



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

August 19, 2026

Administrator
HERITAGE LIVING CENTER
619 WEST SIXTH STREET
PARK RAPIDS, MN 56470

RE: CCN:245405

Cycle Start Date: August 5, 2026

Dear Administrator:

On August 5, 2026, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), 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 November 5, 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 February 5, 2027 (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



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Administrator
HERITAGE LIVING CENTER
619 WEST SIXTH STREET
PARK RAPIDS, MN 56470

Re: State Nursing Home Licensing Orders
Event ID: 284ED1-H1

Dear Administrator:

The above facility survey was completed on August 5, 2026 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

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

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

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

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

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

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Bemidji District Office
Health Regulation Division
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Email: Jennifer.bahr@state.mn.us
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You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

Please feel free to call me with any questions.

Sincerely,



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Re: State Nursing Home Licensing Orders
Event ID: 284ED1-H1

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

Please feel free to call me with any questions.

Sincerely,



Kamala Fiske-Downing
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Minnesota Department of Health
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Electronically Delivered
September 8, 2026

Administrator
HERITAGE LIVING CENTER
619 WEST SIXTH STREET
PARK RAPIDS, MN 56470

RE: CCN: 245405
Cycle Start Date: September 8, 2026

Dear Administrator:

On September 8, 2026, the Minnesota Department of Health and Public Safety, completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Sincerely,

A handwritten signature in black ink that reads 'Kamala Fiske-Downing'.

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



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

September 8, 2026

Administrator
HERITAGE LIVING CENTER
619 WEST SIXTH STREET
PARK RAPIDS, MN 56470

Re: Reinspection Results
Event ID: 284ED1-H2

Dear Administrator:

On September 8, 2026 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on August 5, 2026. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

A handwritten signature in black ink that reads 'Kamala Fiske-Downing'.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245405		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/05/2026	
NAME OF PROVIDER OR SUPPLIER HERITAGE LIVING CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 619 WEST SIXTH STREET , PARK RAPIDS, Minnesota, 56470			
(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 8/3/26-8/5/26, 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			08/31/2026	
F0000	INITIAL COMMENTS On 8/3/26 - 8/5/26, a standard recertification survey (S5405044) was completed at your facility by the Minnesota Department of Health to determine compliance with §42 CFR Part 483, Subpart B, Requirements for Long Term Care Facilities. Your facility was found to be not in compliance. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's 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			08/31/2026	
F0684 SS = D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the		F0684	1. Resident GW was transferred to the hospital to be evaluated and monitored upon return. All HLC residents who have a change in condition were at risk of this deficiency. All current HLC residents were reviewed for monitoring/assessment following any initially recognized acute change in condition. There were currently none. 2. HLC’s Change of Condition policy was reviewed and found to be appropriate and compliant. 3.Education was provided to all TMAs/LPNs/RNs and DON on the Change of Condition Policy and		08/31/2026	

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: 245405		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/05/2026	
NAME OF PROVIDER OR SUPPLIER HERITAGE LIVING CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 619 WEST SIXTH STREET , PARK RAPIDS, Minnesota, 56470			
(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
F0684 SS = D	Continued from page 1 residents' choices. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to ensure a resident received ongoing nursing assessment and monitoring following an acute change in condition for 1 of 2 residents (R5) reviewed for changes in condition. Findings include: R5's significant change Minimum Data Set (MDS) dated 7/13/26 identified the assessment was completed due to R5's admission to hospice care. R5 had intact cognition and was dependent with most activities of daily living (ADLs), including dressing, grooming, and toileting. R5 was dependent with transfers and unable to ambulate. R5 had an indwelling Foley catheter and was always incontinent of bowel. R5 did not exhibit rejection of care or other behaviors during the assessment period. Diagnoses included right above-the-knee amputation, heart failure, chronic obstructive pulmonary disease (COPD), diabetes, anxiety, and a history of transient ischemic attack and cerebral infarction (stroke). R5's care plan, revised 7/13/26, identified R5 had altered respiratory status related to heart disease, asthma, anemia, COPD, and a history of tuberculosis. Goals included maintaining a normal breathing pattern and pulse oximetry above 90 percent. Staff were directed to monitor, document, and report breathing abnormalities to the physician, administer nebulizers and inhalers as ordered, and obtain vital signs weekly and as needed. The care plan identified R5 had altered elimination related to bowel incontinence and an indwelling urinary catheter. Staff were directed to provide perineal care after each incontinent episode and record the amount and consistency of bowel movements. The care plan identified R5 had diabetes with a goal to experience no complications related to diabetes. Interventions directed staff to administer medications as ordered, monitor for side effects, and monitor, document, and report to the physician as needed symptoms of hypoglycemia or hyperglycemia, increased thirst and appetite, weight loss, and fatigue. R5's progress notes identified the following:			F0684	Continued from page 1 they have completed acknowledgement of policy on August 31, 2026. 4. DON or designee will audit ongoing monitoring/assessment following a change of condition weekly x four weeks and then monthly x5 months. An audit form was created to monitor compliance. The results of the audits will be reported to the QAPI committee for further recommendations. This deficiency has been remedied on August 31, 2026.		08/31/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245405		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/05/2026	
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F0684 SS = D	Continued from page 2 On 6/28/26, R5 woke early and ordered four ice creams for breakfast and stated they were for his diarrhea. Later, R5 was heard shouting for help and was seated in his wheelchair at the end of the bed. R5 denied pain, breathing difficulty, or chest pain and refused to allow staff to obtain his vital signs. R5 stated he did not know what was going on with him. Staff notified the on-call physician, who ordered laboratory testing, which R5 initially refused. Later during the day shift, R5 allowed staff to attempt to obtain blood for the ordered laboratory testing twice; however, the samples hemolyzed and could not be used. R5 was confused and hallucinating. Staff updated the on-call physician, who stated another provider would see R5 the following day. On 6/28/26 at 10:34 p.m., staff documented R5 had been incontinent of seven large, loose, tarry stools. Staff made several attempts to convince R5 to go to the emergency room for evaluation; however, R5 refused. R5 also refused all oral intake during the evening shift. On 6/29/26 at 10:07 a.m., R5 was transferred to the hospital due to increased stools and hypotension. R5's blood pressure was 55/36, pulse was 53 beats per minute, and temperature was 99.2 degrees Fahrenheit. R5's medical record lacked evidence a licensed nurse assessed R5 or that staff monitored R5's vital signs and clinical condition during the evening and night shifts following his acute change in condition, which included seven large, loose, tarry stools and refusal of oral intake. R5's Blood Pressure Summary identified staff recorded R5's blood pressure two to three times per day from 6/16/26 through 6/27/26; however, no blood pressure was recorded on 6/28/26 or prior to R5's assessment and transfer to the hospital on 6/29/26. During an interview on 8/4/26 at 2:43 p.m., licensed practical nurse (LPN)-B stated the second floor was usually staffed with a trained medication assistant (TMA) and a nursing assistant (NA). If the TMA needed assistance, such as when a resident experienced a change in condition or required insulin administration, a nurse from the first floor would go to the second floor and provide the necessary nursing services. If an LPN or registered nurse (RN) was scheduled on the second floor, the nurse completed their own assessments. LPN-B stated assessments were documented in the			F0684			08/31/2026

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F0684 SS = D	Continued from page 3 resident's progress notes. During an interview on 8/4/26 at 2:47 p.m., RN-A stated when she began her shift on 6/29/26, she reviewed the shift report and went to assess R5. RN-A stated she first obtained R5's vital signs because R5 was sweaty and did not feel well. RN-A discussed R5's condition with him, and R5 agreed to go to the emergency room for evaluation. RN-A stated she had been informed R5 previously refused hospital evaluation. RN-A stated she would have expected increased monitoring and vital sign assessments during the previous shifts due to R5's change in condition. RN-A was unable to locate evidence staff monitored R5's condition and stated it appeared staff did not obtain R5's vital signs during the evening or night shift. During a telephone interview on 8/4/26 at 3:42 p.m., LPN-C stated she worked the evening shift on 6/28/26 and remembered R5 repeatedly refused to go to the emergency department for evaluation. LPN-C thought the TMAs obtained R5's vital signs twice during the shift. LPN-C stated she did not document the vital signs in R5's medical record and acknowledged the vital signs should have been documented. LPN-C stated she knew the on-call provider had been notified during the day shift; therefore, staff did not update the provider during the evening shift because R5 continued to refuse transfer to the emergency department for evaluation. During an interview on 8/4/26 at 5:40 p.m., RN-D stated she worked the day shift on 6/28/26 and remembered R5 experienced significant hallucinations. RN-D stated she was told R5 wanted four cups of ice cream for breakfast and wondered whether R5's symptoms were related to his blood glucose because he had diabetes. RN-D contacted the on-call provider because of R5's confusion and attempted to obtain blood for the ordered laboratory testing; however, the samples clotted and could not be used. RN-D stated she attempted to obtain R5's blood pressure, but the machine repeatedly displayed an error. RN-D then attempted to palpate R5's pulse and blood pressure but was unable to obtain them. R5 would not allow staff to place a blood pressure cuff on him, and when staff were able to attempt it, the machine continued to display an error. RN-D stated the on-call provider said R5 needed to go to the emergency room; however, R5 was his own person and refused to go. RN-D stated R5 was sweating but would not allow staff to touch him to			F0684			08/31/2026

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F0684 SS = D	Continued from page 4 obtain his vital signs or blood glucose. R5 hollered for help throughout the shift, but when staff entered his room, R5 stated he had not asked for help and directed staff to leave. RN-D stated R5 became more like himself toward the end of the day shift, which was when staff were able to attempt obtaining the blood samples; however, R5 allowed staff to provide care for only a short time before he again refused to be touched. During an interview on 8/4/26 at 5:33 p.m., TMA-A stated she worked the evening shift on 6/28/26. Staff offered R5 several opportunities to go to the emergency room because of his condition. R5 was not eating or drinking but repeatedly stated he wanted to wait. TMA-A thought her coworker had obtained R5's vital signs but was unsure where they would have been documented. TMA-A stated R5 appeared grayish, and staff offered him everything they could offer. TMA-A stated TMAs and NAs were trained to obtain vital signs. Routine weekly vital signs were prompted for documentation by the electronic medical record. If additional vital sign monitoring was needed, staff wrote the results on paper and gave them to the nurse. TMAs and NAs used a vital sign form to record residents' vital signs, which identified normal ranges. If a vital sign was outside the range identified on the form, staff alerted the nurse. TMA-A stated she was busy administering medications that evening and her coworker was working with R5. Staff had monitored R5's vital signs twice daily from 6/17/26 through 6/27/26 because R5 had been receiving an antibiotic and facility policy required daily monitoring. When a resident completed an antibiotic, staff usually discontinued the daily monitoring. During an interview on 8/5/26 at 5:19 a.m., LPN-D stated she was aware R5 had been declining but did not work the night of 6/28/26. LPN-D stated R5 could be difficult to work with. R5 was noncompliant and rude but was his own person and staff could not force him. LPN-D stated she would document R5's vital signs if he allowed staff to obtain them or document his refusal. LPN-D stated she would document R5's appearance and behavior and document if R5 refused transfer to the emergency room or refused to allow staff to monitor his vital signs. During an interview on 8/5/26 at 6:23 a.m., NA-F stated she worked on 6/28/26 and R5 had been			F0684			08/31/2026

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F0684 SS = D	Continued from page 5 really confused. NA-F stated staff were in R5's room anywhere from every five minutes to every 30 minutes. Usually, R5 was very independent and called staff only when he really needed assistance; however, R5 used his call light frequently that morning and was very confused. NA-F stated R5 would not allow the RN to obtain his vital signs. Staff attempted to use the blood pressure cuff on both arms but repeatedly received an error. NA-F stated R5's routine was very different. R5 would not eat or change his clothes. NA-F remembered R5's nose was running frequently and R5 was leaning heavily over his lap. R5 appeared to be in pain but refused to go to the doctor. During a telephone interview on 8/5/26, at 11:09 a.m. the administrator stated she was not sure of all the details regarding R5's acute change in condition on 6/28/26 but would look into it further. [no further details were received] During an interview on 8/5/26 at 12:21 p.m., the director of nursing (DON) stated staff were expected to document the care and monitoring they provided. The facility's Change in a Resident's Condition or Status Policy, revised October 2024, identified the facility would promptly notify the resident, attending physician, and resident representative of changes in a resident's medical or mental condition and/or status. The policy directed the RN manager to document information related to changes in the resident's condition in the resident's medical record.			F0684			08/31/2026
F0744 SS = D	Treatment/Service for Dementia CFR(s): 483.40(b)(3) §483.40(b)(3) A resident who displays or is diagnosed with dementia, receives the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to consistently implement and evaluate individualized interventions to address persistent expressions of distress for 1 of 1 resident (R31) reviewed for dementia care. This resulted in prolonged periods of R31 hollering without staff intervention and contributed to distress for another resident (R7), who had a known history of post-traumatic stress disorder (PTSD) with loud			F0744	An IDT meeting was held on 8/20/26 to complete a root cause analysis of her hollering. Progress note made by RN. All HLC residents who have dementia were at risk of this deficiency. All current HLC residents were reviewed for treatment/service for dementia related behaviors. HLC’s Dementia Care Policy was reviewed and found to be appropriate and compliant. Education was provided to all nursing and activity staff regarding ongoing treatment/service for dementia symptoms. DON or designee will audit dementia treatment/service for residents with dementia weekly x four weeks and then monthly x5 months. An audit form was created to monitor compliance. The results		08/31/2026

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F0744 SS = D	Continued from page 6 noises identified as a trigger. Findings include: R31 R31's quarterly Minimum Data Set (MDS) dated 4/28/26, identified R31 had a severe cognitive impairment and had diagnoses that included Alzheimer's disease, dementia, delusional disorders, and depression. R31 exhibited facial expressions (e.g. grimaces, wincing, wrinkled forehead, furrowed brow, clenched teeth or jaw) as indicators of pain or possible pain and received scheduled pain medication and non-medication interventions for pain. R31's Cognitive Loss/Dementia Care Area Assessment (CAA) dated 2/23/26, identified R31's goal was to maintain by management of symptoms and behaviors. Staff would encourage R31 to make as many choices as possible, needs anticipated by staff when needed. R31's Behavioral Symptoms CAA dated 2/23/26, identified R31's goal was to improve by utilizing behavioral interventions. Medications administered to manage depression and behavioral symptoms, monitored routinely. R31's Pain CAA dated 2/23/26, identified R31's goal was to maintain with current pain management regimen effective. R31 had scheduled medications, non-medication interventions, and as needed (PRN) medications available. R31's care plan revised 5/6/26, identified R31 had behaviors of yelling out, grabbing at staff, and swearing related to dementia, and Alzheimer's disease, delusional disorder, and depression. Interventions included: Intervene as necessary to protect the rights and safety of others. Approach/Speak in a calm manner. Divert attention. Remove the situation and take R31 to alternate location as needed. Monitor behavior episodes and attempt to determine underlying causes. Consider location, time of day, people involved, and situations. Document behavior and potential causes. When R31 was exhibiting verbal/physical behaviors (yelling out; declining cares; grabbing; swearing) leave R31 in a safe space and return later to provide task.			F0744	Continued from page 6 will be reported to the QAPI committee for further recommendations. This deficiency has been remedied on August 31, 2026.		08/31/2026

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F0744 SS = D	Continued from page 7 R7 R7’s Trauma Informed Care dated 11/25/24, identified R7 had a history of childhood neglect and abuse which can make R7 feel angry/irritable, anxious and distraught. There was no pattern to how often the feeling related to the situation occurred. Loud noises were a trigger for R7. A close relationship with siblings and other family members helped make R7 feel better. Preference for private room and R7 used tv or a white noise machine to block out neighboring sounds. R7’s quarterly MDS dated 7/8/26, identified R7 had severe cognitive impairment and diagnoses included Post-Traumatic Stress Disorder (PTSD), depression, migraine and cirrhosis of the liver. R7 required cleanup/set up assistance with eating but was independent with all other care areas. R7 exhibited no behaviors R7’s care plan revised 7/22/26, identified R7 had actual or potential for post-traumatic stress disorder related to childhood neglect and abuse. Interventions included the following: observe for changes in mood/behavior/sleep/eating and side effects of medications. During an observation on 8/3/26 at 11:04 a.m., R31 was sitting in her wheelchair in the common area in front of the tv. R31 was hollering incoherently and loudly. R31 could be heard throughout the wing. Licensed practical nurse (LPN)- stated R31 was having mouth pain, and staff were trying to figure out what to do. R31 had been given pain medication. At 11:16 a.m., R31 continued to holler out. R31’s eyes were closed and she was sitting with her feet elevated and a pillow behind her head. At 11:38 a.m., R31 was assisted to the dining room for her noon meal. R31 continued to holler out loudly but the other residents weren't acknowledging her hollering. LPN-A, R31 and two other residents were in the dining room. At 11:48 a.m., R31 continued to holler out incoherently. R31’s tablemates joined her at the table but neither said anything when R31 hollered out. The other residents quietly sat with their eyes closed waiting for the meal to start. At 12:01 p.m., R31 continued to holler “uhhhhhh” loudly. Nursing assistant (NA)-B stated R31 hollered a lot like that. R31 was in a lot of pain. “It’s been			F0744			08/31/2026

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F0744 SS = D	Continued from page 8 going on a while now.” During an interview on 8/3/26 at 1:39 p.m., family member (FM)-A stated R31 did have problems with her teeth and staff had been working with insurance to get R31 to an oral surgeon because R31 would not open her mouth for the regular dentist and R31 ground her teeth. FM-A stated he was told staff could feel where R31’s teeth were broken off. Staff applied a numbing gel to R31’s gums/teeth and R31 had pain medications as well. However, FM- stated “the doctor said it shouldn’t hurt” R31. R31 did the hollering. FM-A wasn’t sure if it was pain or if R31 had a behavior. FM-A knew if you held R31’s hand or rubbed her feet, R31 calmed down. During an observation on 8/3/26 at 5:58 p.m., NA-A assisted R31 to the common area and stated, “you probably don’t want to sit here because she’s going to be noisy.” R31 was hollering loudly until registered nurse (RN)-A brought an oral soothing device. The oral soothing device was a fabric pouch with a plastic handle that could be filled with ice. RN-A stated R31 ground her teeth, and the facility has been unable to get her a mouth guard. The oral soothing device was filled with lemon flavored icy to help soothe R31’s oral pain. R31 did suck and chew on the oral soothing device but continued to holler out around it. At 6:01 p.m., R31 opened her mouth and RN-A removed the oral soothing device. RN-A went down the hall and R31 began hollering again. At 6:06 p.m., R31 continually hollered loudly. RN-A returned with an ice pack and held it against R31’s check. R31 continued hollering and RN-A asked if it was too cold. R31’s hollering remained unchanged. RN-A asked R31 if she wanted to go for a walk. R31 continued hollering and kicked her feet into the air. RN-A told R31 to squeeze RN-A’s hand if the ice pack was too cold. R31 lightly held RN-A’s hand. At 6:10 p.m., R31 had continually hollered. RN-A pushed R31’s wheelchair past the nursing assistants and asked if it was normal for R31 to “holler like this”. The nursing assistants nodded and said yes. At 6:14 p.m., RN-A and the director of nursing (DON) brought R31 to her room. The DON stated hollering was R31’s “norm” and left the room. At 6:17 p.m., RN-A brought R31 back to the common area in front of the tv. RN-A then left the area.			F0744			08/31/2026

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F0744 SS = D	Continued from page 9 At 6:24 p.m., R31 hollered non-stop. R7 was inside her room, which as adjacent and shared a wall the tv area, with the door shut and could be heard clearly yelling “shut up!” through the shut door. R31 continued hollering. At 6:26 p.m., R31 continued hollering. R7 was sitting in her recliner and was “trying to watch tv”. R7 is scowling and shaking her head and yelled “Shut up!” “It’s just nonstop. Day and night. It drives me nuts!” R7 stated it didn’t do any good to say anything to the staff, but “seriously can’t they just move her somewhere else?” R7 stated she understood R31 lived at the facility but R31 didn’t have to sit right outside R7’s room. At 6:32 p.m., R31 hollered nonstop with tone and intensity increased. Staff did not move R31 or approach R31 or R7 to attempt redirection. During an interview on 8/4/26 at 10:12 activity aide (AA)-A sat next to R31 talking softly and assisted R31 to eat an icy while holding/stroking R31’s hands. R31 occasionally made sound, but the sound had decreased in tone and intensity significantly. At 10:33 a.m., AA-A told R31 AA-A needed to go chart and would see R31 later. During an interview 8/4/26 at 10:37 a.m., AA-A stated R31 had hollering behaviors for “quite a while now”. AA-A stated the nurses were working with R31’s insurance to get an oral procedure approved. AA-A stated R31’s hollering lessened when some sat with R31 and held her hands. It also increased when R31’s family had visited and had to leave. AA-A stated R31 had the behavior prior to the dental problem being identified. AA-A stated she was unsure if it was pain or did the pain increase the behavior and the behavior just continued. The other residents did complain. Another resident recently moved upstairs so she wouldn’t have to listen to it anymore. R7 complained as well. Sometimes staff tried to move R31 to the dining room because there was a tv there too when R7 complained. AA-A stated she did not know if there was anything else the staff could do. During an observation on 8/4/26 at 10:44 a.m., R31 started hollering again. NA-C was sitting at the desk, and housekeeping was going room to room. No staff approached R31. At 10:51 a.m., R31 hollered nonstop. NA-C left the desk but never approached R31. Housekeeping continued going room to room.			F0744			08/31/2026

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F0744 SS = D	Continued from page 10 At 11:09 a.m., NA-C approached R31 and placed a wedge cushion between R31 and R31's left wheelchair armrest. NA-C told R31 she would be back to get her for lunch shortly. At 11:11 a.m., RN-A approached R31, put on a pair of gloves and applied essential oils to R31's neck. RN-A stated sometimes the essential oils and neck rub helped R31. R31 did stop hollering while R31 rubbed R31's neck. At 11:19 a.m., RN-A walked away from R31 and R31 began hollering. At 11:21 a.m., RN-A returned with a nutritional shake and R31 drank the shake using a straw. R31 stopped hollering. During an interview on 8/4/26 at 2:17 p.m., NA-D stated R31 screamed "all the time", "every day". R31 was in a lot of pain, and the hollering was the only way for R31 to communicate. R31 had an oral soothing device that R31 could chew on that helped. When R31's family was there, that helped too. Staff believed R31 was scared to be alone and hollered because of that as well. Other residents did complain about R31's hollering. R7 complained but was usually good about it. R7 just shut her door and tried to ignore it. At 2:21 p.m., NA-D returned with the oral soothing device and a towel. NA-D stated R31 would not always open her mouth and rubbed R31' lips with the device telling R31 that it would feel good. NA-D placed the device in R31's mouth, placed the towel in R31's lap and walked away. "Let's see if that helps for a little bit." R31 continued to holler around the device. At 2:28 p.m., R31's hollering increased in tone and loudness, yelling approximately every 15 seconds. R7 was in her room with the door shut and can be heard clearly yelling "Shut up! Just shut up!" There were 5 staff sitting at the desk for afternoon report. No staff approached either resident. R31 and R7 continued hollering. At 2:31 p.m., NA-D approached R31 and placed the oral soothing device back into R31's mouth. "You just have to keep sticking it in her mouth". R31 chewed on the device but continued hollering in a muffled hum. NA-D went back to the desk. At 2:36 p.m., the oral soothing device fell out of R31's mouth and R31 is screaming incoherently. R7			F0744			08/31/2026

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F0744 SS = D	Continued from page 11 screamed “Shut up!” behind her closed door but could be clearly heard. Staff continued to sit at the desk without approaching R31 or R7. At 2:40 p.m., shift report was done and staff stood up from the desk. R31 and R7 were hollering. NA-E approached R31 and assisted R31 to an upright position. R31 continued to scream. No staff checked on R7. NA-E walked away from R31 with R31’s oral soothing device and walked with the other 4 staff down the hall. R31 and R7 continued hollering. At 2:44 p.m., NA-E brought R31’s oral soothing device to R31 and placed it in R31’s mouth. R31 chewed and sucked on the device. NA-E stated R31 hollered every day, all day. Sometimes rubbing R31’s legs helped because R31’s muscles would get stiff. Sometimes the chewing ice helped. That was all staff usually did. NA-E then stated staff didn’t always have to hold R31’s device for R31 but NA-E chose to at that time to prevent R31 from spitting it out. R7 did get really upset about R31’s hollering. R7 had behaviors too and screamed at R7 which wasn’t right either. R31 couldn’t help it. Staff were supposed to go in and talk to R7 and just try to calm her down. At 2:50 p.m., NA-E placed the oral soothing device in R31’s mouth, removed her gloves and walked away from R31. R7 hollered “shut up” but NA-E did not go in and talk to R7. At 2:53 p.m., R31 spit out the oral soothing device and was hollering again. R7 repeatedly hollered in her room. At 2:57 p.m., NA-E sat down at the desk, didn’t approach either resident and was working on the electronic tablet. R31 and R7 continued hollering. During an interview on 8/4/26 at 3:07 p.m., NA-A stated R31 yelled and screamed all day, every day. Sometimes R31 was quiet in the mornings but by 2:00-3:00 p.m., R31 hollered until she went to bed at 7:00 p.m. After that, R31 tended to be quieter. Staff gave R31 ice. R31’s oral soothing device had fallen into R31’s lap where it melted and R31 had an approximately 6-inch circle of wet on her left thigh. Sometimes R31 would hold the oral soothing device in her mouth but staff really should hold it for R31. Sometimes R31 would be quiet for about 1 minute. R31 liked to go outside too and like it when it was quiet and peaceful. R7 did get upset by R31’s hollering and screamed shut up. NA-A stated staff couldn’t put R31 in her room because that would isolate R31.			F0744			08/31/2026

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F0744 SS = D	Continued from page 12 At 3:13 p.m., NA-A walked away telling R31 he would be right back. R31 immediately began hollering again. During an interview on 8/5/26 at 10:44 a.m., RN-A stated she was the unit manager for R31 and R7. R31 had ongoing teeth pain, and this had been a consistent concern for a few months. The first sign was R31 had cheek/face swelling. She was seen and treated with an antibiotic and a dental referral was sent. A local dentist had been able to do an evaluation but R31 requires an oral surgeon. Insurance approval has been difficult and R31 was going to have additional imaging. R31 did have pain medications as well as non-pharmacy interventions such as food, drink, ice, heat, essential oils, massage, and repositioning. RN-A felt the staff had been trying their best to manage R31's pain but had met every barrier possible. However, RN-A expected staff to follow R31 and R7's care plans to address behaviors. During an interview on 8/5/26 at 11:52 a.m., the DON stated she expected staff to acknowledge resident behaviors and to follow care plans to ensure resident needs were met. During a telephone interview on 8/5/26 at 12:36 p.m., the administrator stated she expected staff to follow resident care plan regarding dementia care to meet the residents' needs. Document review identified the facility had not completed an assessment of R31's persistent hollering to determine the underlying cause or contributing factors, including whether the hollering was related to pain, dementia-related distress, fear of being alone, environmental factors, or a combination of factors. Although staff identified multiple possible causes for R31's hollering and individualized interventions that reduced or stopped the hollering, the information had not been incorporated into an individualized approach that differentiated interventions for possible pain from interventions for R31's dementia-related behavioral symptoms. A dementia care policy was requested but not received.			F0744			08/31/2026
F0760 SS = D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its-			F0760	R43 was assessed and found no harm from medication error. All residents at HLC could be at risk of this deficiency. All staff who administer medications were educated on the Medication Administration policy. All residents who are		08/31/2026

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F0760 SS = D	Continued from page 13 §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to ensure a resident was free from a significant medication error when a registered nurse (RN) administered 5 milligrams (mg) of morphine sulfate instead of the prescribed 2 mg dose for 1 of 1 resident (R43) reviewed for medication administration. Findings include: R43's significant change Minimum Data Set (MDS) dated 7/7/26 identified R43 had severe cognitive impairment and diagnoses that included Alzheimer's disease, coronary artery disease, and dementia. R43's physician orders dated 7/30/26 identified the following: morphine sulfate concentrate oral solution 100 mg/5 milliliters (mL): place and dissolve 2 mg (0.1 mL) buccally (between the gum and inner lining of the cheek) every four hours for pain. morphine sulfate concentrate oral solution 100 mg/5 mL: place and dissolve 5 mg (0.25 mL) buccally every hour as needed (PRN) for breakthrough moderate to severe pain rated 4-10 out of 10 or shortness of breath. R43's electronic medication administration record (EMAR), reviewed on 8/5/26, identified R43 received the scheduled 2 mg (0.1 mL) dose of morphine sulfate at 4:00 p.m. The EMAR further identified R43 had not received a PRN dose of 5 mg (0.25 mL). During an observation on 8/3/26 at 4:04 p.m., RN-B withdrew 0.25 mL (5 mg) of morphine sulfate concentrate 100 mg/5 mL using the syringe provided with the medication. RN-B brought the medication into R43's room and administered the medication buccally. RN-B returned to the medication cart, removed the narcotic record book from the drawer, and documented that 0.1 mL of morphine sulfate had been administered. RN-B stated she administered 0.25 mL to R43 because the medication box label identified 0.25 mL. RN-A stated she was the unit manager and R43's			F0760	Continued from page 13 prescribed liquid morphine were audited for correct labels/medication errors; all were correct. HLC's Medication Administration Policy was reviewed and found to be appropriate and compliant. Staff member was coached regarding medication error. All nursing staff who administer medications were retrained on the medication administration policy. DON or designee will audit medication administration for accuracy weeklyx4 weeks and monthly x5 months. An audit form was created to monitor compliance. The results of the audits will be reported to the QAPI committee for further recommendations. This deficiency has been remedied on 8/31/2026.		08/31/2026

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F0760 SS = D	Continued from page 14 medication order had recently changed. RN-A stated 0.1 mL was the correct dose. However, RN-B explained and confirmed to RN-A that she had administered 0.25 mL. RN-A stated, "That's an error," and asked whether R43 was okay. RN-A and RN-B assessed R43 following the medication error. R43's vital signs and condition were unchanged. RN-A stated when a medication dose changed, a sticker should have been applied to the medication label to ensure staff double-checked the dose. RN-A stated a medication error report would be completed and the director of nursing (DON) would be notified. During a telephone interview on 8/5/26 at 10:54 a.m., RN-E stated she was notified of R43's medication error on 8/3/26 at approximately 4:45 p.m. RN-E stated because R43 had been routinely receiving morphine sulfate, the medication error was not a concern that required further evaluation. During an interview on 8/5/26 at 11:52 a.m., the DON stated RN-A reported the medication error immediately after it occurred. The DON spoke with RN-B, who acknowledged the error. RN-B received education regarding the importance of completing the five rights of medication administration: right resident, right medication, right dose, right route, and right time. The DON stated RN-B followed the directions on the medication label; however, facility policy required staff to follow the EMAR. The DON sent an alert to all trained medication aides (TMAs) and nursing staff and provided facility-wide education. The DON stated she expected staff to follow facility policy to ensure resident safety. During a telephone interview on 8/5/26 at 12:36 p.m., the administrator stated she expected staff to follow facility policy for medication administration to ensure resident safety. During a telephone interview on 8/5/26 at 1:11 p.m., the consultant pharmacist stated R43 could have experienced increased drowsiness from the medication error but did not expect adverse effects because R43 had already been receiving morphine sulfate. The consultant pharmacist stated staff were expected to follow facility policy to ensure medications were administered safely. The facility's Liquid Narcotic Administration Policy, revised 1/2025, identified the purpose of the procedure was to provide guidelines for the safe administration of oral liquid narcotic medications. The policy directed staff to:			F0760			08/31/2026

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F0760 SS = D	Continued from page 15 Verify there was a physician's order for the medication to be administered. Review the resident's care plan for special needs. Assemble necessary equipment and supplies. Place the EMAR within easy viewing distance. Unlock the medication cart and narcotic drawer. Select the medication from the medication cart. Check the medication label and confirm the medication and dose with the EMAR. Prepare the correct dose of medication. When using a syringe, staff were required to use the syringe provided with the medication and draw up the correct amount. An ordered amount of less than 5 cubic centimeters (cc) required use of a syringe. Contact hospice for approval of an initial hospice medication dose; subsequent doses did not require approval unless otherwise indicated. Check the narcotic record against the previous drug count and medication supply and report discrepancies to the DON and complete an incident report for errors.			F0760			08/31/2026
F0761 SS = D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately			F0761	R43 was assessed and found no harm with medication error. R43 had a change of direction label added. All residents at HLC who have a dosage change are at risk of this deficiency. All current HLC residents with dosage changes in medication were reviewed for “change of dose” labels on bottles/bubble packs of medication. HLC’s Medication Administration policy was reviewed and found to be appropriate and compliant. HLC developed new policy entitled Missing or Incorrect Medication Label Policy. All staff members who distribute medication were educated on HLC’s Medication Error policy and the new Missing or Incorrect Medication Label Policy. DON or designee will audit medication with changed dosage for label placement and medication administration record for accuracy weeklyx4 weeks and monthly x5 months. An audit form was created		08/31/2026

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F0761 SS = D	Continued from page 16 locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to ensure a medication label accurately reflected the current physician-ordered dose for 1 of 1 resident (R43) reviewed for medication labeling. The incorrect label contributed to R43 receiving 5 milligrams (mg) of morphine sulfate instead of the prescribed 2 mg dose. Findings include: R43's significant change Minimum Data Set (MDS) dated 7/7/26 identified R43 had severe cognitive impairment and diagnoses that included Alzheimer's disease, coronary artery disease, and dementia. R43's physician orders dated 7/30/26 identified the following: morphine sulfate concentrate oral solution 100 mg/5 milliliters (mL): place and dissolve 2 mg (0.1 mL) buccally (between the gum and inner lining of the cheek) every four hours for pain. morphine sulfate concentrate oral solution 100 mg/5 mL: place and dissolve 5 mg (0.25 mL) buccally every hour as needed (PRN) for breakthrough moderate to severe pain rated 4-10 out of 10 or shortness of breath. During an observation on 8/3/26 at 4:04 p.m., registered nurse (RN)-B withdrew 0.25 mL (5 mg) of morphine sulfate concentrate 100 mg/5 mL using the syringe provided with the medication. RN-B brought the medication into R43's room and administered the medication buccally. RN-B returned to the medication cart, removed the narcotic record book from the drawer, and documented the date, time, and that 0.1 mL of morphine sulfate had been administered. RN-B stated she administered 0.25 mL to R43 because the medication label identified 0.25 mL. RN-A stated she was the unit manager and R43's order had recently changed. RN-A stated 0.1 mL was			F0761	Continued from page 16 to monitor compliance. The results will be reported to the QAPI committee for further recommendations. This deficiency has been remedied on 8/31/2026.		08/31/2026

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F0761 SS = D	Continued from page 17 the correct scheduled dose. However, RN-B explained and confirmed to RN-A that she had administered 0.25 mL. RN-A stated, "That's an error," and asked whether R43 was okay. RN-A and RN-B assessed R43 following the medication error. R43's vital signs and condition remained unchanged. RN-A stated when a medication dose changed, a sticker should be applied to the medication label to alert staff to the change and ensure staff double-checked the dose. RN-A stated a medication error report would be completed and the director of nursing (DON) would be notified. R43's morphine sulfate concentrate oral solution 100 mg/5 mL medication label directed staff to place and dissolve 5 mg (0.25 mL) buccally every four hours for pain. The medication label did not reflect R43's current scheduled physician order for 2 mg (0.1 mL) every four hours for pain. No sticker or other notification identifying the change in the scheduled dose was attached to the medication.During an interview on 8/5/26 at 11:52 a.m., the DON stated RN-B followed the directions on the medication label and there was no sticker attached to the medication to alert staff that the dose had changed. The DON stated facility-wide education was provided and staff were expected to follow facility policy to ensure resident safety. During a telephone interview on 8/5/26 at 12:36 p.m., the administrator stated she expected staff to follow facility policy for medication administration to ensure resident safety. During a telephone interview on 8/5/26 at 1:11 p.m., the consultant pharmacist stated facility staff were expected to follow facility policy to ensure medications were administered safely. The facility's General Medication Pass Policy, revised 1/2025, directed staff to read medication labels three times before dispensing medications and follow the six rights of medication administration, including the right dose and right documentation. The policy did not identify a process for ensuring medication labels were updated or otherwise modified when a physician's medication order changed.			F0761			08/31/2026
F0880 SS = D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control			F0880	All residents were at risk based on HLC’s failure to maintain a facility-wide infection surveillance system that identified, collected, analyzed and trended signs of systems including those that did not result in antimicrobial treatment (viral). HLC has included		08/31/2026

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F0880 SS = D	Continued from page 18 The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a resident; including but not limited to: (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	F0880	Continued from page 18 information regarding antimicrobial surveillance in their infection surveillance system, which includes tracking for onset, duration, s/sx precautions initiated and removed . DON audited resident notes for all current residents and notated any symptoms of viral activity on infection control log. Any resident who requires EBP precautions could be at risk for precautions not being followed. HLC's infection control surveillance policy was reviewed and found to be appropriate and compliant. HLC's Enhanced Barrier Precautions policy was reviewed and found to be appropriate. DON was educated regarding the infection control surveillance policy. She developed a staff form that is filled out for anti-microbial/viral signs and symptoms. DON tracks both progress notes and new forms and track symptoms and signs for anti-microbials/viruses. DON re-educated contract hospice staff regarding Enhanced Barrier Precautions. DON or designee will audit Infection control tracking and trending, including anti-microbials/virus symptoms, weekly x four weeks and then monthly x5 months. An audit form was created to monitor compliance. The results will be reported to the QAPI committee for further recommendations. This deficiency has been remedied on 8/31/2026. DON or designee will audit contract staff compliance with Enhanced Barrier precautions weekly x four weeks and then monthly x5 months. The results will be reported to the QAPI committee for further recommendations. This deficiency has been remedied on 8/31/2026.	08/31/2026

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F0880 SS = D	Continued from page 19 (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 interview and document review, the facility failed to maintain a facility-wide infection surveillance system that identified, collected, analyzed, and trended signs and symptoms of possible infections and communicable diseases, including those that did not result in antimicrobial treatment. This deficient practice had the potential to affect all 41 residents who resided in the facility. In addition, the facility failed to ensure enhanced barrier precautions (EBP) were implemented for 1 of 1 resident (R5) reviewed for assistance with activities of daily living (ADLs) and wound care. Findings include: SURVEILLANCE: The facility's infection surveillance line list dated May 2026 identified resident name, location, infection date, infection type, diagnosis, medication, provider, outcome, resolution date, and bacteria. The line list identified two lower respiratory infections, two cases of cellulitis, one oral infection, one episode of diarrhea with incontinence, one pyelonephritis (kidney infection), two yeast infections, and one wound infection. All infections identified on the May 2026 line list were treated with antimicrobial medications. The line list did not identify signs or symptoms of possible infections or communicable diseases that did not result in antimicrobial treatment or viral illnesses. The facility's infection surveillance line list dated			F0880			08/31/2026

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F0880 SS = D	Continued from page 20 June 2026 identified resident name, location, infection date, infection type, diagnosis, medication, provider, outcome, resolution date, and bacteria. The line list identified one fungal infection, one lower respiratory infection, one wound infection, two cases of cellulitis, three urinary tract infections, and one case of anaplasmosis (a tick-borne disease caused by the bacterium Anaplasma phagocytophilum). The line list did not identify signs or symptoms of possible infections or communicable diseases that did not result in antimicrobial treatment or viral illnesses. The facility's infection surveillance line list dated July 2026 identified resident name, location, infection date, infection type, diagnosis, medication, provider, outcome, resolution date, and bacteria. The line list identified one case of cellulitis, five urinary tract infections, and one case of shingles. The line list did not identify signs or symptoms of possible infections or communicable diseases that did not result in antimicrobial treatment or untreated viral illnesses. The facility's infection surveillance line list for August 2026 was requested but was not received. During an interview on 8/5/26 at 11:29 a.m., the director of nursing (DON) stated she had served as the facility's infection preventionist (IP) since January 2026. The DON stated she "tried" to review antibiotics that had been ordered and entered into the facility's system weekly. Once each month, the DON gathered the infection information for review at the Quality Assurance and Performance Improvement (QAPI) meeting. The DON stated the facility planned to transition to a different dashboard portal in September 2026, which would make the surveillance process smoother. The DON had not completed the infection surveillance tracking for August 2026 because she generally collected the information during the first week of the following month. The DON stated when an antibiotic was initiated, nursing staff were responsible for beginning antibiotic monitoring. At times, a medical provider requested infection monitoring before a medication was ordered. Nursing staff were also expected to enter a nursing progress note for signs and symptoms of infection, and those notes were reviewed during interdisciplinary team (IDT) meetings.			F0880			08/31/2026

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F0880 SS = D	Continued from page 21 Although the DON stated infection information was reviewed during IDT meetings, the facility was unable to provide IDT meeting documentation demonstrating the review, analysis, or trending of infection surveillance information. The DON stated she did not track signs or symptoms of possible infections when the symptoms did not result in treatment, such as common cold symptoms. The DON acknowledged that tracking those signs and symptoms and conducting infection surveillance in the moment would allow staff to identify possible infections and take measures to prevent the potential spread of infection. During a telephone interview on 8/5/26 at 12:36 p.m., the administrator stated tracking and trending infection information in the moment allowed staff to identify infections and prevent the potential spread of infection. The facility's undated Infection Surveillance Overview policy identified infection prevention began with routine and ongoing surveillance to identify possible communicable diseases or infections before they could spread to other persons in the facility or potentially cause an outbreak. The policy identified the facility had established a system, based on national standards of practice and the facility assessment, to closely monitor all residents who exhibited signs or symptoms of infection through ongoing surveillance. The surveillance system was to include a systematic method for collecting, analyzing, and interpreting data, followed by dissemination of the information to identify infections, infection risks, and outbreaks to individuals who could improve outcomes. The policy identified the intent of surveillance was to identify possible communicable diseases or infections before they could spread to other persons in the facility. Surveillance was identified as crucial to promptly identifying possible clusters, changes in prevalent organisms, or increases in infection rates. Surveillance results were to be used to plan infection control activities, determine the need for corrective action, direct in-service education, and identify individual resident problems requiring intervention.			F0880			08/31/2026

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F0880 SS = D	Continued from page 22 EBP: R5's significant change Minimum Data Set (MDS) dated 7/13/26 identified the assessment was completed due to R5's admission to hospice care. R5 had intact cognition and was dependent with most activities of daily living (ADLs), including dressing, grooming, and toileting. R5 was dependent with transfers and unable to ambulate. R5 had an indwelling Foley catheter and was always incontinent of bowel. Diagnoses included right above-the-knee amputation, heart failure, chronic obstructive pulmonary disease (COPD), diabetes, anxiety, and a history of transient ischemic attack and cerebral infarction (stroke). R5's care plan, revised 7/13/26, identified R5 had an indwelling urinary catheter. Interventions directed staff to position the catheter bag and tubing below the level of the bladder, change the catheter every four weeks and as needed, and monitor and document intake and output according to facility policy. R5 had actual impairment to skin integrity. Staff were directed to elevate R5's heels while in bed, encourage good nutrition and hydration, keep R5's skin clean and dry, observe for signs of infection, and use a pressure-relieving mattress in bed and cushion in the chair. Staff were directed to assist R5 with morning and evening care. R5 required total assistance of one staff member with dressing and grooming. During an observation on 8/4/26 at 9:59 a.m., registered nurse (RN)-E and hospice aide (HA)-D assisted R5 with a bed bath. An EBP sign was posted outside R5's room and directed staff to wear gloves and a gown when assisting R5 with ADLs, including bathing, dressing, grooming, transfers, catheter care, and wound care. A personal protective equipment (PPE) cart was located in the hallway immediately next to R5's door and contained disposable gowns and gloves. A large, dark gray, round bin was located inside R5's room and contained used gowns. RN-E and HA-D wore disposable gloves but did not wear gowns while providing R5's care. RN-E applied a clean, self-adhesive dressing over an ulcer on R5's lower right buttock. A second clean, self-adhesive dressing was observed directly above the buttock wound covering R5's coccyx wound and was dated with RN-E's initials and the current date.			F0880			08/31/2026

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F0880 SS = D	Continued from page 23 RN-E and HA-D then assisted R5 into a pair of jeans. HA-D emptied the wash basin into the sink, removed her gloves, and washed her hands. RN-E removed her gloves, applied alcohol-based hand rub (ABHR), and began completing a nursing assessment with R5. A joint interview was conducted with HA-D and RN-E on 8/4/26 at 10:05 a.m. HA-D stated she had not worn a gown over her clothing while assisting R5 with his bed bath that morning. HA-D stated she thought a disposable gown was required only when providing catheter care. HA-D stated the facility had never instructed her to wear PPE when providing care to a resident on precautions. RN-E stated she also thought PPE was required only when providing catheter care and stated the facility had never instructed her regarding when PPE was required when caring for residents on EBP. RN-E acknowledged she should have worn a gown while assisting R5 with care and dressing changes. During a telephone interview on 8/5/26 at 11:09 a.m., the administrator stated the facility took EBP very seriously and routinely completed audits to ensure staff compliance. The administrator stated she did not think facility staff were aware the hospice staff were not following EBP guidance because clear signage was posted on residents' doors to direct staff regarding required precautions. The administrator stated the hospice staff were educated and the problem was corrected. During an interview on 8/5/26 at 12:21 p.m., the director of nursing (DON) stated residents who required EBP had signage posted on their doors that clearly instructed staff regarding the PPE required when providing care. The DON stated she educated the staff involved and reviewed EBP and contact precautions with them. The facility's Enhanced Barrier Precaution policy dated April 2025, identified EBP was an infection prevention intervention requiring gown and glove use during specified high contact resident care activities to reduce multi drug resistant organisms (MDRO) spread. The policy applied to all staff, contractors, consultants, students, volunteers, residents and visitors within the facility managed communities and across all applicable licensure types. High contact activities when EBP was required included dressing, bathing, transferring, hygiene assistance, changing linens or briefs, toilet assistance, wound care and care or use of			F0880			08/31/2026

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F0880 SS = D	Continued from page 24 indwelling medical devices. Donning of gown and gloves would be required immediately before performing high contact resident care activities.		F0880			08/31/2026	
F0641 SS = A	The facility's Hospice and Nursing Facility Services Agreement, dated 6/10/25, identified the facility would institute, implement, and maintain administrative policies, procedures, and patient care protocols in accordance with recognized professional standards of care and as necessary to implement the provisions of the agreement. Accuracy of Assessments CFR(s): 483.20(g)(h)(i)(j) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. §483.20(h) Coordination. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. §483.20(i) Certification. §483.20(i)(1) A registered nurse must sign and certify that the assessment is completed. §483.20(i)(2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. §483.20(j) Penalty for Falsification. §483.20(j)(1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than \$5,000 for each assessment. §483.20(j)(2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is NOT MET as evidenced by:		F0641			08/31/2026	

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F0641 SS = A	Continued from page 25 Based on interview and document review, the facility failed to ensure medications were accurately coded in the Minimum Data Set (MDS) for 1 of 2 residents (R36) reviewed for MDS accuracy. Findings include: R36's admission MDS dated 7/8/26 identified R36 had a diagnosis of diabetes mellitus and received one insulin injection during the assessment period of 7/2/26 through 7/8/26. R36's July 2026 Medication Administration Record (MAR) identified R36 did not receive insulin during the MDS assessment period. During an interview on 8/5/26 at 8:09 a.m., registered nurse (RN)-C stated she gathered R36's medication information and forwarded the information to the MDS coordinator. RN-A stated R36 received tirzepatide, a glucagon-like peptide-1 (GLP-1) medication used to lower blood glucose levels and had a diagnosis of diabetes with orders for blood glucose monitoring. RN-C stated tirzepatide was identified as "insulin-like" and was documented as insulin. RN-C stated the MDS coordinator was ultimately responsible for completing the MDS. During an interview on 8/5/26 at 8:19 a.m., the MDS director (M)-D and clinical consultant stated staff were expected to review documentation from the MDS assessment period and use that information to complete the MDS. M-D stated R36's tirzepatide should have been coded in Section N of the MDS as an injection, but not as insulin. M-D MDS staff were expected to review each section of the MDS before submission to ensure the assessment was accurate. The facility's MDS policy dated 5/2025 directed staff to use documentation gathered during the assessment period and ensure accurate documentation on the MDS. The policy identified department managers were expected to be knowledgeable of the MDS process to ensure accurate MDS documentation.			F0641			08/31/2026

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20000	Initial Comments *****ATTENTION***** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 8/3/26 - 8/5/26, a standard licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was not in compliance with the MN State Nursing Home Licensure and the following correction orders are issued. Please indicate in your electronic plan of correction you have reviewed these orders, and identify the date when they will be completed. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to			20000			08/31/2026

Office of Primary Care and Health Systems Management

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

Minnesota Department of Health

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20000	Continued from page 1 Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor's findings are the Suggested Method of Correction and Time period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html. The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.			20000			08/31/2026
20550	Comprehensive Resident Assessment; Review CFR(s): MN Rule 4658.0400 Subp. 4 Subp. 4. Review of assessments. A nursing home must examine each resident at least quarterly and must revise the resident's comprehensive assessment to ensure the continued accuracy of the assessment. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to ensure medications were accurately coded in the Minimum Data Set (MDS) for 1 of 2 residents (R36) reviewed for MDS accuracy. Findings include:			20550	Completed.		08/31/2026

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20550	Continued from page 2 R36's admission MDS dated 7/8/26 identified R36 had a diagnosis of diabetes mellitus and received one insulin injection during the assessment period of 7/2/26 through 7/8/26. R36's July 2026 Medication Administration Record (MAR) identified R36 did not receive insulin during the MDS assessment period. During an interview on 8/5/26 at 8:09 a.m., registered nurse (RN)-C stated she gathered R36's medication information and forwarded the information to the MDS coordinator. RN-A stated R36 received tirzepatide, a glucagon-like peptide-1 (GLP-1) medication used to lower blood glucose levels and had a diagnosis of diabetes with orders for blood glucose monitoring. RN-C stated tirzepatide was identified as "insulin-like" and was documented as insulin. RN-C stated the MDS coordinator was ultimately responsible for completing the MDS. During an interview on 8/5/26 at 8:19 a.m., the MDS director (M)-D and clinical consultant stated staff were expected to review documentation from the MDS assessment period and use that information to complete the MDS. M-D stated R36's tirzepatide should have been coded in Section N of the MDS as an injection, but not as insulin. M-D MDS staff were expected to review each section of the MDS before submission to ensure the assessment was accurate. The facility's MDS policy dated 5/2025 directed staff to use documentation gathered during the assessment period and ensure accurate documentation on the MDS. The policy identified department managers were expected to be knowledgeable of the MDS process to ensure accurate MDS documentation. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee should review, and revise policies and procedures related to creating a comprehensive/quarterly assessment to ensure the accuracy of each part of the MDS. The director of nursing or designee should develop a system to educate staff and develop a monitoring system and perform measurable audits to ensure accurate comprehensive/quarterly MDSs are created and implemented. The results of those audits should be taken to the QAPI committee to determine compliance or the need for further monitoring.			20550			08/31/2026

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20550	Continued from page 3 TIME PERIOD FOR CORRECTION: Twenty-one (21) days.		20550	Completed.		08/31/2026	
20875	Adequate and Proper Nursing Care; Monitor TPR CFR(s): MN Rule 4658.0520 Subp. 2 I Subp. 2. Criteria for determining adequate and proper care. The criteria for determining adequate and proper care include: I. Monitoring resident temperature, pulse, respiration, and blood pressure as often as indicated by the resident's condition but at least weekly. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to ensure a resident received ongoing nursing assessment and monitoring following an acute change in condition for 1 of 2 residents (R5) reviewed for changes in condition. Findings include: R5's significant change Minimum Data Set (MDS) dated 7/13/26 identified the assessment was completed due to R5's admission to hospice care. R5 had intact cognition and was dependent with most activities of daily living (ADLs), including dressing, grooming, and toileting. R5 was dependent with transfers and unable to ambulate. R5 had an indwelling Foley catheter and was always incontinent of bowel. R5 did not exhibit rejection of care or other behaviors during the assessment period. Diagnoses included right above-the-knee amputation, heart failure, chronic obstructive pulmonary disease (COPD), diabetes, anxiety, and a history of transient ischemic attack and cerebral infarction (stroke). R5's care plan, revised 7/13/26, identified R5 had altered respiratory status related to heart disease, asthma, anemia, COPD, and a history of tuberculosis. Goals included maintaining a normal breathing pattern and pulse oximetry above 90 percent. Staff were directed to monitor, document, and report breathing abnormalities to the physician, administer nebulizers and inhalers as ordered, and obtain vital signs weekly and as needed. The care plan identified R5 had altered elimination related to bowel incontinence and an indwelling urinary catheter. Staff were directed to provide perineal care after each incontinent episode and		20875			08/31/2026	

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20875	Continued from page 4 record the amount and consistency of bowel movements. The care plan identified R5 had diabetes with a goal to experience no complications related to diabetes. Interventions directed staff to administer medications as ordered, monitor for side effects, and monitor, document, and report to the physician as needed symptoms of hypoglycemia or hyperglycemia, increased thirst and appetite, weight loss, and fatigue. R5's progress notes identified the following: On 6/28/26, R5 woke early and ordered four ice creams for breakfast and stated they were for his diarrhea. Later, R5 was heard shouting for help and was seated in his wheelchair at the end of the bed. R5 denied pain, breathing difficulty, or chest pain and refused to allow staff to obtain his vital signs. R5 stated he did not know what was going on with him. Staff notified the on-call physician, who ordered laboratory testing, which R5 initially refused. Later during the day shift, R5 allowed staff to attempt to obtain blood for the ordered laboratory testing twice; however, the samples hemolyzed and could not be used. R5 was confused and hallucinating. Staff updated the on-call physician, who stated another provider would see R5 the following day. On 6/28/26 at 10:34 p.m., staff documented R5 had been incontinent of seven large, loose, tarry stools. Staff made several attempts to convince R5 to go to the emergency room for evaluation; however, R5 refused. R5 also refused all oral intake during the evening shift. On 6/29/26 at 10:07 a.m., R5 was transferred to the hospital due to increased stools and hypotension. R5's blood pressure was 55/36, pulse was 53 beats per minute, and temperature was 99.2 degrees Fahrenheit. R5's medical record lacked evidence a licensed nurse assessed R5 or that staff monitored R5's vital signs and clinical condition during the evening and night shifts following his acute change in condition, which included seven large, loose, tarry stools and refusal of oral intake. R5's Blood Pressure Summary identified staff recorded R5's blood pressure two to three times per day from 6/16/26 through 6/27/26; however, no blood pressure was recorded on 6/28/26 or prior to R5's assessment and transfer to the hospital on			20875			08/31/2026

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20875	Continued from page 5 6/29/26. During an interview on 8/4/26 at 2:43 p.m., licensed practical nurse (LPN)-B stated the second floor was usually staffed with a trained medication assistant (TMA) and a nursing assistant (NA). If the TMA needed assistance, such as when a resident experienced a change in condition or required insulin administration, a nurse from the first floor would go to the second floor and provide the necessary nursing services. If an LPN or registered nurse (RN) was scheduled on the second floor, the nurse completed their own assessments. LPN-B stated assessments were documented in the resident's progress notes. During an interview on 8/4/26 at 2:47 p.m., RN-A stated when she began her shift on 6/29/26, she reviewed the shift report and went to assess R5. RN-A stated she first obtained R5's vital signs because R5 was sweaty and did not feel well. RN-A discussed R5's condition with him, and R5 agreed to go to the emergency room for evaluation. RN-A stated she had been informed R5 previously refused hospital evaluation. RN-A stated she would have expected increased monitoring and vital sign assessments during the previous shifts due to R5's change in condition. RN-A was unable to locate evidence staff monitored R5's condition and stated it appeared staff did not obtain R5's vital signs during the evening or night shift. During a telephone interview on 8/4/26 at 3:42 p.m., LPN-C stated she worked the evening shift on 6/28/26 and remembered R5 repeatedly refused to go to the emergency department for evaluation. LPN-C thought the TMAs obtained R5's vital signs twice during the shift. LPN-C stated she did not document the vital signs in R5's medical record and acknowledged the vital signs should have been documented. LPN-C stated she knew the on-call provider had been notified during the day shift; therefore, staff did not update the provider during the evening shift because R5 continued to refuse transfer to the emergency department for evaluation. During an interview on 8/4/26 at 5:40 p.m., RN-D stated she worked the day shift on 6/28/26 and remembered R5 experienced significant hallucinations. RN-D stated she was told R5 wanted four cups of ice cream for breakfast and wondered whether R5's symptoms were related to his blood glucose because he had diabetes. RN-D contacted the on-call provider because of R5's confusion and attempted to obtain blood for the ordered laboratory testing; however, the samples clotted and could not			20875			08/31/2026

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20875	Continued from page 6 be used. RN-D stated she attempted to obtain R5's blood pressure, but the machine repeatedly displayed an error. RN-D then attempted to palpate R5's pulse and blood pressure but was unable to obtain them. R5 would not allow staff to place a blood pressure cuff on him, and when staff were able to attempt it, the machine continued to display an error. RN-D stated the on-call provider said R5 needed to go to the emergency room; however, R5 was his own person and refused to go. RN-D stated R5 was sweating but would not allow staff to touch him to obtain his vital signs or blood glucose. R5 hollered for help throughout the shift, but when staff entered his room, R5 stated he had not asked for help and directed staff to leave. RN-D stated R5 became more like himself toward the end of the day shift, which was when staff were able to attempt obtaining the blood samples; however, R5 allowed staff to provide care for only a short time before he again refused to be touched. During an interview on 8/4/26 at 5:33 p.m., TMA-A stated she worked the evening shift on 6/28/26. Staff offered R5 several opportunities to go to the emergency room because of his condition. R5 was not eating or drinking but repeatedly stated he wanted to wait. TMA-A thought her coworker had obtained R5's vital signs but was unsure where they would have been documented. TMA-A stated R5 appeared grayish, and staff offered him everything they could offer. TMA-A stated TMAs and NAs were trained to obtain vital signs. Routine weekly vital signs were prompted for documentation by the electronic medical record. If additional vital sign monitoring was needed, staff wrote the results on paper and gave them to the nurse. TMAs and NAs used a vital sign form to record residents' vital signs, which identified normal ranges. If a vital sign was outside the range identified on the form, staff alerted the nurse. TMA-A stated she was busy administering medications that evening and her coworker was working with R5. Staff had monitored R5's vital signs twice daily from 6/17/26 through 6/27/26 because R5 had been receiving an antibiotic and facility policy required daily monitoring. When a resident completed an antibiotic, staff usually discontinued the daily monitoring. During an interview on 8/5/26 at 5:19 a.m., LPN-D			20875			08/31/2026

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20875	Continued from page 7 stated she was aware R5 had been declining but did not work the night of 6/28/26. LPN-D stated R5 could be difficult to work with. R5 was noncompliant and rude but was his own person and staff could not force him. LPN-D stated she would document R5's vital signs if he allowed staff to obtain them or document his refusal. LPN-D stated she would document R5's appearance and behavior and document if R5 refused transfer to the emergency room or refused to allow staff to monitor his vital signs. During an interview on 8/5/26 at 6:23 a.m., NA-F stated she worked on 6/28/26 and R5 had been really confused. NA-F stated staff were in R5's room anywhere from every five minutes to every 30 minutes. Usually, R5 was very independent and called staff only when he really needed assistance; however, R5 used his call light frequently that morning and was very confused. NA-F stated R5 would not allow the RN to obtain his vital signs. Staff attempted to use the blood pressure cuff on both arms but repeatedly received an error. NA-F stated R5's routine was very different. R5 would not eat or change his clothes. NA-F remembered R5's nose was running frequently and R5 was leaning heavily over his lap. R5 appeared to be in pain but refused to go to the doctor. During a telephone interview on 8/5/26, at 11:09 a.m. the administrator stated she was not sure of all the details regarding R5's acute change in condition on 6/28/26 but would look into it further. [no further details were received] During an interview on 8/5/26 at 12:21 p.m., the director of nursing (DON) stated staff were expected to document the care and monitoring they provided. The facility's Change in a Resident's Condition or Status Policy, revised October 2024, identified the facility would promptly notify the resident, attending physician, and resident representative of changes in a resident's medical or mental condition and/or status. The policy directed the RN manager to document information related to changes in the resident's condition in the resident's medical record. SUGGESTED METHOD OF CORRECTION: The DON or designee should review, and revise policies and procedures related to assessing and monitoring for a change in condition including but not limited to documentation. The DON or designee should develop a system to educate staff and develop a monitoring system and perform measurable audits to			20875			08/31/2026

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20875	Continued from page 8 ensure accurate identification, assessment and monitoring occur with changes in condition. The results of those audits should be taken to the QAPI committee to determine compliance or the need for further monitoring. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.		20875			08/31/2026	
21375	Infection Control; Program CFR(s): MN Rule 4658.0800 Subp. 1 Subpart 1. Infection control program. A nursing home must establish and maintain an infection control program designed to provide a safe and sanitary environment. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to maintain a facility-wide infection surveillance system that identified, collected, analyzed, and trended signs and symptoms of possible infections and communicable diseases, including those that did not result in antimicrobial treatment. This deficient practice had the potential to affect all 41 residents who resided in the facility. In addition, the facility failed to ensure enhanced barrier precautions (EBP) were implemented for 1 of 1 resident (R5) reviewed for assistance with activities of daily living (ADLs) and wound care. Findings include: SURVEILLANCE: The facility's infection surveillance line list dated May 2026 identified resident name, location, infection date, infection type, diagnosis, medication, provider, outcome, resolution date, and bacteria. The line list identified two lower respiratory infections, two cases of cellulitis, one oral infection, one episode of diarrhea with incontinence, one pyelonephritis (kidney infection), two yeast infections, and one wound infection. All infections identified on the May 2026 line list were treated with antimicrobial medications. The line list did not identify signs or symptoms of possible infections or communicable diseases that did not result in antimicrobial treatment or viral illnesses. The facility's infection surveillance line list dated June 2026 identified resident name, location,		21375	Completed.		08/31/2026	

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21375	Continued from page 9 infection date, infection type, diagnosis, medication, provider, outcome, resolution date, and bacteria. The line list identified one fungal infection, one lower respiratory infection, one wound infection, two cases of cellulitis, three urinary tract infections, and one case of anaplasmosis (a tick-borne disease caused by the bacterium Anaplasma phagocytophilum). The line list did not identify signs or symptoms of possible infections or communicable diseases that did not result in antimicrobial treatment or viral illnesses. The facility's infection surveillance line list dated July 2026 identified resident name, location, infection date, infection type, diagnosis, medication, provider, outcome, resolution date, and bacteria. The line list identified one case of cellulitis, five urinary tract infections, and one case of shingles. The line list did not identify signs or symptoms of possible infections or communicable diseases that did not result in antimicrobial treatment or untreated viral illnesses. The facility's infection surveillance line list for August 2026 was requested but was not received. During an interview on 8/5/26 at 11:29 a.m., the director of nursing (DON) stated she had served as the facility's infection preventionist (IP) since January 2026. The DON stated she "tried" to review antibiotics that had been ordered and entered into the facility's system weekly. Once each month, the DON gathered the infection information for review at the Quality Assurance and Performance Improvement (QAPI) meeting. The DON stated the facility planned to transition to a different dashboard portal in September 2026, which would make the surveillance process smoother. The DON had not completed the infection surveillance tracking for August 2026 because she generally collected the information during the first week of the following month. The DON stated when an antibiotic was initiated, nursing staff were responsible for beginning antibiotic monitoring. At times, a medical provider requested infection monitoring before a medication was ordered. Nursing staff were also expected to enter a nursing progress note for signs and symptoms of infection, and those notes were reviewed during interdisciplinary team (IDT) meetings. Although the DON stated infection information was reviewed during IDT meetings, the facility was			21375			08/31/2026

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21375	Continued from page 10 unable to provide IDT meeting documentation demonstrating the review, analysis, or trending of infection surveillance information. The DON stated she did not track signs or symptoms of possible infections when the symptoms did not result in treatment, such as common cold symptoms. The DON acknowledged that tracking those signs and symptoms and conducting infection surveillance in the moment would allow staff to identify possible infections and take measures to prevent the potential spread of infection. During a telephone interview on 8/5/26 at 12:36 p.m., the administrator stated tracking and trending infection information in the moment allowed staff to identify infections and prevent the potential spread of infection. The facility's undated Infection Surveillance Overview policy identified infection prevention began with routine and ongoing surveillance to identify possible communicable diseases or infections before they could spread to other persons in the facility or potentially cause an outbreak. The policy identified the facility had established a system, based on national standards of practice and the facility assessment, to closely monitor all residents who exhibited signs or symptoms of infection through ongoing surveillance. The surveillance system was to include a systematic method for collecting, analyzing, and interpreting data, followed by dissemination of the information to identify infections, infection risks, and outbreaks to individuals who could improve outcomes. The policy identified the intent of surveillance was to identify possible communicable diseases or infections before they could spread to other persons in the facility. Surveillance was identified as crucial to promptly identifying possible clusters, changes in prevalent organisms, or increases in infection rates. Surveillance results were to be used to plan infection control activities, determine the need for corrective action, direct in-service education, and identify individual resident problems requiring intervention. EBP: R5's significant change Minimum Data Set (MDS) dated 7/13/26 identified the assessment was completed due to R5's admission to hospice care. R5 had intact cognition and was dependent with			21375			08/31/2026

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21375	Continued from page 11 most activities of daily living (ADLs), including dressing, grooming, and toileting. R5 was dependent with transfers and unable to ambulate. R5 had an indwelling Foley catheter and was always incontinent of bowel. Diagnoses included right above-the-knee amputation, heart failure, chronic obstructive pulmonary disease (COPD), diabetes, anxiety, and a history of transient ischemic attack and cerebral infarction (stroke). R5's care plan, revised 7/13/26, identified R5 had an indwelling urinary catheter. Interventions directed staff to position the catheter bag and tubing below the level of the bladder, change the catheter every four weeks and as needed, and monitor and document intake and output according to facility policy. R5 had actual impairment to skin integrity. Staff were directed to elevate R5's heels while in bed, encourage good nutrition and hydration, keep R5's skin clean and dry, observe for signs of infection, and use a pressure-relieving mattress in bed and cushion in the chair. Staff were directed to assist R5 with morning and evening care. R5 required total assistance of one staff member with dressing and grooming. During an observation on 8/4/26 at 9:59 a.m., registered nurse (RN)-E and hospice aide (HA)-D assisted R5 with a bed bath. An EBP sign was posted outside R5's room and directed staff to wear gloves and a gown when assisting R5 with ADLs, including bathing, dressing, grooming, transfers, catheter care, and wound care. A personal protective equipment (PPE) cart was located in the hallway immediately next to R5's door and contained disposable gowns and gloves. A large, dark gray, round bin was located inside R5's room and contained used gowns. RN-E and HA-D wore disposable gloves but did not wear gowns while providing R5's care. RN-E applied a clean, self-adhesive dressing over an ulcer on R5's lower right buttock. A second clean, self-adhesive dressing was observed directly above the buttock wound covering R5's coccyx wound and was dated with RN-E's initials and the current date. RN-E and HA-D then assisted R5 into a pair of jeans. HA-D emptied the wash basin into the sink, removed her gloves, and washed her hands. RN-E removed her gloves, applied alcohol-based hand rub (ABHR), and began completing a nursing assessment with R5. A joint interview was conducted with HA-D and RN-E on 8/4/26 at 10:05 a.m. HA-D stated she had		21375			08/31/2026	

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21375	Continued from page 12 not worn a gown over her clothing while assisting R5 with his bed bath that morning. HA-D stated she thought a disposable gown was required only when providing catheter care. HA-D stated the facility had never instructed her to wear PPE when providing care to a resident on precautions. RN-E stated she also thought PPE was required only when providing catheter care and stated the facility had never instructed her regarding when PPE was required when caring for residents on EBP. RN-E acknowledged she should have worn a gown while assisting R5 with care and dressing changes. During a telephone interview on 8/5/26 at 11:09 a.m., the administrator stated the facility took EBP very seriously and routinely completed audits to ensure staff compliance. The administrator stated she did not think facility staff were aware the hospice staff were not following EBP guidance because clear signage was posted on residents' doors to direct staff regarding required precautions. The administrator stated the hospice staff were educated and the problem was corrected. During an interview on 8/5/26 at 12:21 p.m., the director of nursing (DON) stated residents who required EBP had signage posted on their doors that clearly instructed staff regarding the PPE required when providing care. The DON stated she educated the staff involved and reviewed EBP and contact precautions with them. The facility's Enhanced Barrier Precaution policy dated April 2025, identified EBP was an infection prevention intervention requiring gown and glove use during specified high contact resident care activities to reduce multi drug resistant organisms (MDRO) spread. The policy applied to all staff, contractors, consultants, students, volunteers, residents and visitors within the facility managed communities and across all applicable licensure types. High contact activities when EBP was required included dressing, bathing, transferring, hygiene assistance, changing linens or briefs, toilet assistance, wound care and care or use of indwelling medical devices. Donning of gown and gloves would be required immediately before performing high contact resident care activities. The facility's Hospice and Nursing Facility Services Agreement, dated 6/10/25, identified the facility would institute, implement, and maintain administrative policies, procedures, and patient care protocols in accordance with recognized professional standards of care and as necessary to implement the provisions of the agreement.			21375			08/31/2026

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21375	Continued from page 13 SUGGESTED METHOD OF CORRECTION: The DON or designee could review and revise, as necessary, policy and procedures related the tracking and trending of all potential infections and EBP. The DON or designee should develop a system to educate staff and develop a monitoring system and perform measurable audits to ensure accurate adequate tracking and trending of all potential infections and EBP are in use for those required . The results of those audits should be taken to the QAPI committee to determine compliance or the need for further monitoring. TIME PERIOD FOR CORRECTION: Twenty-One (21) days.		21375			08/31/2026	
21545	Medication Errors CFR(s): MN Rule 4658.1320 A.B.C A nursing home must ensure that: A. Its medication error rate is less than five percent as described in the Interpretive Guidelines for Code of Federal Regulations, title 42, section 483.25 (m), found in Appendix P of the State Operations Manual, Guidance to Surveyors for Long-Term Care Facilities, which is incorporated by reference in part 4658.1315. For purposes of this part, a medication error means: (1) a discrepancy between what was prescribed and what medications are actually administered to residents in the nursing home; or (2) the administration of expired medications. B. It is free of any significant medication error. A significant medication error is: (1) an error which causes the resident discomfort or jeopardizes the resident's health or safety; or (2) medication from a category that usually requires the medication in the resident's blood to be titrated to a specific blood level and a single medication error could alter that level and precipitate a reoccurrence of symptoms or toxicity. All medications are administered as prescribed. An incident report or medication error report must be filed for any medication error that occurs. Any significant medication errors or resident reactions must be reported to the physician or the physician's designee and the resident or the resident's legal guardian or designated representative and an		21545	Completed.		08/31/2026	

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21545	Continued from page 14 explanation must be made in the resident's clinical record. C. All medications are administered as prescribed. An incident report or medication error report must be filed for any medication error that occurs. Any significant medication errors or resident reactions must be reported to the physician or the physician's designee and the resident or the resident's legal guardian or designated representative and an explanation must be made in the resident's clinical record. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to ensure a resident was free from a significant medication error when a registered nurse (RN) administered 5 milligrams (mg) of morphine sulfate instead of the prescribed 2 mg dose for 1 of 1 resident (R43) reviewed for medication administration. Findings include: R43's significant change Minimum Data Set (MDS) dated 7/7/26 identified R43 had severe cognitive impairment and diagnoses that included Alzheimer's disease, coronary artery disease, and dementia. R43's physician orders dated 7/30/26 identified the following: morphine sulfate concentrate oral solution 100 mg/5 milliliters (mL): place and dissolve 2 mg (0.1 mL) buccally (between the gum and inner lining of the cheek) every four hours for pain. morphine sulfate concentrate oral solution 100 mg/5 mL: place and dissolve 5 mg (0.25 mL) buccally every hour as needed (PRN) for breakthrough moderate to severe pain rated 4-10 out of 10 or shortness of breath. R43's electronic medication administration record (EMAR), reviewed on 8/5/26, identified R43 received the scheduled 2 mg (0.1 mL) dose of morphine sulfate at 4:00 p.m. The EMAR further identified R43 had not received a PRN dose of 5 mg (0.25 mL). During an observation on 8/3/26 at 4:04 p.m., RN-B withdrew 0.25 mL (5 mg) of morphine sulfate concentrate 100 mg/5 mL using the syringe provided with the medication. RN-B brought the medication into R43's room and administered the medication			21545			08/31/2026

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21545	Continued from page 15 buccally. RN-B returned to the medication cart, removed the narcotic record book from the drawer, and documented that 0.1 mL of morphine sulfate had been administered. RN-B stated she administered 0.25 mL to R43 because the medication box label identified 0.25 mL. RN-A stated she was the unit manager and R43's medication order had recently changed. RN-A stated 0.1 mL was the correct dose. However, RN-B explained and confirmed to RN-A that she had administered 0.25 mL. RN-A stated, "That's an error," and asked whether R43 was okay. RN-A and RN-B assessed R43 following the medication error. R43's vital signs and condition were unchanged. RN-A stated when a medication dose changed, a sticker should have been applied to the medication label to ensure staff double-checked the dose. RN-A stated a medication error report would be completed and the director of nursing (DON) would be notified. During a telephone interview on 8/5/26 at 10:54 a.m., RN-E stated she was notified of R43's medication error on 8/3/26 at approximately 4:45 p.m. RN-E stated because R43 had been routinely receiving morphine sulfate, the medication error was not a concern that required further evaluation. During an interview on 8/5/26 at 11:52 a.m., the DON stated RN-A reported the medication error immediately after it occurred. The DON spoke with RN-B, who acknowledged the error. RN-B received education regarding the importance of completing the five rights of medication administration: right resident, right medication, right dose, right route, and right time. The DON stated RN-B followed the directions on the medication label; however, facility policy required staff to follow the EMAR. The DON sent an alert to all trained medication aides (TMAs) and nursing staff and provided facility-wide education. The DON stated she expected staff to follow facility policy to ensure resident safety. During a telephone interview on 8/5/26 at 12:36 p.m., the administrator stated she expected staff to follow facility policy for medication administration to ensure resident safety. During a telephone interview on 8/5/26 at 1:11 p.m., the consultant pharmacist stated R43 could have experienced increased drowsiness from the medication error but did not expect adverse effects			21545			08/31/2026

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21545	Continued from page 16 because R43 had already been receiving morphine sulfate. The consultant pharmacist stated staff were expected to follow facility policy to ensure medications were administered safely. The facility's Liquid Narcotic Administration Policy, revised 1/2025, identified the purpose of the procedure was to provide guidelines for the safe administration of oral liquid narcotic medications. The policy directed staff to: Verify there was a physician's order for the medication to be administered. Review the resident's care plan for special needs. Assemble necessary equipment and supplies. Place the EMAR within easy viewing distance. Unlock the medication cart and narcotic drawer. Select the medication from the medication cart. Check the medication label and confirm the medication and dose with the EMAR. Prepare the correct dose of medication. When using a syringe, staff were required to use the syringe provided with the medication and draw up the correct amount. An ordered amount of less than 5 cubic centimeters (cc) required use of a syringe. Contact hospice for approval of an initial hospice medication dose; subsequent doses did not require approval unless otherwise indicated. Check the narcotic record against the previous drug count and medication supply and report discrepancies to the DON and complete an incident report for errors. SUGGESTED METHOD OF CORRECTION: The DON or designee should review, and revise policies and procedures related to administering liquid medications. The DON or designee should develop a system to educate staff and develop a monitoring system and perform measurable audits to ensure accurate medication passes occur. The results of those audits should be taken to the QAPI committee to determine compliance or the need for further monitoring. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.			21545			08/31/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00288		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/05/2026	
NAME OF PROVIDER OR SUPPLIER HERITAGE LIVING CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 619 WEST SIXTH STREET , PARK RAPIDS, Minnesota, 56470			
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21620	Labeling of Drugs CFR(s): MN Rule 4658.1345 Drugs used in the nursing home must be labeled in accordance with part 6800.6300. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to ensure a medication label accurately reflected the current physician-ordered dose for 1 of 1 resident (R43) reviewed for medication labeling. The incorrect label contributed to R43 receiving 5 milligrams (mg) of morphine sulfate instead of the prescribed 2 mg dose. Findings include: R43's significant change Minimum Data Set (MDS) dated 7/7/26 identified R43 had severe cognitive impairment and diagnoses that included Alzheimer's disease, coronary artery disease, and dementia. R43's physician orders dated 7/30/26 identified the following: morphine sulfate concentrate oral solution 100 mg/5 milliliters (mL): place and dissolve 2 mg (0.1 mL) buccally (between the gum and inner lining of the cheek) every four hours for pain. morphine sulfate concentrate oral solution 100 mg/5 mL: place and dissolve 5 mg (0.25 mL) buccally every hour as needed (PRN) for breakthrough moderate to severe pain rated 4-10 out of 10 or shortness of breath. During an observation on 8/3/26 at 4:04 p.m., registered nurse (RN)-B withdrew 0.25 mL (5 mg) of morphine sulfate concentrate 100 mg/5 mL using the syringe provided with the medication. RN-B brought the medication into R43's room and administered the medication buccally. RN-B returned to the medication cart, removed the narcotic record book from the drawer, and documented the date, time, and that 0.1 mL of morphine sulfate had been administered. RN-B stated she administered 0.25 mL to R43 because the medication label identified 0.25 mL. RN-A stated she was the unit manager and R43's order had recently changed. RN-A stated 0.1 mL was the correct scheduled dose. However, RN-B explained and confirmed to RN-A that she had			21620	Completed.		08/31/2026

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21620	Continued from page 18 administered 0.25 mL. RN-A stated, "That's an error," and asked whether R43 was okay. RN-A and RN-B assessed R43 following the medication error. R43's vital signs and condition remained unchanged. RN-A stated when a medication dose changed, a sticker should be applied to the medication label to alert staff to the change and ensure staff double-checked the dose. RN-A stated a medication error report would be completed and the director of nursing (DON) would be notified. R43's morphine sulfate concentrate oral solution 100 mg/5 mL medication label directed staff to place and dissolve 5 mg (0.25 mL) buccally every four hours for pain. The medication label did not reflect R43's current scheduled physician order for 2 mg (0.1 mL) every four hours for pain. No sticker or other notification identifying the change in the scheduled dose was attached to the medication.During an interview on 8/5/26 at 11:52 a.m., the DON stated RN-B followed the directions on the medication label and there was no sticker attached to the medication to alert staff that the dose had changed. The DON stated facility-wide education was provided and staff were expected to follow facility policy to ensure resident safety. During a telephone interview on 8/5/26 at 12:36 p.m., the administrator stated she expected staff to follow facility policy for medication administration to ensure resident safety. During a telephone interview on 8/5/26 at 1:11 p.m., the consultant pharmacist stated facility staff were expected to follow facility policy to ensure medications were administered safely. The facility's General Medication Pass Policy, revised 1/2025, directed staff to read medication labels three times before dispensing medications and follow the six rights of medication administration, including the right dose and right documentation. The policy did not identify a process for ensuring medication labels were updated or otherwise modified when a physician's medication order changed. SUGGESTED METHOD OF CORRECTION: The DON or designee should review, and revise policies and procedures labeling of medication when the direction change. The DON or designee should develop a system to educate staff and develop a monitoring system and ensure medications are labeled appropriately to prevent errors. The results of those			21620			08/31/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00288		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/05/2026	
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21620	Continued from page 19 audits should be taken to the QAPI committee to determine compliance or the need for further monitoring. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.		21620			08/31/2026	