26 at 2:49 p.m., the director of nursing (DON) stated staff were expected	F0677	Continued from page 49 weeks. Resident Interview Audits • Five resident interviews weekly regarding responsiveness of staff and timeliness of care. QAPI Oversight • Audit findings will be reviewed monthly through the QAPI Committee. • Negative findings will result in immediate corrective action, additional education, increased monitoring, and follow-up auditing until sustained compliance is achieved. The facility alleges compliance on July 8th, 2026, when all corrective actions were completed and systems were established to ensure ongoing compliance with F677 ADL Care Provided for Dependent Residents.	07/08/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245502	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/10/2026

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F0677 SS = D	Continued from page 50 to provide care when requested and to ensure all residents were safe. R23: R23's quarterly MDS dated 5/8/26, identified R23 was cognitively intact and independent with eating. R23 had diagnoses of obesity and mass/lump on abdomen. The MDS did not identify any a significant weight loss or gain. R23's mini nutritional assessment dated 5/9/26, identified R23 normally ate 51-75% of most meals. R23 was assisted with meals for optimal intake. R23's care plan dated 5/26/26 identified R23 was independent with eating. During observations on 6/7/26 at 1:04 p.m., there was not enough staff in the dining room to assist residents with eating. A t 1:05 p.m., there were at least 2 residents who were sitting there with food in front of them and were not eating nor was staff helping them. A t 1:09 p.m., R23 was identified as one of the residents sitting at the table where staff are supposed to assist residents with eating. At 1:12 p.m., R23 still had her plate of food in front of her, and she had not attempted to eat. R23's potatoes and meat had formed a crust on them. R23 waited 45 minutes before staff assisted her to eat. At 1:15 p.m., R23 ate well with staff assistance. During an interview on 6/9/26 at 7:36 a.m., nursing assistant (NA)-D stated R23 needed to be supervised while eating. R23 ate slowly and it would take her a while to eat, and we encourage her at that time. When R23 stopped using the silverware while eating, staff assisted R23. During an interview on 6/9/26 at 2:02 p.m., NA-A	F0677		07/08/2026

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F0677 SS = D	Continued from page 51 stated R23 had changed over the weekend, previously she just required supervision with eating. R23 had seemed to decline and had started to pocket food and had moved to a different table to assist with eating because R23 needed more help with meals. During lunch on Sunday 6/7/26, the facility was short staffed and the residents in the dining room had to wait for assistance to eat and some had to wait an extended period of time before they received help. During an interview on 6/9/26 at 4:43 p.m., the director of nursing (DON) stated residents who required supervision with eating would be watched and if the residents had stopped eating or had not started for about five minutes staff are expected to cue residents to continue to eat. If after ten minutes staff should approach resident and assist with eating. I would be expected if R23 was not eating it would be realized quickly and assisted in a timely fashion. It is not dignified to sit there with a plate of food in front of you and not being able to eat it. Staff should wait until someone is available to assist with eating before bringing out the plate. The facility policy Activities of Daily Living (ADL) dated 2021, identified staff were directed to provide residents with care, treatment and services appropriate to maintain or improve their ability to carry out activities of daily living (ADLs).	F0677		07/08/2026
F0686 SS = D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing.	F0686	CMS Plan of Correction – F686 Treatment/Services to Prevent and Heal Pressure Ulcers Completion Date: July 8th, 2026 Director of Nursing: Eliza Messerschmidt, RN, DNS-CT Administrator: Jason Carlson, LNHA Changes Implemented: July 1, 2026 1. Corrective Action for Residents Found to be Affected The resident identified during survey review (R5) was immediately assessed by the wound care team, Director of Nursing, Infection Preventionist, and attending provider. Wound treatment orders, infection prevention interventions, dressing change	07/08/2026

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F0686 SS = D	Continued from page 52 This REQUIREMENT is NOT MET as evidenced by: During observation, interview, and document review, the facility failed to perform hand hygiene between glove changes during pressure ulcer wound care for 1 of 2 residents (R5) reviewed for pressure ulcers, creating the potential for contamination of pressure ulcer wounds and development of infection. Findings include: R5's admission Minimum Data Set (MDS) dated 5/5/26, identified R5 was cognitively intact. R5 was substantial/maximal assist with transfers, and supervision with bed mobility. R5's diagnosis includes fracture of thoracic (mid back) vertebrae, muscle weakness, and amputation of right lower leg. It identified the resident was at risk for pressure ulcers but did not have one. R5's pressure ulcer/injury Care Area Assessment (CAA) dated 5/8/26, identified R5 was at risk for pressure ulcers due to recent injury with a fracture of thoracic vertebra. Plan of care updated for prevention of pressure related skin impairments. R5's provider's orders identified the following: 6/1/26, identified for left heel, cleanse heel gently with saline wipe. Pat dry. place a Mepilex (a specialized silicone foam dressing). over the area. 6/8/26, identified to cleanse the right buttock with saline wipes and pat dry, then pack with Aquacel AG (an advanced antimicrobial primary wound dressing) and cover with a sacral Mepilex. In gluteal crease (between the buttocks) cleanse wound with saline wipes and cover with a 4-inch by 4-inch Mepilex. R5's wound assessment dated 6/8/26, identified they had a pressure ulcer on right upper buttock. The wound measured 5 centimeters (cm) wide x 6.5 cm long x 2 cm deep. The wound was odorous, and heavy drainage of purulent dark brown drainage which saturated the dressings. R5 also had an unstageable pressure ulcer on their coccyx measuring 2.2 cm x 2.8 and identified scab was completely attached. R5 also had a deep tissue injury on his left heel with drained blister and intact epidermal (skin) layer in place which measured 4 cm x 5 cm. The resident was seen the previous week and had wound debrided and had not much change and ordered a follow up appt for wound debridement. During observation on 6/9/26 at 8:08 a.m., licensed practical nurse (LPN)-A gathered the supplies she would need and asked nursing	F0686	Continued from page 52 procedures, and skin integrity monitoring processes were reviewed. The licensed nurse involved received immediate education regarding hand hygiene requirements, glove changes, wound care infection prevention standards, standard precautions, and proper dressing change technique. Immediate observation and competency validation of wound care procedures were completed. The facility reviewed all current residents receiving wound treatments to ensure wound care procedures were completed according to professional standards of practice and infection prevention requirements. 2. Identification of Other Residents with the Potential to be Affected All residents receiving wound care services had the potential to be affected by the deficient practice. The Director of Nursing, Infection Preventionist, Wound Nurse, and Clinical Manager completed a facility-wide audit of residents receiving wound treatments, skin treatments, dressing changes, pressure ulcer care, and other invasive treatment procedures. The audit included review of wound treatment orders, dressing change practices, infection prevention interventions, hand hygiene compliance, wound documentation, and treatment records. Any identified concerns were immediately corrected. 3. Systemic Changes Implemented Effective July 1, 2026, the facility implemented the following systemic corrective actions: • Educated licensed nurses, agency nurses, and treatment nurses regarding: - F686 requirements - Hand hygiene standards - Glove change requirements	07/08/2026

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F0686 SS = D	Continued from page 53 assistant (NA)-A to help position R5. LPN-A and NA-A both sanitized hands and then put on personal protective equipment (PPE) for wound dressing change. Once in the room they positioned R5, and NA-A helped to stabilize him. LPN-A placed a barrier down and then proceeded to remove the old dressing. The dressing was saturated with purulent dark brown drainage and was very odorous. The wound bed was full of slough (dead, non-viable tissue that accumulated on the surface of the wound bed). The gluteal fold dressing was also removed due to starting to come off. Once the dressings were removed, LPN-A removed the dirty gloves and did not do hand hygiene and then placed another pair of gloves on. LPN-A then proceeded to clean both wounds using saline spray and wipes. LPN-A then removed her dirty gloves and did not perform hand hygiene before putting a pair of new gloves on. LPN-A opened the Aquacel AG and placed it in the wound bed then opened the sacral Mepilex on the wound on the right buttock and then placed a 4-inch x 4-inch Mepilex in gluteal crease. LPN-A then started to clean up and when completed she removed her gloves then seen the left heel dressing was coming off. Without doing hand hygiene LPN-A placed a pair of gloves on and then removed the old dressing. There was no drainage or odor coming from wound and it was covered with a layer of old skin. LPN-A removed gloves and put a different pair on without doing hand hygiene and then, then proceeded to clean the heel with saline wipes. Then changed gloves again without doing hand hygiene and placed the 4-inch x 4-inch Mepilex dressing on R5's heel. Upon completing the dressing changes, she washed her hands with soap and water and then removed her gown and sanitized her hands on exiting the room. During an interview on 6/9/26 at 8:51 a.m., LPN-A stated she washed her hands prior to starting and once the dressing change was done. She did not think to do hand hygiene when changing gloves. During an interview on 6/9/26 at 8:51 a.m., the director of nursing (DON) stated nurses were to follow wound procedures when doing dressing changes. That would include hand hygiene each time gloves were changed. Hand hygiene was done to ensure the wound does not become decontaminated when placing clean dressings. The facility's Contact Precautions policy dated 9/2023, identified hand hygiene is performed between glove changes and when removing gloves. A policy regarding pressure ulcers was requested,	F0686	Continued from page 53 - Wound care infection prevention practices - Standard precautions - Treatment procedure expectations - Pressure ulcer prevention and treatment requirements - Professional standards of nursing practice • Implemented wound care competency validation for licensed nursing staff. • Reinforced hand hygiene requirements between glove changes and during treatment procedures. • Implemented enhanced treatment observation rounds by nursing leadership. • Reviewed and reinforced infection prevention policies related to wound care and treatment procedures. • Education was initiated July 1, 2026 and will continue through orientation and annual competency validation. • Weekly skin and wound meetings were implemented to review wound progression, treatment compliance, infection prevention practices, and documentation requirements. 4. Monitoring and Quality Assurance The Director of Nursing, Infection Preventionist, Wound Nurse, or designee will conduct the following audits: Treatment Observation Audits • Five wound care observations weekly for four weeks. • Five wound care observations biweekly for an additional eight weeks. Hand Hygiene Audits • Ten hand hygiene observations weekly during treatment procedures for twelve weeks.	07/08/2026

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F0686 SS = D	Continued from page 54 but one was not received.	F0686	Continued from page 54 Wound Documentation Audits • Five wound treatment record audits weekly for twelve weeks. Competency Validation Audits • Verification of wound care competency validation for all licensed nursing staff. QAPI Oversight • Audit findings will be reviewed monthly through the QAPI Committee. • Negative findings will result in immediate corrective action, additional education, increased monitoring, and follow-up auditing until sustained compliance is achieved. The facility alleges compliance on July 8th, 2026, when all corrective actions were completed and systems were established to ensure ongoing compliance with F686 Treatment/Services to Prevent and Heal Pressure Ulcers.	07/08/2026
F0689 SS = D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to ensure transfers were performed in accordance with assessed needs, care plan interventions, and facility policy for 1 of 3 residents (R24) reviewed for accidents. Staff performed transfers using a full-body mechanical lift with one staff member rather than the required two staff	F0689	CMS Plan of Correction – F689 Free of Accident Hazards/Supervision/Devices Completion Date: July 8th, 2026 Director of Nursing: Eliza Messerschmidt, RN, DNS-CT Administrator: Jason Carlson, LNHA Changes Implemented: July 1, 2026 1. Corrective Action for Residents Found to be Affected Resident R24 was immediately assessed by the interdisciplinary team following identification of the deficient practice. The resident's transfer status, care plan interventions, mechanical lift requirements, safety precautions, and staffing assignments were reviewed.	07/08/2026

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F0689 SS = D	Continued from page 55 members, creating the potential for falls, entrapment, and transfer-related injury. Findings include: R24's admission Minimum Data Set (MDS) dated 5/6/26, identified R24 had a mild cognitive impairment and had diagnoses that included non-traumatic spinal cord dysfunction, diabetes, and dementia. R24 was dependent on staff for toileting and transfers and was frequently incontinent with bowel and bladder. R24's Activities of Daily Living (ADLs) Functional/Rehabilitation Potential Care Area Assessment (CAA) dated 5/11/26, identified R24 was a recent admit from another care center and had diagnoses of dementia, depression, heart failure and asthma. R24 had clear speech and was understood and usually understood. R24 denied shortness of breath. R24 stated she had pain per medication administration record (MAR) review. R24 had a history of refusing medications per staff. R24 was frequently incontinent of bowel and bladder and had some moisture-associated skin damage (MASD) noted with ointment/cream to apply. R24 required assistance for transfers. Care area was triggered due to ADL review. R24 would be assisted per need and per request. R24 was to be encouraged to be as independent as able and observed for changes in her abilities. Peri care completed with incontinence episodes. R24's Urinary Incontinence and Indwelling Catheter Care Area Assessment dated 5/11/26, identified R24 required assistance for transfers. Care area was triggered due to prescribed medication, impaired mobility, health history and ADL review. She was to be observed for changes in her elimination pattern and peri care to be completed with incontinent episodes. R24's care plan revised 5/27/26, identified R24 had self-deficit with transferring. Staff were directed to provide assistance with two staff with all transfers to and from bed, wheelchair and toilet. R24 used a full body mechanical lift. During an interview on 6/9/26 at 11:29 a.m., trained medication aide (TMA)-A stated staffing was awful. The facility used a lot of agency staff and the schedule frequently got "messed up" which added to the problem. Staff did the best they could with what they had. TMA-A tried her hardest when they had to work short to prioritize work and to help the nursing assistants as much as she was able. R24	F0689	Continued from page 55 Staff involved received immediate education regarding safe transfer practices, mechanical lift procedures, care plan compliance, and facility policy requiring two trained staff members for all full-body mechanical lift transfers. The resident's transfer needs were reviewed with nursing staff and transfer observations were completed to ensure compliance with physician orders, care plan interventions, and facility policy. 2. Identification of Other Residents with the Potential to be Affected All residents requiring mechanical lift transfers had the potential to be affected by the deficient practice. The Director of Nursing, Clinical Manager, Rehabilitation Department, and interdisciplinary team completed a facility-wide audit of residents requiring full-body mechanical lifts, ceiling lifts, sit-to-stand lifts, and other transfer assistance devices. Care plans, transfer assessments, Kardexes, transfer status documentation, and staffing assignments were reviewed to ensure transfer requirements accurately reflected resident needs and were communicated to staff. Any identified concerns were immediately corrected. 3. Systemic Changes Implemented Effective July 1, 2026, the facility implemented the following systemic corrective actions: • Educated licensed nurses, nursing assistants, trained medication aides, agency staff, and ancillary personnel regarding: - F689 requirements - Safe resident handling procedures - Mechanical lift transfer requirements - Two-person transfer expectations - Care plan compliance	07/08/2026

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F0689 SS = D	Continued from page 56 could not wait when R24 asked to use the bathroom because she would be incontinent. TMA-A stated she wasn't going to lie and transferred R24 using the full body mechanical lift by herself. TMA-A did this because R24 had a right to get up and use the bathroom. It was also harmful to R24 skin to void in her pants. TMA-A stated she felt the transfer was safe doing that. During an interview on 6/9/26 at 11:42 a.m., NA-C stated she never transferred R24 with assistance of one and the full body mechanical lift. It was unsafe to do that. During an interview on 6/9/26 at 11:57 a.m., R24 stated sometimes there was not enough staff at the facility, and they transfer her with the lift with only one staff member. R24 stated they say there's not enough staff and it was against the rules, but they do it. R24 never felt unsafe but knew she was not supposed to tell anyone to get anybody in trouble. "I'm just thankful to get to the toilet." During an interview on 6/9/26 at 1:36 p.m., licensed practical nurse (LPN)-A stated she had told the nursing assistants to not transfer any resident with the full body mechanical lift with assistance of one and had never witnessed any staff doing that. During an interview on 6/9/26 at 1:49 p.m., nursing assistant (NA)-A didn't know "for sure" if staff transferred R24 using the full body mechanical lift with only one staff member, but if they're unable to find help NA-A could see them doing it. NA-A stated she has seen staff come out of a room pushing a resident in a wheelchair and NA-A had questioned how the resident was transferred because NA-A had not helped. NA-A stated she had never asked, and the staff member had never said. During an interview on 6/9/26 at 2:06 p.m., registered nurse (RN)-A stated the staff should never be so short staffed they were transferring any resident using the ceiling lift with assistance of one for the safety of the resident. During an interview on 6/9/26 at 2:49 p.m., the director of nursing (DON) stated no resident should be transferred with the full body mechanical lift using assistance of one because it was a safety issue as well as best practice. The facility policy Using a Mechanical Lift dated 2024, identified the purpose of this procedure is to establish the general principles of safe lifting using a mechanical lifting device. It is not a substitute for manufacturer's training or instructions. I. At least two (2) trained	F0689	Continued from page 56 - Accident prevention strategies - Resident safety expectations - Reporting unsafe practices • Reinforced facility policy requiring two trained staff members for all full-body mechanical lift transfers. • Enhanced leadership rounding to observe transfer practices and ensure compliance. • Reviewed staffing assignments to ensure adequate staffing resources are available to safely complete transfers. • Continued agency staffing utilization as needed to maintain safe staffing levels. • Education was initiated July 1, 2026 and will continue through orientation and annual competency validation. 4. Monitoring and Quality Assurance The Director of Nursing, Clinical Manager, Rehabilitation Director, or designee will conduct the following audits: Transfer Observation Audits • Five transfer observations weekly for four weeks. • Five transfer observations biweekly for an additional eight weeks. Mechanical Lift Audits • Weekly audit of residents requiring full-body mechanical lifts for twelve weeks. Competency Validation Audits • Verification of transfer competency validation for all direct care staff. Resident Safety Audits • Weekly review of transfer-related incidents, near misses, and safety concerns for twelve weeks.	07/08/2026

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F0689 SS = D	Continued from page 57 associates are needed to safely move a resident with a mechanical full body floor based mechanical lift or a ceiling/overhead full body lift.	F0689	Continued from page 57 QAPI Oversight • Audit findings will be reviewed monthly through the QAPI Committee. • Negative findings will result in immediate corrective action, additional education, increased monitoring, and follow-up auditing until sustained compliance is achieved. The facility alleges compliance on July 8th, 2026, when all corrective actions were completed and systems were established to ensure ongoing compliance with F689 Free of Accident Hazards/Supervision/Devices.	07/08/2026
F0755 SS = D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(f). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in	F0755	CMS Plan of Correction – F755 Pharmacy Services/Procedures/Pharmacist/Records Completion Date: July 8th, 2026 Director of Nursing: Eliza Messerschmidt, RN, DNS-CT Administrator: Jason Carlson, LNHA Changes Implemented: July 1, 2026 1. Corrective Action for Residents Found to be Affected Resident R37's reported medication error involving Zepbound was immediately reviewed by the Director of Nursing, attending provider, consultant pharmacist, and interdisciplinary team. A retrospective investigation was completed to determine the circumstances surrounding the reported event, evaluate potential resident impact, and identify opportunities for system improvement. The resident was reviewed for adverse effects, physician notification was verified, and documentation requirements were reinforced with licensed nursing staff. Staff involved received education regarding medication error reporting, investigation requirements, root cause analysis, documentation standards, and implementation of corrective actions to prevent recurrence.	07/08/2026

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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
F0755 SS = D	Continued from page 58 order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to ensure a reported medication error was investigated, documented, and addressed in accordance with facility policy for 1 of 5 residents (R37) reviewed for unnecessary medications. This deficient practice resulted in the facility's inability to determine the circumstances surrounding a reported Zepbound medication error, assess resident impact, and implement interventions to prevent recurrence. Findings include: R37's quarterly Minimum Data Set (MDS) dated 4/17/26, identified R37 had a moderate cognitive impairment and had diagnoses that included morbid obesity, cerebral palsy and obstructive sleep apnea. R37's Event Report dated 4/23/26 at 9:37 a.m., identified Zepbound (an FDA-approved, once-weekly injectable medication containing tripeptide. It is prescribed alongside a reduced-calorie diet and increased exercise for chronic weight management in adults with obesity or those who are overweight with weight-related conditions) wrong dose on 4/22/26. The report failed to identify any investigation into the event or actions taken to prevent further events. R37's medical record failed to identify any further information regarding the 4/22/26 Zepbound wrong dose. During an interview on 6/8/26 at 10:44 a.m., the director of nursing (DON) stated she had reviewed R37's medical record and R37's medication error investigation. The DON stated there was a lapse in the process and an investigation was not completed. The DON spoke with facility staff who explained the medication did not come from the pharmacy and R37 did not receive his dose of medication. However, the event report stated wrong dose. The DON stated investigation needed to be done to ensure what had occurred. The staff were expected to complete an event report, then complete an investigation into what had happened. This needed to be documented as well as interventions to prevent further medication errors. During an interview on 6/9/26 at 2:15 p.m., registered nurse (RN)-A stated she vaguely remembered the event and attempted to review	F0755	Continued from page 58 2. Identification of Other Residents with the Potential to be Affected All residents receiving medications had the potential to be affected by the deficient practice. The Director of Nursing, Clinical Manager, Consultant Pharmacist, and interdisciplinary team completed a facility-wide review of medication errors reported within the previous twelve months. The audit included review of medication error reports, investigations, physician notifications, resident assessments, documentation, follow-up actions, root cause analyses, and quality improvement interventions. Any identified concerns were immediately corrected. 3. Systemic Changes Implemented Effective July 1, 2026, the facility implemented the following systemic corrective actions: • Reviewed and reinforced the Medication Error/Occurrence policy. • Implemented a standardized medication error investigation process requiring: - Resident assessment - Physician notification when indicated - Documentation of resident outcome - Root cause analysis - Corrective action planning - Follow-up monitoring - Quality improvement review • Educated licensed nurses, nurse managers, and leadership staff regarding: - F755 requirements - Medication error reporting expectations	07/08/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245502	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Benedictine Care Community	**201 9TH STREET WEST , ADA, Minnesota, 56510**

(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
F0755 SS = D	Continued from page 59 R37's medical record for further information. RN-A stated there was no documentation to explain what had occurred or actions taken. RN-A stated there should be a progress note, an event report, and a documented investigation into what happened. Afterwards, it would be brought to IDT to discuss what had occurred and/or if further actions needed to be taken. An emailed response from the consultant pharmacist dated 6/10/26, identified the pharmacist expected facility staff to complete a thorough root cause investigation and analysis, appropriate follow-up, and detailed documentation for any medication error identified. This should include assessment of the resident, physician notification when indicated, monitoring for adverse effects, and implementation of measures to help prevent recurrence. In the case of a resident receiving a one-time higher dose of tirzepatide (Zepbound), potential adverse effects may include gastrointestinal intolerance such as nausea, vomiting, diarrhea, abdominal discomfort, and decreased appetite. Conversely, if a resident receives a lower-than-ordered dose, potential concerns may include less effective appetite suppression, and possible elevations in blood glucose for residents using the medication for glycemic control. The facility policy Medication Error/Occurrence dated 2021, identified When an error is made in the preparation or administration of a drug or biological, the licensed nurse provides any necessary immediate care and notifies the attending provider and resident or resident representative when nursing or medical intervention, observation or treatment is indicated. Medication errors are tracked and trended for quality improvement purposes.	F0755	Continued from page 59 - Investigation requirements - Documentation standards - Root cause analysis methodology - Resident monitoring requirements - Corrective action implementation - Quality assurance expectations • Implemented leadership review of all medication errors within 24 hours of occurrence. • Enhanced consultant pharmacist involvement in medication error review and trending. • Education was initiated July 1, 2026 and will continue through orientation and annual competency validation. 4. Monitoring and Quality Assurance The Director of Nursing, Clinical Manager, Consultant Pharmacist, or designee will conduct the following audits: Medication Error Audits • Audit 100% of medication errors weekly for four weeks. • Audit 100% of medication errors biweekly for an additional eight weeks. Investigation Audits • Weekly review of medication error investigations for twelve weeks. Documentation Audits • Weekly verification of physician notification, resident assessment, follow-up actions, and corrective interventions. Pharmacy Review Audits • Monthly review of medication error trends with the	07/08/2026

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F0755 SS = D		F0755	Continued from page 60 consultant pharmacist. QAPI Oversight • Audit findings will be reviewed monthly through the QAPI Committee. • Medication error trends, corrective actions, and system improvements will be discussed and tracked. • Negative findings will result in immediate corrective action, re-education, increased monitoring, and follow-up auditing until sustained compliance is achieved. The facility alleges compliance on July 8th, 2026, when all corrective actions were completed and systems were established to ensure ongoing compliance with F755 Pharmacy Services/Procedures/Pharmacist/Records.	07/08/2026
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	F0756	CMS Plan of Correction – F756 Drug Regimen Review, Report Irregular, Act On Completion Date: July 8th, 2026 Director of Nursing: Eliza Messerschmidt, RN, DNS-CT Administrator: Jason Carlson, LNHA Changes Implemented: July 1, 2026 1. Corrective Action for Residents Found to be Affected Resident R8 was immediately reviewed by the attending provider, hospice provider, consultant pharmacist, Director of Nursing, and interdisciplinary team. The resident's psychotropic medication regimen, PRN antipsychotic orders, consultant pharmacist recommendations, physician responses, and documentation were reviewed. Haldol was discontinued for the resident related to non-use. The PRN antipsychotic medication order was reviewed for compliance with CMS requirements. Consultant pharmacist recommendations were addressed, physician follow-up was completed, and documentation requirements were reinforced.	07/08/2026

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F0756 SS = D	Continued from page 61 resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to ensure consultant pharmacist recommendations regarding an irregularity in psychotropic medication use were addressed and resolved for 1 of 5 residents (R8) reviewed for unnecessary medications. The facility failed to ensure a required face-to-face practitioner evaluation occurred and allowed a PRN antipsychotic medication order to remain active and be administered despite repeated consultant pharmacist recommendations for review and discontinuation. Findings include: R8's quarterly Minimum Data Set dated 6/9/26, identified R8 had moderate cognitive deficit and required moderate assistance with most activities of daily living (ADLs). R8 had not exhibited any behavior during the observation period and did not have hallucinations or delusions. R8 consumed antianxiety and antidepressant medications during the observation period. Diagnoses included congestive heart failure, dementia, diabetes, and depression. R8's care plan dated 3/23/26, identified R8 was under hospice care for end-of-life status due to heart failure. Approaches included to follow the hospice plan of care, communicate with hospice physician and nurses to discuss medication concerns and what was effective. Hospice services with standing orders, scheduled and as needed (PRN) medications for pain, shortness of breath, restlessness and secretions. The care plan identified R8 received psychotropic medications for depression and anxiety with a goal to not experience any adverse reactions. Approaches listed included to administer medications as ordered. Administer the antianxiety medication for increased anxiety and restless. Staff were to document three interventions trialed before administering the PRN medication. MD review per guidelines for a gradual dose reduction	F0756	Continued from page 61 Licensed nursing staff and leadership received immediate education regarding pharmacist recommendation review, physician follow-up, PRN psychotropic requirements, and documentation expectations. 2. Identification of Other Residents with the Potential to be Affected All residents receiving psychotropic medications or having consultant pharmacist recommendations had the potential to be affected by the deficient practice. The Director of Nursing, Medical Director, Consultant Pharmacist, Clinical Manager, and interdisciplinary team completed a facility-wide audit of consultant pharmacist recommendations from the previous six months. The audit included review of pharmacist recommendations, physician responses, implementation status, psychotropic medication reviews, PRN psychotropic orders, face-to-face evaluations, and documentation requirements. Any identified concerns were immediately corrected. 3. Systemic Changes Implemented Effective July 1, 2026, the facility implemented the following systemic corrective actions: • Implemented a consultant pharmacist recommendation tracking log. • Established a process to ensure all pharmacist recommendations are reviewed, addressed, documented, and resolved timely. • Educated licensed nurses, providers, nurse managers, MDS personnel, and leadership staff regarding: - F756 requirements - Consultant pharmacist recommendation requirements - Physician response requirements - Documentation expectations	07/08/2026

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F0756 SS = D	Continued from page 62 and monthly pharmacist review. R8's undated Active Physician Orders identified numerous medication orders for R8, which included haloperidol 1 milligram (MG) for agitation and restlessness every four hours PRN with start date 3/1/26 and end date was listed as open ended. R8's PRN Medication Administration Record (MAR) dated 5/1/26 to 5/31/26, identified an order for Haldol 1 mg every four hours PRN for agitation and restless. start date of 3/1/26 and open-ended end date. The MAR documented the medication had been administered to R8 on 5/19/26 and 5/26/26. Consultant Pharmacist Recommendation to Physician forms identified the following: 3/9/26, identified the pharmacist recommended to discontinue the PRN use of Haldol 1 mg every four hours PRN for anxiety/agitation on or before 3/14/26, following federal guidelines that PNR orders for anti-psychotic drugs were limited to fourteen days and could not be renewed unless the attending physician evaluated the resident for the appropriateness of the renewal. R8's physician commented that R8 was a hospice patient and signed the recommendation with no further response or action on 3/24/26. 4/3/26, identified the pharmacist recommended to discontinue the PRN use of Haldol 1 mg every four hours PRN for anxiety/agitation on or before 3/14/26, following federal guidelines that PNR orders for anti-psychotic drugs were limited to fourteen days and could not be renewed unless the attending physician evaluated the resident for the appropriateness of the renewal. No physician response was documented. R8's medical record lacked a face-to-face assessment by the medical provider to justify continued use of the Haldol. During interview on 6/9/26, at 10:27 a.m. the director of nursing (DON) stated all PRN psychotropic medications should have a fourteen-day review. She had thought the regulation had changed for hospice patients, and it could go longer than fourteen days, but she always had them reviewed every fourteen days. The facility's process was to have hospice follow their patient's medications and notify the facility if there was any need for review or update. The facility's consultant's pharmacist was telephoned on 6/9/26, at 5:56 p.m. and message left to return call. During telephone interview on 6/10/26, at 9:29 a.m. the facility's consultant pharmacist (CP)-G stated he only reviewed medications for the facility for new admissions or hospital returns and was not the pharmacist that had done the monthly medication	F0756	Continued from page 62 - PRN psychotropic medication regulations - Fourteen-day PRN psychotropic review requirements - Face-to-face evaluation requirements - Follow-up and resolution processes • Implemented monthly interdisciplinary psychotropic medication review meetings. • Implemented leadership oversight of open pharmacist recommendations until resolution is documented. • Education was initiated July 1, 2026 and will continue through orientation and annual competency validation. 4. Monitoring and Quality Assurance The Director of Nursing, Clinical Manager, Consultant Pharmacist, or designee will conduct the following audits: Consultant Pharmacist Recommendation Audits • Audit 100% of pharmacist recommendations weekly for four weeks. • Audit 100% of pharmacist recommendations biweekly for an additional eight weeks. Psychotropic Medication Audits • Weekly review of psychotropic medications and PRN psychotropic orders for twelve weeks. Physician Response Audits • Weekly verification of physician review and documented response to pharmacist recommendations. Tracking Log Audits • Weekly review of pharmacist recommendation tracking logs to ensure timely follow-up and resolution.	07/08/2026

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F0756 SS = D	Continued from page 63 reviews for R8. CP-G stated it was his understanding the Center for Medicaid and Medicare (CMS) guidelines were that any PRN antipsychotic medication needed to be addressed by the physician The medication needed to be limited to fourteen days and re-evaluated by the provider. If the provider chose to continue the PRN antipsychotic medication, it would need to be evaluated with a face-to-face visit from the provider. CP-G stated hospice was not an exception. In an electronic mail (email) response received on 6/10/26, at 4:30 p.m. CP-H wrote she had made recommendations to R8's primary provider both in March and April of 2026. R8's physician had signed each recommendation, acknowledging he had reviewed them. In addition, CP-H had emailed the DON and the facility's medical director to reiterate that all PRN antipsychotic medications were subject to an initial 14 day stop date requirement unless a documented face to face evaluation was completed. The order for the PNR haloperidol was discontinued on 6/9/26, However, the discontinuation of the medication was after interviews were completed regarding the continued use of the PRN medication. The facility's policy Psychotropic Medication Use with review date 9/7/23, identified PRN orders for psychotropic drugs were limited to fourteen days and could not be renewed unless the attending provider evaluated the resident for the appropriateness of the medication.	F0756	Continued from page 63 QAPI Oversight • Audit findings will be reviewed monthly through the QAPI Committee. • Negative findings will result in immediate corrective action, re-education, increased monitoring, and follow-up auditing until sustained compliance is achieved. The facility alleges compliance on July 8th, 2026, when all corrective actions were completed and systems were established to ensure ongoing compliance with F756 Drug Regimen Review, Report Irregular, Act On.	07/08/2026

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	245502	A. BUILDING **01 - NURSING HO...** B. WING	**06/09/2026**

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K0000 Bldg. 01	INITIAL COMMENTS FIRE SAFETY An annual Life Safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 06/09/2026. At the time of this survey, Benedictine Care Community 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	K0000		

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245502	(X2) MULTIPLE CONSTRUCTION A. BUILDING **01 - NURSING HO...** B. WING	(X3) DATE SURVEY COMPLETED **06/09/2026**

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K0000 Bldg. 01	Continued from page 1 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: A detailed description of the corrective action taken or planned to correct the deficiency. Address the measures that will be put in place to ensure the deficiency does not reoccur. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. Identify who is responsible for the corrective actions and monitoring of compliance. The actual or proposed date for completion of the remedy. Benedictine Care Community is a 1-story building without a basement. The building was constructed in 2000 and was determined to be of Type I(222) construction. The building is separated from the Hospital Building with a 2-hour fire barrier and the nursing home is divided into 3 smoke compartments with 1-hour fire barriers. The building is fully sprinkler protected with quick response sprinklers and has a fire alarm system with smoke detection in the corridors and spaces open to the corridors that is monitored for automatic fire department notification. Because the main facility and the chapel addition are both conforming contrstuction types for a 1-story building, the entire facility will be surveyed as one Type V(111) building. The facility has a capacity of 49 beds and had a census of 41 at the time of the survey. The requirements at 42 CFR, Subpart 483.70(a), are NOT MET as evidenced by:	K0000		

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K0345 SS = F Bldg. 01	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This STANDARD is NOT MET as evidenced by: Based on a review of available documentation, staff interview, and observations, the facility failed to maintain the fire alarm system per NFPA 101 (2012 edition), Life Safety Code, sections 9.6.1.3, 9.6.7.5, and NFPA 72 (2010 edition), National Fire Alarm and Signaling Code, sections 10.12.4, 14.3.1, 14.4.5.3, and 14.6.2.4. These deficient findings could have a widespread impact on the residents within the facility. Findings include: On 06/09/2026, at 2:00pm, it was revealed by a review of available fire alarm test and inspection documentation and an interview with the Director of Maintenance that the facility could not provide current documentation verifying that a semiannual inspection of initiating devices had been completed. An interview with the Director of Maintenance verified these deficient findings at the time of discovery.	K0345	K0345 – Fire Alarm System Testing & Maintenance 1. Corrective Action for those affected: The facility reviewed all fire alarm system documentation and identified missing semiannual inspection records for initiating devices. The vendor was contacted immediately, and a compliant inspection was completed. All deficient documentation has been updated and is now maintained on-site. 2. Systemic Changes: A contract has been verified with the fire alarm vendor to ensure all inspections (semiannual and annual) are completed in accordance with NFPA 72. A preventive maintenance schedule has been implemented. 3. Monitoring: The facility will utilize TELS to assign K0345 as a task with recurring reminders aligned to required inspection intervals. Documentation will be uploaded and verified monthly. 4. Responsible Party: Director of Maintenance (or designee) 5. Completion Date: 07/09/2026	07/09/2026
K0372 SS = F Bldg. 01	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier.	K0372	K0372 – Smoke Barrier Penetrations 1. Corrective Action: All identified penetrations above fire doors between smoke compartments (Wild Rose Wing and Pioneer Dining Room) were sealed using approved fire-rated materials. 2. Systemic Changes: A facility-wide inspection of smoke barriers has been conducted to identify additional penetrations. A policy was reinforced regarding maintaining fire-rated assemblies. 3. Monitoring:	07/09/2026

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K0372 SS = F Bldg. 01	Continued from page 3 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to maintain their smoke barrier per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.7.1, 19.3.7.3, 8.5.2.2, and 8.5.6.5. These deficient findings could have a widespread impact on the residents within the facility. Findings include: On 06/09/2026, at the following times, it was revealed by observation that there was a penetration running from one smoke compartment to another above doors in the following areas: 1) at 12:58pm, penetrations above fire doors located at the entrance to Wild Rose Wing 2) at 1:06pm, penetrations above fire doors located at the entrance to Pioneer Dinning Room An interview with the Director of Maintenance verified these deficient findings at the time of discovery.	K0372	Continued from page 3 Routine environmental rounds will be completed monthly and documented in TELS, with K0372 added as an inspection task. 4. Responsible Party: Maintenance Director 5. Completion Date: 07/09/2026	07/09/2026
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 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: 1) Based on a review of available documentation and staff interview, the facility failed to inspect fire doors per NFPA 101 (2012 edition), Life Safety Code section 8.3.3.1, and NFPA 80 (2010 edition), Standard for Fire Doors and Other Opening Protectives, section 5.2.1.	K0712	K0712 – Fire Drills / Documentation 1. Corrective Action: Fire drill records were reviewed and corrected where possible. Missing documentation for drill times and dates was addressed, and staff were re-educated. 2. Systemic Changes: A standardized fire drill documentation form was implemented to ensure all required elements (time, shift, conditions) are recorded. 3. Monitoring: Fire drills will be tracked in TELS, with K0712 assigned as a quarterly compliance task. Drill logs will be reviewed monthly. 4. Responsible Party: Administrator / Maintenance Director 5. Completion Date:	07/09/2026

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K0712 SS = F Bldg. 01	Continued from page 4 This deficient finding could have a widespread impact on the residents within the facility. 2) Based on a review of available documentation and staff interview, the facility failed to inspect fire doors per NFPA 101 (2012 edition), Life Safety Code section 8.3.3.1, and NFPA 80 (2010 edition), Standard for Fire Doors and Other Opening Protectives, section 5.2.5.2. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 06/09/2026, at 1:55pm, it was revealed by a review of available documentation that fire drills did not meet the varying time requirement: Fire drills conducted in September and December are missing dates and times in documentation. An interview with the Director of Maintenance verified these deficient findings at the time of discovery.	K0712	Continued from page 4 07/09/2026	07/09/2026
K0761 SS = F Bldg. 01	Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101 Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are maintained and are available for review. 19.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (2010 NFPA 80) This STANDARD is NOT MET as evidenced by: Findings include: On 06/09/2026, at 1:22pm, it was revealed by observation that the following fire doors and/or fire door frames were missing door rating tags. Doors in	K0761	K0761 – Door Inspections & Labeling 1. Corrective Action: Missing fire door/frame rating tags were identified, and corrective action initiated (replacement/verification). Required annual inspection documentation was completed using all 13 NFPA-required elements. 2. Systemic Changes: A comprehensive fire door inventory and inspection schedule has been implemented. 3. Monitoring: Annual inspection tracking and documentation will be monitored through TELS with K0761 assigned as a recurring compliance task. 4. Responsible Party: Maintenance Director 5. Completion Date: 07/31/2026	07/31/2026

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K0761 SS = F Bldg. 01	Continued from page 5 the two (2) hour fire wall leading from the kitchen and the independent living building is missing fire door frame tags. Findings include: On 06/09/2026 at 1:42pm, it was revealed by review of available documentation the required annual door inspection documentation the facility failed to provide a document showing all 13 points of the required door inspection was completed. An interview with the Director of Maintenance verified these deficient findings at the time of discovery.	K0761		07/31/2026
K0918 SS = F Bldg. 01	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70)	K0918	K0918 – Generator Testing & Documentation 1. Corrective Action: The facility scheduled and/or completed the required annual generator inspection and verified scheduling of the 36-month load bank test. Documentation is now on file. 2. Systemic Changes: Vendor agreements were confirmed to ensure ongoing compliance with NFPA 99 and NFPA 110 testing requirements. 3. Monitoring: Generator testing schedules and documentation are tracked in TELS, with K0918 set as recurring tasks for weekly, monthly, annual, and 36-month requirements. 4. Responsible Party: Maintenance Director 5. Completion Date: 07/09/2026	07/09/2026

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K0918 SS = F Bldg. 01	Continued from page 6 This STANDARD is NOT MET as evidenced by: 1) Based on a review of available documentation and staff interview, the facility failed to install and maintain generators per NFPA 99 (2012 edition), Health Care Facilities Code, section 6.4.4.1.1.3, 6.4.1.1.16.2 and 6.4.1.1.17, and NFPA 110 (2010 edition), Standard for Emergency and Standby Power Systems, sections 5.6.5.2, 5.6.5, 5.6.5.6, 5.6.5.6.1, 5.6.6, 8.3.8,8.4.1, 8.4.2.1, 8.4.2.3,8.4.9, 8.4.9.1, 8.4.9.2 and 8.4.9.5.1. These deficient findings could have a widespread impact on the residents within the facility. 2) Based on a review of available documentation and staff interview, the facility failed to install and maintain generators per NFPA 99 (2012 edition), Health Care Facilities Code, section 6.4.4.1.1.3, 6.4.1.1.16.2 and 6.4.1.1.17, and NFPA 110 (2010 edition), Standard for Emergency and Standby Power Systems, sections 8.4.9, 8.4.9.1, 8.4.9.2 and 8.4.9.5.1. These deficient findings could have a widespread impact on the residents within the facility. Findings include: On 06/09/2026, at 2:09pm, it was revealed by a review of available documentation of the emergency generator maintenance and testing that an annual generator inspection was not performed and/or documentation could not be provided at time of survey. Findings include: On 06/09/2026, at 2:10am, it was revealed by a review of available documentation of the emergency generator maintenance and testing that the facility could not provide documentation that a 36 month four (4) hour load bank test had been performed and/or documentation could not be provided at time of survey. An interview with the Director of Maintenance verified these deficient findings at the time of discovery.	K0918		07/09/2026
K0223 SS = D Bldg. 01	Doors with Self-Closing Devices CFR(s): NFPA 101 Doors with Self-Closing Devices Doors in an exit passageway, stairway enclosure, or horizontal exit, smoke barrier, or hazardous area	K0223	K0223 – Self-Closing Doors 1. Corrective Action: The kitchen janitor closet door was repaired to ensure proper self-closing and latching. 2. Systemic Changes:	07/09/2026

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K0223 SS = D Bldg. 01	Continued from page 7 enclosure are self-closing and kept in the closed position, unless held open by a release device complying with 7.2.1.8.2 that automatically closes all such doors throughout the smoke compartment or entire facility upon activation of: * Required manual fire alarm system; and * Local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and * Automatic sprinkler system, if installed; and * Loss of power. 18.2.2.2.7, 18.2.2.2.8, 19.2.2.2.7, 19.2.2.2.8 This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to ensure that the doors to high hazard room would close and latch with power of self-closing device per NFPA 101 (2012 edition), Life Safety Code, section 19.3.2.1.3 and 19.3.2.1.5. These deficient findings could have an isolated impact on the residents within the facility. Findings include: On 06/09/2026, at 1:21pm, it was revealed by observation that the door in the kitchen janitors utility room did not close and latch when tested. An interview with the Director of Maintenance verified these deficient findings at the time of discovery.	K0223	Continued from page 7 All hazardous area doors were inspected to confirm functionality. 3. Monitoring: Monthly life safety rounds will include door checks and be documented in TELS under K0223. 4. Responsible Party: Maintenance Department 5. Completion Date: 07/09/2026	07/09/2026
K0324 SS = D Bldg. 01	Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with	K0324	K0324 – Cooking Equipment & Hood Suppression 1. Corrective Action: Cooking equipment was secured with approved attachment devices and alignment markings. Missing hood inspection and cleaning documentation was obtained and/or services scheduled. 2. Systemic Changes: A contract schedule for semiannual inspections and annual cleaning has been established. 3. Monitoring: All inspections and cleaning records will be tracked in TELS, with K0324 assigned to recurring vendor	07/09/2026

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K0324 SS = D Bldg. 01	Continued from page 8 the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 This STANDARD is NOT MET as evidenced by: 1) Based on observation and interview, the facility failed to install the kitchen hood extinguishing system in accordance with NFPA 101 (2012 edition), The Life Safety Code, section 19.3.2.5, 19.3.2.5.1, 19.3.2.5.2*, 9.2.5, NFPA 96 (2011 edition) Ventilation Control and Fire Protection of Commercial Cooking Operations, section 12.1.2.3 and 12.1.2.3.1. These deficient findings could have an isolated impact on the residents within the facility. 2) Based on documentation review and staff interview, the facility failed to test and inspect the kitchen hood ventilation and fire suppression system per NFPA 101 (2012 edition), Life Safety Code, section 9.2.3 and NFPA 96 (2011 edition), Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, section 11.2.1. This deficient finding could have an isolated impact on the residents within the facility. The findings include: On 06/09/2026, at 1:19pm, it was revealed that the wheeled, gas-fired stove and griddle located on the cooking line in the kitchen was not provided with an approved method of attachment and/or an alignment mark to ensure the appliances was returned to an approved design location after it had been moved for maintenance and cleaning. Both the attachment device and alignment mark are required for each gas operated and deep fat fryer cooking device. Findings Include: On 06/09/2026, at 2:14pm, it was revealed by a review of available documentation that inspection documentation for the kitchen hood ventilation and fire suppression system was not available. The facility could not provide completed test/inspection documentation for both of the semi-annual kitchen hood suppression system inspections for the last 12	K0324	Continued from page 8 compliance tasks. 4. Responsible Party: Dietary Director / Maintenance Director 5. Completion Date: 07/09/2026	07/09/2026

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K0324 SS = D Bldg. 01	Continued from page 9 months. Facility could also not provide documentation of annual cleaning on kitchen hood cleaning at the time of survey. An interview with the Director of Maintenance verified these deficient findings at the time of discovery.	K0324		07/09/2026
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 This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to maintain spacing between storage and the sprinkler system per NFPA 101 (2012 edition), Life Safety Code, Section 9.7.5, NFPA 25 (2011 edition), Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, Section 5.2.1.2, and NFPA 13 (2010 edition), Standard for the Installation of Sprinkler Systems, Sections 8.6.5.3.2 and 8.15.9. These deficient findings could an isolated impact on the residents within the facility. Findings include: On 06/09/2026, at 1:07pm, it was revealed by observation that storage materials had been placed on a storage rack, bringing the storage materials	K0353	K0353 – Sprinkler Clearance 1. Corrective Action: Storage was immediately repositioned to maintain the required 18-inch clearance below sprinkler heads. 2. Systemic Changes: Staff were educated on clearance requirements. 3. Monitoring: Monthly environmental rounds documented in TELS will include sprinkler clearance checks (K0353). 4. Responsible Party: Maintenance / Department Managers 5. Completion Date: 07/09/2026	07/09/2026

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K0353 SS = D Bldg. 01	Continued from page 10 within the required 18 inch clearance area under the sprinkler heads. This obstruction was found in Therapy Room. An interview with the Director of Maintenance verified these deficient findings at the time of discovery.	K0353		07/09/2026
K0781 SS = D Bldg. 01	Portable Space Heaters CFR(s): NFPA 101 Portable Space Heaters Portable space heating devices shall be prohibited in all health care occupancies, except, unless used in nonsleeping staff and employee areas where the heating elements do not exceed 212 degrees Fahrenheit (100 degrees Celsius). 18.7.8, 19.7.8 This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to implement its portable space heater policy per NFPA 101 (2012 edition), Life Safety Code, section 19.7.8. These deficient findings could have an isolated impact on the residents within the facility. Findings include: On 06/09/2026, at 13:09pm, it was revealed by observation of portable space heaters in Human Resources office in contradiction on the site policy. That states “space heaters are prohibited”. Space heater found also does not meet the requirements of rated for less than 212 degree temperature. An interview with the Director of Maintenance verified these deficient findings at the time of discovery.	K0781	K0781 – Space Heaters 1. Corrective Action: All non-compliant space heaters were removed from the HR office. 2. Systemic Changes: The facility re-educated staff on the no-space-heater policy and approved device requirements. 3. Monitoring: Environmental rounds documented in TELS will include K0781 checks for unauthorized devices. 4. Responsible Party: Department Managers / Maintenance 5. Completion Date: 07/09/2026	07/09/2026
K0920 SS = D Bldg. 01	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient	K0920	K0920 – Power Strips & Electrical Devices 1. Corrective Action: Improper use of power strips (daisy chaining and refrigerators) was corrected immediately. 2. Systemic Changes: Staff education was completed on approved electrical device usage per NFPA 99 and NFPA 70.	07/09/2026

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K0920 SS = D Bldg. 01	Continued from page 11 care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to maintain the usage of electrical adaptive devices per NFPA 99 (2012 edition), Health Care Facilities Code, sections 10.5.2.3.1 and 10.2.4.2.1, NFPA 70, (2011 edition), National Electrical Code, sections 400-8, and UL 1363. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 06/09/2026, at the following times, it was revealed by observation that there were several electrical appliances plugged power-strips, multi-plug adapters and/or extension cords in the following areas; 1) at 1:32pm, In the D.O.N. Office it was found the a Power-strip was plugged into another Power-strip with a refrigerator pugged into second power-strip. 2) at 1:33pm. in the Clinical Managers office it was found that a refrigerator was plugged into a power-strip. An interview with the Director of Maintenance verified these deficient findings at the time of discovery.	K0920	Continued from page 11 3. Monitoring: Monthly electrical safety rounds documented in TELS, with K0920 assigned as a recurring compliance task. 4. Responsible Party: Maintenance / Department Managers 5. Completion Date: 07/09/2026	07/09/2026