DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
June 26, 2025

Administrator
The Gardens At Winsted
551 Fourth Street North
Winsted, MN 55395-0750

RE: CCN: 245459
Cycle Start Date: May 1, 2025

Dear Administrator:

On June 24, 2025, 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,

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
May 15, 2025

Administrator
The Gardens At Winsted LLC
551 Fourth Street North
Winsted, MN 55395-0750

RE: CCN: 245459
Cycle Start Date: May 1, 2025

Dear Administrator:

On May 1, 2025, 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 widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

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

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

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

DEPARTMENT CONTACT

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

Nikki Harvey, Regional Operations Supervisor
St. Cloud A District Office
Health Regulation Division
Minnesota Department of Health
4140 Thielman Lane
Saint Cloud, Minnesota 56301-4557
Email: nikki.harvey@state.mn.us
Office: (320) 223-7318 Mobile: (320) 216-5631

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 August 1, 2025 (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 November 1, 2025 (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

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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 CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245459	A. BUILDING _____ B. WING _____	C 05/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GARDENS AT WINSTED LLC	551 FOURTH STREET NORTH WINSTED, MN 55395

(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
E 000	Initial Comments On 4/28/25 - 5/1/25, a survey for compliance with §483.73, Appendix Z, Emergency Preparedness Requirements for Long Term Care Facilities 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.	E 000		
F 000	INITIAL COMMENTS On 4/28/25 - 5/1/25, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed with NO deficiencies cited (In Compliance): H54593334C (MN00100756). H54593330C (MN00103249). H54593333C (MN00110411). H54593335C (MN00111531). H54593336C (MN00112351). H54593787C (MN00112619). The following complaints were reviewed and found not in Compliance: H54593332C (MN00100936) with a deficiency cited at (F584). H54593328C (MN00103328) with a deficiency cited at (F584). H54593327C (MN00107441) with a deficiency	F 000		

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

Electronically Signed | 05/23/2025

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 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.

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F 000	Continued From page 1 cited at (F689). H54593329C (MN00107592) with a deficiency cited at (F584). H54593331C (MN00109378) with a deficiency cited at (F584). The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.	F 000		
F 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to ensure a self-administration of medications assessment was completed, and orders obtained, for all medications kept at bedside for 1 of 1 residents (R9) observed with medications at their bedside. Findings include: R9's quarterly Minimum Data Set (MDS) dated	F 554	Submission of this Response and Plan of Correction is not a legal admission that a deficiency exists or that this Statement of Deficiency was correctly cited and is also not to be construed as an admission of fault by the facility, the Administrator or any employees, agents or other individuals who draft or may be discussed in this Response and Plan of Correction. In addition, preparation and submission of	6/6/25

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F 554	Continued From page 2 4/11/25, indicated R9 was alert and oriented and able to communicate her needs. The MDS lacked any indication of behavioral concerns. R9 was able to complete activities of daily living (ADLs) independently, except for meeting her toileting and bathing needs. R9's medical diagnoses included anemia (low levels of healthy cells to carry oxygen), depression (a mood disorder with symptoms of sadness), chronic obstructive pulmonary disease with acute exacerbation (a persistent respiratory disease that may cause long-term, progressive lung damage), insomnia, nicotine dependence, chronic pain syndrome, gastroesophageal reflux disease (GERD), osteoporosis, unspecified fall, history of cerebral infarction (stroke) without residual deficits (last effects related to the stroke). R9's care plan revised on 1/28/25, identified R9 was a fall risk related to diagnosis of fracture of the left femur (thigh bone) with subsequent encounter for closed fracture with routing healing, age related osteoporosis, and chronic pain. The care plan also identified an alteration in mobility related to fracture of left femur. The care plan indicated R9 was independent with ambulation in halls with a four wheeled walker. R9 was also noted to use an electric wheelchair to get around both inside and outside of the facility. The care plan went on to identify alteration in comfort. R9 was identified to receive pain medication as ordered by the doctor. Staff were directed to document on the effectiveness of the pain medication. R9 was to express discomfort/pain to staff. Staff were directed to monitor for side effects of medication. The care plan also identified R9 chose to self administer elderberry chews. The care plan directed staff to monitor usage of bedside meds, and assess that resident	F 554	this Plan of Correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in the allegations. Accordingly, the Facility has prepared and submitted this Plan of Correction prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission of a Plan of Correction within ten (10) days of the survey as a condition to participate in Title 18 and Title 19 programs. This Plan of Correction is submitted as the facility's credible allegation of compliance. F554 s/s D -The process for satisfying this requirement has been reviewed and revised as needed to ensure residents are assessed and determined to be safe for self-administration of medications. -Residents who reside in the facility and can self-administer medications have the potential to be affected if this regulation is not met. -R9 has been assessed for self-administration of medications and appropriate physician orders obtained, along with appropriate care plan revisions completed. -All current residents that have been assessed and deemed able to self-administer medications have orders and are care planned. -All residents (new and existing) that request to self-administer medication will be assessed after each request and prior	

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F 554	Continued From page 3 is capable of self-administering chewable's. A review of R9's medical record indicated a Self Administration of Medication (SAM) Evaluation, dated 4/24/25, identified R9's medication was correctly labeled per regulatory guidelines. The document also indicated the resident is able to demonstrate to the satisfaction of the nurse manager and designee. The assessment identified R9 was able to self administer elderberry chews per manufacturer directions. The SAM lacked indication of assessment for any additional medications. R9's Pain Evaluation was completed on 4/11/25, and identified R9 received scheduled pain medications, as well as received PRN medications. The assessment indicated R9 received non-medication intervention for pain, however, the document lacked information regarding the interventions and their effectiveness. During initial observation and interview on 4/28/25 at 1:07 p.m., R9 was observed to have a three bottles of over the counter medications on her bedside table. The bottles of over the counter medications (OTC) were as follows: "Hair, Skin, and Nail Vitamins", a bottle of 60 tablets which was approximately 1/4 full, Elderberry Gummies 100 mg, a full bottle of 40 gummies with the security label still in place, and a bottle of Glucosamine/Chondroitin and MSM supplement, 60 caplets per bottle, with approximately 1/3 bottle remaining. R9 stated she used the Glucosamine/Chondroitin and MSM supplement for pain management. A review of R9's orders was completed. It was	F 554	to being able to self-administer medications -Policies and procedures were reviewed and revised as needed to ensure future instances are avoided. -All nursing staff who have the responsibility and credentials to administer medications received education using Monarch Healthcare self-medication administration policy. -Monitoring to assure compliance will include, but is not limited to, audits completed three (3) times per week for two (2) weeks; two (2) times per week for four (4) weeks; and monthly thereafter for one (1) month. Audit results will be reviewed at QAPI. Any deficient practice will be identified and corrected at the time of occurrence. -Director of Nursing or designee is responsible party. -Corrective action will be completed on or before 6/6/25.	

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F 554	Continued From page 4 noted the following medications were ordered for management of chronic pain: - Duloxetine HCl 30 mg (milligrams) two capsules by mouth daily for depression and chronic pain. This was started on 3/19/25. - Meloxicam 7.5 mg one tablet by mouth daily for osteoarthritis. This medication was started on 3/12/2025. - Gabapentin Capsule 300 mg three capsules (900 mg) by mouth three times a day for pain. This medication was started on 7/08/2024. - Tizanidine HCl Give four to eight mg every six hours as needed (PRN) for related chronic pain syndrome. This medication was started on 7/8/24. The following medications were ordered on 4/26/25: - Hydrocodone-Acetaminophen Oral Tablet 5-325 mg. Give one tablet by mouth three times a day related to chronic pain syndrome - Hydrocodone-Acetaminophen Oral Tablet 5-325 mg. Give one tablet by mouth as needed for breakthrough pain for 30 days daily as needed for breakthrough pain. Do not give within 2 hours of scheduled. During interview on 5/01/25 at 12:42 p.m., the director of nursing (DON) stated R9's pain level appeared to be managed through observation. DON stated R9 had orders for both routine medications for pain management, as well as PRN medications ordered. DON stated she was unaware of any medications at bedside. R9 had new orders implemented after the pain assessment was completed. DON stated the additional medications would need to be assessed for potential interactions with other medications by the provider and an order was needed in order for her to continue the	F 554		

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F 554	Continued From page 5 medications at bedside. DON stated a SAM was needed for each medication kept at bedside. A review of the facility policy, Self Administration of Medications, dated 2/2024, was reviewed and identified resident had the right to self-administer medications if the interdisciplinary team has determined that it is clinically appropriate and safe for the resident to do so. If it is determined that it is safe for resident to self administer, this determination was documented in the medical records. The decision that the resident can safely self administer is reassessed periodically based on changes in the resident's medical and/or decision making process.	F 554		
F 565 SS=D	Resident/Family Group and Response CFR(s): 483.10(f)(5)(i)-(iv)(6)(7) §483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner. (ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation. (iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings. (iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility.	F 565		6/6/25

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F 565	Continued From page 6 (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group. §483.10(f)(6) The resident has a right to participate in family groups. §483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to act and ensure voiced concerns in the resident council were addressed in a timely manner. This had potential to affect 6 of 6 residents (R8, R28, R33, R7. R3, and R11), identified to have attended the meetings in the past two months. Findings include: On 4/30/25 at 8:32 a.m., the resident council president (R7) gave permission for the survey team to review previous minutes of resident council meetings. These minutes were provided and identified the following concerns: October 14, 2024: No resident attendance roster included in the meeting minutes. Concerns identified related to Therapeutic Recreation: Identified goal to get more activities/crafts for residents. November 11, 2024: No resident attendance roster included in the meeting minutes. Concerns	F 565	Submission of this Response and Plan of Correction is not a legal admission that a deficiency exists or that this Statement of Deficiency was correctly cited and is also not to be construed as an admission of fault by the facility, the Administrator or any employees, agents or other individuals who draft or may be discussed in this Response and Plan of Correction. In addition, preparation and submission of this Plan of Correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in the allegations. Accordingly, the Facility has prepared and submitted this Plan of Correction prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission of a Plan of Correction within ten (10) days of the survey as a condition to participate in Title 18 and Title 19	

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F 565	Continued From page 7 identified related to Therapeutic Recreation: Trying to get more games and exercises going. More crafting. Bingocize has stopped. Bingo is transitioning. December 9, 2024: No resident attendance roster included in the meeting minutes. Concerns identified related to Therapeutic Recreation: Working on calendar. More snack ideas. January 13, 2025: Residents in attendance: R8, R2, R33, R32, and R7. No Therapeutic Recreation concerns were identified. A review of the facility Grievance Policy was completed. February 10, 2025: Residents in attendance: R28, R11, R3, and R7. Concerns identified related to Therapeutic Recreation: Trying VR (virtual reality)(Rendever) headsets more. Need activity ideas. March 10, 2025: Residents in attendance: R8, R7, R3, R28, and R16. Concerns identified related to Therapeutic Recreation: Trying to bring more things onto daily calendar. Daily Chronicle, Table Tidbits, When is Bingo night coming back? April 21, 2025: Residents in attendance: R6, R8, R7, R11, and R28. Concerns identified related to Therapeutic Recreation: Getting seven iPad's. Request for more activities. Newspaper to remain in the chapel lounge. On 4/30/25 at 3:00 p.m., a Resident Council meeting was held during survey. During routine questions regarding Council recommendations made/grievances voiced, the council members stated there had been grievances voiced/recommendations made regarding Therapeutic Recreations, however, the residents have not been informed of the resolutions. R3 stated a request has been made for daily reading of the Star Tribune, additionally indicating this would cost nothing, aside from staff commitment.	F 565	programs. This Plan of Correction is submitted as the facility's credible allegation of compliance. F565 s/s D -The process for satisfying this requirement has been reviewed and revised as needed, to ensure voiced concerns during resident council meetings are addressed timely. -Residents attending resident council can potentially be affected if this requirement is not met. -R8, R28, R33, R7, R3, and R11 were followed up with to ensure that their concerns are heard and addressed. -All staff, including the Therapeutic Recreation Director, have been educated to the requirement using the regulation. -The Therapeutic Recreation Director was reeducated on use of the Monarch Healthcare Management Resident Council meeting minutes and response form to document voiced concerns during resident council meetings. -Monitoring to assure compliance will include, but is not limited to, audits completed three (3) times per week for two (2) weeks; two (2) times per week for four (4) weeks; and monthly thereafter for one (1) month. Audit results will be reviewed at QAPI. Any deficient practice will be identified and corrected at the time of occurrence. -Therapeutic Recreation Director and/or designee is responsible party. -Corrective action will be completed on or before 6/6/25.	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GARDENS AT WINSTED LLC	551 FOURTH STREET NORTH WINSTED, MN 55395

(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
F 565	Continued From page 8 R3 stated this had been previously a well attended activity, but no longer occurred. R7 commented Bingo used to be four days a week. In addition to this, Bingocize occurred as well. Bingocize no longer occurs, per R7. When asked about the Independent Leisure activities identified on the calendar, R7 stated "sometimes" they are little "blurbs" as to a weekend activity, however, generally there are no weekend activities. Residents present at meeting voiced agreement with comments made. R7 stated "We were told there would be new activities. They said there would be interactive games, no on knew what that was.". R7 identified there was previously an exercise program which was done with television which had been popular, however, was no longer offered. A review of the facility activity calendars from April 2025 and March 2025 lacked indication of offering of newspaper reading and craft activities appeared only on one occasion (3/2/25). A review of the March 2025 Activity Calendar indicated there were seven days where the only activities identified were "Independent leisure", and eight days listed as Independent Leisure in April. A request was made for the facility policy for Therapeutic Program Development, however, none was available. A request was also made for the policy for Resident Council Management and follow though on grievances and recommendations made through Resident Council, however, no policy for Resident Council follow through was provided.	F 565		
F 576 SS=E	Right to Forms of Communication w/ Privacy CFR(s): 483.10(g)(6)-(9)	F 576		6/6/25

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F 576	Continued From page 9 §483.10(g)(6) The resident has the right to have reasonable access to the use of a telephone, including TTY and TDD services, and a place in the facility where calls can be made without being overheard. This includes the right to retain and use a cellular phone at the resident's own expense. §483.10(g)(7) The facility must protect and facilitate that resident's right to communicate with individuals and entities within and external to the facility, including reasonable access to: (i) A telephone, including TTY and TDD services; (ii) The internet, to the extent available to the facility; and (iii) Stationery, postage, writing implements and the ability to send mail. §483.10(g)(8) The resident has the right to send and receive mail, and to receive letters, packages and other materials delivered to the facility for the resident through a means other than a postal service, including the right to: (i) Privacy of such communications consistent with this section; and (ii) Access to stationery, postage, and writing implements at the resident's own expense. §483.10(g)(9) The resident has the right to have reasonable access to and privacy in their use of electronic communications such as email and video communications and for internet research. (i) If the access is available to the facility (ii) At the resident's expense, if any additional expense is incurred by the facility to provide such access to the resident. (iii) Such use must comply with State and Federal	F 576		

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F 576	Continued From page 10 law. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure resident mail was delivered to residents on Saturdays for 2 of 2 residents (R3 and R28) who voiced concerns with mail delivery during Resident Council. This had the potential to affect all 37 residents residing in the facility. Findings include: On 4/30/25 at 3:00 p.m., a Resident Council meeting was held with six residents from varied areas of the facility. During the meeting, R3 voiced a concern mail was not delivered to residents on Saturdays. This was verified by R28. R3 indicated mail was delivered to the facility on Saturdays and was placed in the black box outside of the front entrance. Historically, this was then gathered on Monday morning and delivered by the receptionist. This process has changed somewhat since the position of receptionist was not currently filled. On 5/1/25, at 9:53 a.m. the business office manager (BOM) affirmed the mail is delivered by the post office to the outside collection box. BOM stated the business office gets it Monday, as the key is locked up for the post office box outside. BOM stated the mail delivery is then coordinated on Mondays. During interview on 5/1/25, at 10:34 a.m. , interim administrator (IA) acknowledged awareness of mail delivery on Saturdays. Corporate nurse (CN)-A stated she was unaware of this requirement.	F 576	Submission of this Response and Plan of Correction is not a legal admission that a deficiency exists or that this Statement of Deficiency was correctly cited and is also not to be construed as an admission of fault by the facility, the Administrator or any employees, agents or other individuals who draft or may be discussed in this Response and Plan of Correction. In addition, preparation and submission of this Plan of Correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in the allegations. Accordingly, the Facility has prepared and submitted this Plan of Correction prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission of a Plan of Correction within ten (10) days of the survey as a condition to participate in Title 18 and Title 19 programs. This Plan of Correction is submitted as the facility's credible allegation of compliance. F576 s/s E -The process for satisfying this requirement has been reviewed and revised as needed, to ensure mail is delivered timely as voice during resident council. -All residents residing in the facility have the potential to be affected if this regulation is not met.	

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F 576	Continued From page 11 On 5/1/25, at approximately 11:19 a.m. CN-A informed survey team member upon review of facility process, they were mistaken. CN-A stated the mail was not delivered to the facility on Saturdays. On 5/1/25, at 11:29 a.m., a call was placed to the United States Post Office in follow up. At this time, surveyor was informed by Post Master mail delivery occurred Monday through Saturday to the facility and the mail was placed in the locked box outside of the facility. On 5/1/25, at 11:39 a.m., IA stated upon investigation with the mail delivery, they spoke with corporate maintenance director and had been informed mail delivery on Saturdays was at the discretion of the community as to whether or not mail is delivered to facilities on Saturdays. Surveyor informed IA they had spoken with Post Master who had affirmed mail was delivered to this facility on Saturdays. IA stated she would seek further clarification on this. Surveyor provided contact information for local Unities States Post Office. No additional information was provided by the facility regarding mail deliver. A facility policy was requested for mail delivery on Saturdays, however, was informed no policy was available.	F 576	-R3 and R28 have both had their mail delivered. -The process was reviewed and revised as needed to ensure that mail is delivered timely, each day that the post office drops off mail. Mail will be dropped off in one location and delivered appropriately by facility staff each day. -All staff, including the Therapeutic Recreation Director, have been educated to the process and requirement using the regulation. -The Therapeutic Recreation Director was reeducated on use of the Monarch Healthcare Management Resident Council meeting minutes and response form to document voiced concerns during resident council meetings. -Monitoring to assure compliance will include, but is not limited to, audits completed three (3) times per week for two (2) weeks; two (2) times per week for four (4) weeks; and monthly thereafter for one (1) month. Audit results will be reviewed at QAPI. Any deficient practice will be identified and corrected at the time of occurrence. -Therapeutic Recreation Director and/or designee is responsible party. -Corrective action will be completed on or before 6/6/25.	
F 577 SS=C	Right to Survey Results/Advocate Agency Info CFR(s): 483.10(g)(10)(11) §483.10(g)(10) The resident has the right to- (i) Examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with	F 577		6/6/25

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F 577	Continued From page 12 respect to the facility; and (ii) Receive information from agencies acting as client advocates, and be afforded the opportunity to contact these agencies. §483.10(g)(11) The facility must-- (i) Post in a place readily accessible to residents, and family members and legal representatives of residents, the results of the most recent survey of the facility. (ii) Have reports with respect to any surveys, certifications, and complaint investigations made respecting the facility during the 3 preceding years, and any plan of correction in effect with respect to the facility, available for any individual to review upon request; and (iii) Post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public. (iv) The facility shall not make available identifying information about complainants or residents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure both recertification survey results, as well as additional complaint investigations, were available for review. This had the potential to effect all 37 residents residing in the facility, along with family, visitors and staff. Findings include: During the recertification visit of 4/28/25 through 5/1/25, the facility survey results were observed to be placed in a binder near the main entrance for review. Upon arrival to the facility, on 4/28/25 at approximately 11:45 a.m., it was noted the survey binder contained the recertification	F 577	Submission of this Response and Plan of Correction is not a legal admission that a deficiency exists or that this Statement of Deficiency was correctly cited and is also not to be construed as an admission of fault by the facility, the Administrator or any employees, agents or other individuals who draft or may be discussed in this Response and Plan of Correction. In addition, preparation and submission of this Plan of Correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in the allegations. Accordingly, the Facility has prepared and	

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F 577	Continued From page 13 surveys from the past three years of recertification, (2022, 2023, 2024), however, lacked documentation and follow up for complaint investigations completed during those years. During interview on 5/1/25, at 7:37 a.m. interim administrator (IA) stated complaint investigations were routinely posted in the binder. A review was completed of the binder at this time by surveyor and IA, and at that time, it was noted there was additional documentation present in the binder, which had not been identified on 4/28/25. On 5/1/25, at 8:02 a.m., a review was completed by surveyor with the survey binder, in conjunction with complaint investigations, from the period between current and last recertification surveys. The following documentation was observed to be lacking: The facility binder lacked documentation in the form of a CMS 2567 (Formal investigation documentation required by the Centers for Medicare and Medicaid Services-CMS) for investigations completed during the following dates: 1/2/25-1/3/25, 2/20/25-2/24/25, and 5/13/24-5/14/24. Additionally, although a letters was in place for the findings of the revisit/desk audit of 4/17/25 the 2567 was not present. The binder lacked any indication of the revisits of 6/24/24 and 8/19/24. An interview was completed in follow up on on 5/1/25, at 10:29 a.m., with IA and CN-A. CN-A stated the requirements for survey postings was for the facility to post the last three years of all annual survey and complaint investigations. Upon review of the survey binder postings, CN-A	F 577	submitted this Plan of Correction prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission of a Plan of Correction within ten (10) days of the survey as a condition to participate in Title 18 and Title 19 programs. This Plan of Correction is submitted as the facility's credible allegation of compliance. F577 s/s C -The process for satisfying this requirement has been reviewed and revised as needed, to ensure the facility has both recertification and complaint survey results available for public viewing. - All residents and visitors of the facility have the potential to be affected if this regulation is not met. - The binder containing the missing documents was reviewed and revised as needed to add the missing elements. - All staff have been reeducated to the requirement using the regulation. - Audits will be completed three (3) times per week for two (2) weeks; two (2) times per week for two (2) weeks; one (1) time per week for one (1) week; and monthly thereafter for one (1) month. Audit results will be reviewed at QAPI, with any deficient practice corrected at the time of occurrence. - Administrator or designee is the responsible party. -Corrective action will be completed on or before 6/6/25.	

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F 577	Continued From page 14 affirmed the above listed information was not present in the binder. CN-A verified it was her understanding that the 2567's were a requirement for all investigations completed, including revisits/desk audits. A request was made for the facility policy for posting of survey results was made and was informed there was no policy available by corporate nurse (CN)-A.	F 577		
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition;	F 584		6/6/25

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F 584	Continued From page 15 §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observations, interviews and document review, the facility failed to ensure resident living areas are free from odors for 2 of 2 residents (R8 and R14) in the sample whose room odors permeated the surrounding halls. This had the potential to affect residents in surrounding rooms, visitors and facility staff. In addition the facility failed to fully investigate missing personal items for 1 of 1 residents (R9) with reports of missing clothing that was reported missing for approximately two months. Findings include: R8 In review of R8's Diagnosis Report (print date 4/30/25) documented the diagnoses of morbid obesity with alveolar hypoventitlation {a condition where the lungs don't move enough air in and out, leading to a buildup of carbon dioxide (hypercapnia) and a decrease in oxygen levels in the blood}, and type 2 diabetes. R8's 5-day	F 584	Submission of this Response and Plan of Correction is not a legal admission that a deficiency exists or that this Statement of Deficiency was correctly cited and is also not to be construed as an admission of fault by the facility, the Administrator or any employees, agents or other individuals who draft or may be discussed in this Response and Plan of Correction. In addition, preparation and submission of this Plan of Correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in the allegations. Accordingly, the Facility has prepared and submitted this Plan of Correction prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission of a Plan of Correction within ten (10) days of the survey as a condition to participate in Title 18 and Title 19	

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F 584	Continued From page 16 Minimum Data Set (MDS) - post hospitalization, dated 2/12/25, indicated R8 was independent with self cares, requiring partial/moderate assistance with toileting and substantial/maximal assistance with showering/bath. In review of R8's Brief Interview for Mental Status (BIMS), resident was assessed to be cognitively intact. During screening interview on 4/28/25 at 2:12 p.m., there was a distinct urine and other odors to R8's room, however, R8 stated it was due to being toileted after an incontinent bowel movement. On 4/29/25 at approximately 9:30 a.m., noted a strong almost necrotic odor (a foul-smelling odor that often arises from the breakdown of dead tissue and bacterial activity within the wound) emanating from R8's room. R8 was noted to be sitting in his wheel chair, reading papers on his tray table. R8 was asked about the odor, to which he stated he had not yet done his morning cares. During an interview on 4/29/2025 at 10:17 a.m., nursing assistant (NA)-A stated R8 has a really strong odor to himself, and refuses staff to assist him with his activities of daily living (ADLs). R8 only feels a need for a weekly bath and did his own peri-area and washing up. "We offer to assist and will occasionally allow staff to wash his back." A review of R8's care planned area of Self care (dated 7/17/24), under the "Intervention/Tasks" section the following was documented: "Assist resident with personal hygiene including pericares in the morning, evening and as needed. Resident will at times refuse for staff to assist with completing cares as he prefers to be independent with this task."	F 584	programs. This Plan of Correction is submitted as the facility's credible allegation of compliance. F584 s/s E -The process for satisfying this requirement has been reviewed and revised as needed, to ensure resident and visitor areas are free from odors and missing items are investigated. -All residents and visitors of the facility can potentially be affected if this requirement is not met. -Odor originating from R8 and R14 has been addressed by both facility nursing staff and environmental services. -Items identified by R9 as missing were discussed with resident and IDT; and a search was performed per policy. -All Yona Healthcare employees have been reeducated to the requirement using Yona Healthcare Policy and Procedure. -All staff have been educated to the requirement using Monarch Healthcare policy and procedure. -Nursing staff and Yona Healthcare employees are trained and expected to address odors, in order to promote a clean and homelike environment for all occupants of the facility. -Monitoring to assure compliance will include, but is not limited to, audits completed three (3) times per week for two (2) weeks; two (2) times per week for four (4) weeks; and monthly thereafter for one (1) month. Audit results will be reviewed at QAPI. Any deficient practice will be identified and corrected at the time of occurrence.	

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F 584	Continued From page 17 Throughout the day of 4/29/25, the odor continued to be noted as one passed R8's room. During environmental tour on 4/29/25 at 3:30 p.m., the following facility staff accompanied surveyor to R8's room: regional maintenance director (CMD), regional administrator (RA), the facility's maintenance director (FM), director of nursing (DON) and interim administrator (IA). CMD stated he was unaware of the odor until this morning when he arrived and walked by R8's room. CMD stated he would check with the facility house keeping department to see if an odor block container had been placed. DON stated R8 didn't have any open areas that would have potentially caused the smell. DON attributed the smell to resident being obese with multiple abdominal folds, R8 has an issue with yeast build up in those areas. DON stated R8 provides all his personal cares while he was not wishing staff to assist due to embarrassment. R8 occasionally allows staff to wash his back and assist during showers, however refused staff to assist with pericare and washing and drying of abdominal folds. During further interview on 4/29/25 at 4:40 p.m., CMD and facility housekeeping director (FHD), noted R8 was not currently in his room, showed the facility had placed an odor block container behind his wardrobe and was 1/2 empty. FHD stated the house keepers have done a deep cleaning of R8's room and every time resident has a shower and/or his sheets are changed, housekeeping wipes down R8's mattress with a sanitizer / deodorizer. FHD stated the odor goes away for a short period of time then returns.	F 584	-Environmental Services Director, Director of Nursing, and/or designee is responsible party. -Corrective action will be completed on or before 6/6/25.	

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F 584	Continued From page 18 R14 In review of R14's Diagnosis Report (print date 4/30/25) documented the diagnoses of Neuromuscular dysfunction of bladder, lumbar spina bifida with hydrocephalus (a birth defect where the spine and spinal cord don't close completely, is often associated with hydrocephalus, a condition where excess fluid accumulates in the brain) and morbid obesity. R14's significant change MDS, dated 3/25/25, indicated R14 was cognitively intact and required supervision and touch assistance with verbal cueing for all ADLs. During initial tour of surveyor's assigned area, on 4/28/24 at 1: 00 p.m., which included R14's room, a strong odor of urine was noted, emanating from resident's room. It was also noted the door to R14's room was closed. The odor could be noted into the adjacent dayroom and within approximately 6 feet of the joining hall of rooms. On 4/28/25 at 1:13 p.m., after knocking on R14's door and being invited in, the odor of urine became even more apparent. Inside the room, R14 was laying on her bed using her iPad as introductions were made. Against the window was was a bariatic commode, the curtains were pulled and lights were out. While being interviewed, R14 was asked about the odor in the room. R14 stated the odor in the room is from her, and stated she doesn't notice it, "I have the scent sticks that cover and absorb." When asked how often housekeeping comes in to clean, R14 stated at least weekly. R14 stated she is working on writing fantasy series of books and needed to concentrate. R14 stated she toilets herself, only asking staff to assist when she is tired.	F 584		

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F 584	Continued From page 19 During interview on 04/28/2025 at 1:34 p.m., nursing assistant (NA) - A stated she is responsible for the resident on the south end of the wing. NA-A stated R14 rarely leaves the room, occasionally when they can talk her into having a shower. R14 washes self after set up by staff, but usually refuses assistance. NA stated R14's room has had an odor for a very long time, and she doesn't always allow staff to come in, especially housekeeping. During interview on 04/28/2025 at 3:50 p.m., NA-B stated R14 requires assistance with most of her cares, however normally only allowed set up of supplies. NA-B stated staff do encourage her to allow them to assist, but she feels she does an adequate job herself. R14 did request staff, in the evenings to assist her to the commode, when she was tired. R14 did not like staff touch her stuff. In a further interview on 04/28/2025 at 6:12 p.m., NA-C stated she occasionally helped near R14's room. NA-C stated the room and the hall area of R14's room had a strong odor of urine for awhile. NA stated R14 kept the room door closed and did not allow many staff in, R14 felt she was independent. During environmental tour on 4/29/25 at 3:45 p.m., the following facility staff accompanied surveyor to R14's room: CMD, RA, the FM, DON and IA. The door to R14's room was closed and while standing in the adjacent dayroom and joining hall, the facility team assembled stated they to were able to notice the strong urine odor. CDM state he was unaware of the issues and the facility could utilize an odor blocker container in	F 584		

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F 584	Continued From page 20	F 584		

the room if it had not already been placed. The DON and FM stated R14 doesn't leave the room and rarely allows housekeeping to clean the room. DON stated R14 will allow for a weekly cleaning (usually Friday) as she did not want to be disturbed. R14 only lets the staff change her sheets when she thought they were dirty enough.

In a further interview on 4/29/25 at 4:40 p.m., CMD and the FHD stated the facility had placed a odor block container (located between R14's bed and bedside cabinet), but the room needed a through deep cleaning which R14 has not allowed.

A review of R14's care plan area of Self care (last revised 10/02/24), documented that R14 was to have the assistance of one with personal hygiene. In further review of this care plan for "Elimination", with a revision date of 9/10/24, indicated the following: "Provide assistance with peri-cares AM, HS, following each incontinent episode, and [as needed]."

The policy entitled: Daily Cleaning Procedures (YONA Solutions - undated), the following areas and processes were outlined: 1. wash hands, put on gloves and place wet floor sign at the door entrance, 2. knock on door and enter room, 3. empty trash, 4. high dust, 5. disinfect, 6. spot clean walls and inspect privacy curtains, 7. clean room, 8. dust mop, 9. damp mop and 10. place soiled rags in plastic bag on cart, remove and discard gloves, and wash hands prior to leaving room. Each of the sections provided staff definitions / descriptors of what was involved in each of the tasks.

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F 584	Continued From page 21 The policy entitled: Deep Clean Procedures (YONA Solutions - undated), mirrored the "Daily Cleaning Procedure policy, however directed staff to include the cleaning of dressers, chairs, closet, windows, heating unit, night stand, bed, bedside tables, lights over the bed, call light and remove build-up on floor between room and hallway. R9 R9's quarterly MDS of 4/11/25, indicated R9 was alert and oriented and readily able to communicate her needs. The MDS lacked any indication of behavioral concerns. R9 was able to complete activities of daily living (ADL's) independently, except for meeting her toileting and bathing needs. R9's medical diagnoses included anemia (low levels of healthy cells to carry oxygen), chronic obstructive pulmonary disease with acute exacerbation (a persistent respiratory disease that may cause long-term, progressive lung damage), chronic pain syndrome, and history of cerebral infarction (stroke) without residual deficits (lasting effects related to the stroke). During interview on 4/28/25 at 12:58 p.m., R9 stated she had an item of clothing, a pink Under Armor long sleeve shirt, which she had sent to the laundry which had not been returned. R9 stated she had informed the housekeeping assistant (HA)-A of this. R9 stated this had been missing for approximately two months and had not been found yet. On 4/29/25 at 4:35 p.m., facility housekeeping director (FHD) stated she was unaware of any missing items, but would follow up with HA-A, as	F 584		

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F 584	Continued From page 22 HA-A often spoke with R9. FHD stated HA-A had left for the day and would follow up on 4/30/25. On 4/30/25, surveyor spoke with both HA-A and FHD, who both stated the item had not yet been found. It was identified this was missing for approximately two months without being found. HA-A stated R9 had totes of personal belongings and thought she had seen a pink item through the clear side of the tote. HA-A stated FHD was going to go through them with R9 in attempt to locate the item. On 5/1/25 at 11:00 a.m., FHD stated she had looked in tote with both R9 and the corporate licensed social worker (CLSW), and was unable to find the item in R9's totes. FHD stated missing items were identified during morning meetings, and then FHD and HA-A proceeded to look for it. FHD stated there was no time frame for follow through and there was no tracking system in place that she was aware of, however, stated her previous boss had tracked this on paper. FHD stated R9's missing clothing was reviewed again this morning in report. FHD stated she planned to make a policy, and planned to track items on piece of paper. FHD stated she was unaware of any items previously being replaced, as items were typically found. On 5/1/25 at 11:30 a.m., FHD stated there was a policy in place, however, she was unaware of this. The Missing Item report form was filed in a pocket folder near the elevator. The document was dated 10/20. FHD was unaware of this, and had not used a tracking log to monitor missing items. A review of the facility grievance log, from 8/28/24	F 584		

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F 584	Continued From page 23 to 5/1/25, indicated 15 items identified as being missing, and of those items, 11 items were found. Of the four missing items, three of the remaining items missing were replaced by the facility, with the replacement of one of the items refused. The facility policy, Lost, Missing and Damaged Items policy, last reviewed 2/23 identified if an item was said to be missing, a Grievance Form was to be completed. The policy identified the employee who received the original missing valuables communication was responsible for initiating the Grievance form. The form was then to be signed by the person who completed the missing item report. This report was then to be returned to the Administrator's or Social Services office. The grievance process was then to be followed to determine the appropriate next steps. The Complaint and Grievance Policy, last revised 9/23, identified once a grievance was received, the Administrator, or designated grievance official completed an investigation to determine the validity of the grievance. Once the grievance was received, and the investigation was completed, the resident was provided with a verbal or written summary of the findings. The summary findings included date of grievance, summary of the grievance, steps taken to investigate, summary of the pertinent finding/conclusions, a statement which identified if the grievance was confirmed, and the dated the written decision was issued.	F 584		
F 585 SS=D	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity	F 585		6/6/25

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F 585	Continued From page 24 that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may	F 585		

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F 585	Continued From page 25 be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations; (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation	F 585		

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F 585	Continued From page 26 of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Based record review and interview the facility failed to follow up on grievances for 1 of 1 residents (R7) reviewed for grievances during the period 9/7/24 to 5/1/25. Findings include: On 4/30/25 at 3:14 p.m., during Resident Council, the question was asked: If the facility does not respond to concerns, does the Grievance Official provide a rationale for the response. R7 stated he was aware of the grievance process, and had filed multiple grievances, however, stated the last grievances, he did not received a response. A request was made for the grievance log from the past six months, as well as the resolutions of the grievances received. A log was received from 10/24/25 to 5/1/25. During this time, grievances were filed by R7 on 9/7/24, 11/18/24 (twice, for separate issues), 12/15/24, 12/15/24, 12/21/25, and 1/13/25. A resolution form was completed for the grievance of 9/7/24, with documentation completed on 10/14/24, which identified "Grievance confirmed". The documentation	F 585	Submission of this Response and Plan of Correction is not a legal admission that a deficiency exists or that this Statement of Deficiency was correctly cited and is also not to be construed as an admission of fault by the facility, the Administrator or any employees, agents or other individuals who draft or may be discussed in this Response and Plan of Correction. In addition, preparation and submission of this Plan of Correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in the allegations. Accordingly, the Facility has prepared and submitted this Plan of Correction prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission of a Plan of Correction within ten (10) days of the survey as a condition to participate in Title 18 and Title 19 programs. This Plan of Correction is submitted as the facility's credible allegation of compliance.	

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F 585	Continued From page 27 indicated: "investigation was ongoing and told resident [we] would continue to check in.". Additionally, the narrative question "Was resident/family satisfied with resolution" identified "Understood but not "satisfied" per se." Although the documentation reflected resident understood but was not satisfied, the documentation lacked indication of further follow through with resident. Further, the form identified "N/A (not applicable)-no ongoing issues noted. The narrative note was completed on 10/14/24, and two additional grievances regarding call light times were filed on 9/19/24 and 10/8/24, although not by R7. A second form of resolution form was provided for concerns identified 11/18/24, was provided with documentation completed 12/3/24, which indicated the delay in response to this grievance was related to ongoing investigation. The grievance log indicated the concern was related to CNA (certified nursing assistant) behavior and the resolution form indicated that grievance was confirmed. The documentation indicated R7 preferred his shower at 9:30 p.m., and this was not always possible. The documentation identified that R7's shower was changed to Wednesday's as R7 preferred a shower later in the day. The documentation indicated resident was satisfied with resolution. A lack of documentation of resolution was noted for the following grievances filed: 11/18/24, one response was provided. Although there had been two issues identified, only one addressed in resolution. The second grievance on 11/18/24 was related to call light response times. 12/15/24, 12/15/24, 12/21/25, and 1/13/25. Additional grievance documentation was lacking for the	F 585	F585 s/s D -The process to satisfy this requirement has been reviewed and revised as needed, to ensure the facility follows up on grievances reported during resident council. -All residents have the potential to be affected if this regulation is not met. -R7 was met with to discuss any and all outstanding grievances. -All staff received education in accordance with Monarch Healthcare Policy and Procedure to ensure grievances are appropriately resolved. -Compliance audits will be completed weekly for four (4) weeks, and monthly thereafter for one (1) month. Audit results will be reviewed at QAPI. Any deficient practice will be identified and corrected at the time of occurrence. -Administrator or designee is responsible party. -Corrective action will be completed on or before 06/06/25.	

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F 585	Continued From page 28 dates of 2/23/25 to 5/1/25. During interview on 5/1/25 at 4:10 p.m., the corporate licensed social worker (CLSW) acknowledged the follow through on grievances historically had not been handled in a timely fashion and had addressed this with the current administrator. In addition to timely follow through, there were multiple grievances filed which had not been addressed at all, which CLSW stated should have been completed. The undated facility policy, Resident Council, identified: A Resident Council Response Form was utilized to track issues and their resolution. The facility department related to any issues was responsible for addressing the item(s) of concern. The facility policy, Complaint and Grievance Policy, most recently revised 9/2023, identified that any complaints were to be investigated per policy. The policy stated the administrator, or designated grievance official, was to complete and investigation of the grievance to determine it's validity. The facility policy further identified a verbal, or written summary if requested, was to be provided to the complainant of proposed action on the grievance no later than five (5) business days after the receipt of the grievance. The policy went on to identify if the administrator to resolve the grievance as outlined, the information was to be sent on to the Vice President (VP) of Operations of Monarch Healthcare Management. The policy further identified all completed grievance forms were to be kept on record at the facility for a period of no less than three years.	F 585		
F 679 SS=E	Activities Meet Interest/Needs Each Resident	F 679		6/6/25

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F 679	Continued From page 29 CFR(s): 483.24(c)(1) §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by: Based on observation, interview and documentation, the facility failed to identify personal activity preferences, develop resident specific care plan, and coordinate activities of interest for 5 of 5 residents (R3, R22, R28. R31,and R36) reviewed for activities. Findings include: R3 R3's annual Minimum Data Set (MDS) assessment, dated 1/2/25, indicated R3 was cognitively intact and was readily able to communicate her thoughts, needs and wishes. R3's quarterly assessment of 4/4/25, indicated R3 had lower extremity deficit in mobility and was able to get around with the use of a wheelchair. R3's medical diagnoses included metabolic encephalopathy (brain dysfunction caused by systemic metabolic disturbances), anemia (a disease caused by low red blood cells that can cause shortness of breath and fatigue), hypertension (high blood pressure), diabetes	F 679	Submission of this Response and Plan of Correction is not a legal admission that a deficiency exists or that this Statement of Deficiency was correctly cited and is also not to be construed as an admission of fault by the facility, the Administrator or any employees, agents or other individuals who draft or may be discussed in this Response and Plan of Correction. In addition, preparation and submission of this Plan of Correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in the allegations. Accordingly, the Facility has prepared and submitted this Plan of Correction prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission of a Plan of Correction within ten (10) days of the survey as a condition to participate in Title 18 and Title 19 programs. This Plan of Correction is	

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F 679	Continued From page 30 mellitus (a group of disease that affect how the body uses blood sugar), arthritis (swelling or tenderness of one or more joints), multiple sclerosis (a chronic disease which affects your nervous system and causes inflammation, damage, and scarring in your brain and spinal cord), and idiopathic peripheral autonomic neuropathy (a disease which occurs when the nerves that are located outside of the brain and spinal cord (peripheral nerves) are damaged). R3's care plan indicated R3 was alert and oriented and was independent with her own activity choices. It also identified R3 was able to make her leisure needs known. It went on to state she was open to invites to facility group activities. The goal statement indicated "Resident will continue to make independent choices related to her daily activities. She will express satisfaction with her current activity level through positive statements and continued daily activities of choice." R3's care plan interventions included: Invite and encourage R3 to participate in facility activities that she may enjoy. The care plan indicated staff were to target cards/games, crafts, music and social events. Staff were to offer to assist as needed. Additional interventions included staff were to provide with a monthly activity calendar for her room and offer to assist her as needed. Staff were directed to respect resident's right to refuse activities. Staff were also directed to provide facility updates, notify of upcoming special events, and to offer supplies for in-room activities. R3's Activity Participation Review of 1/8/24 and 4/10/25 were reviewed. The documents indicated R3's care plan was reviewed and goals were met. Under the review of the Activity Plan Review, the	F 679	submitted as the facilitys credible allegation of compliance. F679 s/s D -The process for satisfying this requirement has been reviewed and revised as needed, to ensure the facility develops and implements resident specific care plans, along with activities of interest for resident participation in activities each day of the week. - All residents residing in the facility have the potential to be affected if this requirement is not met. - The plan of care for R3, R22, R28, R31, and R36 were reviewed and revised as needed to ensure there is a section for participation in activities, along with documentation of resident specific activities. - All other alike residents were reviewed with care plans revised as necessary to ensure the requirement is being met. - The Therapeutic Recreation Director was educated to the requirement utilizing the regulation as guidance to ensure that the issue does not reoccur and all current and future residents have specific care plans with activities of interest. - All necessary staff have received training and education to the requirement utilizing the regulation as guidance - Audits will be completed three (3) times per week for two (2) weeks; two (2) times per week for two (2) weeks; one (1) time per week for one (1) week; and monthly thereafter for one (1) month. Audit results will be reviewed at QAPI, with any deficient practice corrected at the time of	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 679	Continued From page 31 documents indicated the activity related focuses remained appropriate per care care. The documentation lacked indication for changes in activity focus, goals, or interventions. R3's Daily Activity Attendance reviewed from 1/1/25 through 4/30/25. Although R3's care plan stated enjoys crafts, the Daily Activity Attendance records lacked indication of participation in crafts in January, February, March and April. R3's care plan indicated she enjoyed cards/games. A review of the Activity Attendance lacked indication of participation in the months of January, February, March and April. Although these were areas of interest, interventions were not implemented/participated in, this was not addressed in the Activity Participation Review to determine if these areas continued to be R3's primary areas of interest. Additionally, although crafts were identified as an area of interest, there was no documentation present to indicate how these interests were supported or facilitated. R3's electronic medical record (EMR) lacked additional information regarding activities attendance, either in narrative notes or scanned documents. The EMR lacked documentation of activity attendance for 2025. During interview on 4/28/25, at 1:57 p.m. R3 stated the activities program consisted of Bingo. R3 stated she had wished they would do exercises, or do routine readings of the daily newspapers. R3 was aware of budgetary concerns, however, indicated these activities lacked additional cost, with the exception of staff time. On 4/29/25, at 3:08 p.m. a review was completed	F 679	occurrence. - Therapeutic Recreation Director is responsible party. -Corrective action will be completed on or before 6/6/25.	

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F 679	Continued From page 32 of the April Activity Calendar. It was noted there were no weekend activities identified, with the exception of the notation "Independent Leisure". A review of the Activity Calendar identified the latest activity started at 3:45 p.m. on Tuesdays for Bible Study. There were no craft activities identified on the April Activity Calendar. During interview on 4/30/25, at 9:58 a.m. activities director (AD) stated the staff who managed the activities kept a running record for each resident. AD stated she was unsure as to when/if they were scanned into the EMR, however, stated she had hand written records in her drawer and had binders for each month since October of 2024. AD stated the documents and information had not been scanned in, or entered, since she had started her role in October. AD stated the residents were asked at Resident Council meetings if there were activities they were interested in. The activity department then assisted with coordination of the activities. They tried "new activities". AD stated she also received ideas for activities from other therapeutic recreation directors. The activity calendar was reviewed with AD. AD stated the activity "Rendever" was a virtual reality experience with four headsets, four controllers, and an iPad. This was last used in February, however, was discontinued due to a lack of interest by the residents. Upon review of the activity calendars from March and April, the AD affirmed Rendever continued to be listed as a weekly activity. During the Resident Council meeting, and during individual interviews, residents identified budgetary concerns and the impact on activities (example provided was a decrease in Bingo frequency, absence of Bingocize, and a change of prizes). AD stated Bingo was no longer prized	F 679		

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F 679	Continued From page 33 with quarters, but prizes given were candy, snacks, or items used on a daily basis. AD stated there were staff for weekend activities, however, the activities were not placed on the calendar. AD stated residents were informed of weekend activities on Fridays when the weekend calendar was passed out with menus. AD stated there are different activities that they were going to be doing, which included reading the newspaper at 4:00 p.m. AD affirmed there were no evening activities, "unless CNA (certified nursing assistant) staff try to do something with them." She was unsure if CNA's did this. AD stated she was unaware of any concerns identified with Activities, however, added concerns were "very rarely identified". AD was aware of the request from one resident for outings. Upon review of the calendar, noted many of the events were religious themed in nature (Bible study, Catholic services, Lutheran services, hymn sing) with few activities potentially being of interest to younger residents. AD stated the activity staff generally went with what the residents like to do and offered "different things", adding they were going to trial a "book club". AD stated more one to one interactions were added to the activity program, as a lot of residents refused to go out to activities. AD stated one to one visits were done by activity staff, and the activity staff provided her notes regarding the visits. She had not documented one to one visits in the EMR. AD stated the care plans were updated when they were due (Initial, quarterly, significant change, and annual reviews). On 5/1/25, at 10:06 a.m. a review of the May activity calendar was completed and it was noted reading of the newspaper was added on a weekly basis in the morning, however, not in the evening as discussed. In addition, the Twins schedule was	F 679		

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F 679	Continued From page 34 added to the calendar. A facility policy was requested for activities program development and implementation, but was identified as not available. R22 R22's admission MDS dated 2/11/25, indicated R22 was cognitively intact and required extensive assistance with activities of daily living (ADLs). R22's medical diagnoses included stricture of artery (abnormal narrowing or constriction of an artery), hypertension, neuropathy (disorder that impairs the function of nerves, often causing pain, numbness, tingling, or weakness in the body), major depression, diabetes, and vitreous degeneration (changes in the vitreous humor, the clear, jelly-like substance that fills the space between the lens and retina in the eye). R22's care plan indicated R22 was independent with her daily activity choices, enjoyed reading and watching TV, was interested in participating in facility group activities, preferring smaller groups. R22 was noted to have a supportive family. The goal statement indicated R22 would express satisfaction with activity level through positive statements and continued daily activities of choice. R22's care plan interventions included: Invite and encourage to participate in facility group activities. Targeting crafts, card games, music, gardening, and being outside. Staff were to offer assistance as needed. Additional interventions included staff were to provide with a monthly activity calendar for her room and offer to assist her as needed. Staff were directed to respect resident right to refuse activities. Staff were also directed to provide facility updates, notify of upcoming special events, and to offer	F 679		

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F 679	Continued From page 35 supplies for in-room activities, such as a deck of cards and reading materials. R22's therapy recreation (TR) evaluation and social history assessment dated 2/6/25, indicated R22 enjoyed cards and games, arts and crafts, exercises and sports, music, reading, television (TV), going to church, being wheeled around outside, gardening and plants, and small group activities. R22's Daily Activity Attendance was not found within the electronic medical record. Upon request from the activity staff, handwritten attendance sheets were provided. Although R22's care plan stated enjoys arts and crafts, the Daily Activity Attendance records lacked indication of participation in arts and crafts in February, March and April. R22's care plan indicates she enjoys cards/games. A review of the Activity Attendance lacked indication of participation in the months of February, March and April. R22's care plan stated she enjoyed exercise, TV and reading; review of Daily Activity Attendance records lacked indication of participation in these activities. When interviewed on 4/28/25, at 12:43 p.m. R22 stated there was not enough activities, nothing to do on weekends, nothing to do after supper. R22 stated would really like more activities to do, found herself bored, and was tired of watching TV. On 4/29/25, at 3:08 p.m. a review was completed of the April Activity Calendar. It was noted there were no weekend activities identified, and the calendar identified activities on those days to be "Independent Leisure". A review of the Activity Calendar identified the latest activity starts at 3:45	F 679		

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F 679	Continued From page 36 p.m. on Tuesdays for Bible Study. There were no craft activities identified on the April Activity Calendar. When interviewed on 4/30/25, at 9:58 a.m. activities director (AD) stated the staff who managed the activities kept a tracking record for each resident. AD stated she was unsure as to when/if they were scanned into the EMR, although did have the handwritten records in her drawer in binders for each month since October of 2024. AD stated the residents were asked at Resident Council meetings as to which activities they would like to have done. AD stated she received activity ideas from other therapeutic recreation directors. AD stated there were staff for weekend activities, however, the activities are not placed on the calendar. AD stated residents are informed of weekend activities on Fridays when they passed out the calendar for the weekend. AD affirmed there were no evening activities, and added, "unless CNA staff try to do something with them." AD stated she was unsure if CNA's did this. When interviewed on 5/01/25, at 1:07 p.m. trained medication aid (TMA)-A stated R22 watched a lot of TV, would be nice if there were more activities for the residents including weekends and evenings, calendars are copy pasted from the month before, there was no variety offered. R28 R28's quarterly MDS dated 4/10/25, indicated R28 had moderate cognitive impairment and was independent with ADL's. R28's medical diagnoses included cirrhosis of liver with ascites	F 679		

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F 679	Continued From page 37 (severe liver damage leading to scarring and fluid buildup in the abdomen), protein-calorie malnutrition, congestive heart failure (CHF), hepatic encephalopathy, acute cystitis (sudden inflammation of the urinary bladder), and anxiety. R28's care plan indicated R28 was independent with her activity choices. The care plan also identified R28 enjoyed watching TV, reading, coloring, playing on her phone, and was interested in facility group activities. The goal statement indicated R28 would remain independent with daily activity choices, express satisfaction with her current activity level through positive statements and continued daily activities of choice. R28's care plan interventions included invite and encourage to participate in facility group activities she may enjoy, with staff targeting music, crafts, sports/exercises, social events, and cards/games. Staff were to offer to assist to and from activities as needed. Staff to offer hand massage, aromatherapy and/or healing touch for physical and psychosocial comfort. Additional interventions included staff were to provide with a monthly activity calendar for her room and offer to assist her as needed. Staff were also directed to provide facility updates, notify of upcoming special events, and to offer supplies for in-room activities, such as magazines, deck of cards, coloring supplies, and crafts. R28's Activity Participation Review dated 4/14/25 was reviewed. The document indicated that resident's care plan was reviewed, and goals were met. The document indicated that the activity related focuses remained appropriative per care plan. The documentation lacked indication for any changes in activity focus, goals, or interventions.	F 679		

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F 679	Continued From page 38 R28's TR Evaluation and Social history assessment dated 10/22/24, indicated R28 enjoyed cards, games, crafts, making jewelry, exercises and sports with watching sports and bicycling indicated, variety of music, reading local news and magazines, walking, shopping, gardening, small groups, anything to stay busy. R28's Daily Activity Attendance was not found within the electronic medical record. Upon request from the activity staff, handwritten attendance sheets were provided. Although R28's care plan stated enjoys arts and crafts, the Daily Activity Attendance records indicated one participation in arts and crafts in January, February, March and April. R22's care plan indicates she enjoys cards/games, exercise, TV, music, and reading. A review of the Activity Attendance lacked indication of participation in these activities in the months of January, February, March and April. When interviewed on 4/28/25, at 1:29 p.m. R28 stated there was nothing to do on weekends. R28 stated she would like to have something more to do than watching TV. On 4/29/25, at 3:08 p.m. a review was completed of the April Activity Calendar. It was noted there were no weekend activities identified, and the calendar identified activities on those days to be "Independent Leisure". A review of the Activity Calendar identified the latest activity starts at 3:45 p.m. on Tuesdays for Bible Study. There were no craft activities identified on the April Activity Calendar. When interviewed on 4/30/25, at 9:58 a.m.	F 679		

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F 679	Continued From page 39 activities director (AD) stated the staff who managed the activities kept a tracking record for each resident. AD stated she was unsure as to when/if they were scanned into the EMR, although did have the handwritten records in her drawer in binders for each month since October of 2024. AD stated the residents were asked at Resident Council meetings as to which activities they would like to have done. AD stated she received activity ideas from other therapeutic recreation directors. AD stated there were staff for weekend activities, however, the activities are not placed on the calendar. AD stated residents are informed of weekend activities on Fridays when they passed out the calendar for the weekend. AD affirmed there were no evening activities, and added, "unless CNA staff try to do something with them." AD stated she was unsure if CNA's did this. On 4/30/25, at 1:56 p.m. R28 was observed sitting on the edge of her bed, with TV on. R28 stated "there's nothing else to do around here." On 4/30/25, at 2:58 p.m. R28 was walking down the hallway, stated she had won a dollar at bingo then stated "now there's nothing to do the rest of the day." When interviewed on 5/01/25, at 1:07 p.m. TMA-A stated R28 would get her nails done, occasionally worked on puzzles on the table down the hall. R31 R31's admission MDS dated 3/13/25, indicated R31 was cognitively intact and required extensive assistance with ADLs. R31's diagnoses included	F 679		

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F 679	Continued From page 40 bipolar, atrial fibrillation, insomnia, diabetes, history of strokes, chronic kidney disease, cushings syndrome (hormone disorder caused by too much cortisol), and atherosclerotic heard disease. R31's care plan lacked any evidence of an activity plan of care having been created for R31. R31's TR Evaluation and Social History assessment dated 3/10/25, indicated R31 enjoyed painting, soft jazz, soul music, watching TV, reading, trips, shopping, wheeling around, and small groups. R31's Daily Activity Attendance was not found within the electronic medical record. Upon request from the activity staff, handwritten attendance sheets were provided. Although R31's TR Evaluation and Social History indicated R31 enjoyed, painting, soft jazz, soul music, watching TV, reading, trips, shopping, wheeling around, and small groups a review of R31's Daily Activity Attendance records lacked indication of participation in any of these activities in March or April. When observed on 4/29/25, at 11:14 a.m. and 3:51 p.m. R31 was lying in bed with lights off and no TV or music on. On 4/29/25, at 3:08 p.m. a review was completed of the April Activity Calendar. It was noted there were no weekend activities identified, and the calendar identified activities on those days to be "Independent Leisure". A review of the Activity Calendar identified the latest activity starts at 3:45 p.m. on Tuesdays for Bible Study. There were no craft activities identified on the April Activity	F 679		

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F 679	Continued From page 41 Calendar. When observed on 4/30/25, at 7:20 a.m., 2:07 p.m. and 2:58 p.m. R31 was lying in bed with lights off, no TV or music on in room. When interviewed on 4/30/25, at 9:58 a.m. activities director (AD) stated the staff who managed the activities kept a tracking record for each resident. AD stated she was unsure as to when/if they were scanned into the EMR, although did have the handwritten records in her drawer in binders for each month since October of 2024. AD stated the residents were asked at Resident Council meetings as to which activities they would like to have done. AD stated she received activity ideas from other therapeutic recreation directors. AD stated there were staff for weekend activities, however, the activities are not placed on the calendar. AD stated residents are informed of weekend activities on Fridays when they passed out the calendar for the weekend. AD affirmed there were no evening activities, and added, "unless CNA staff try to do something with them." AD stated she was unsure if CNA's did this. When observed on 5/01/25, at 9:19 a.m. 10:20 a.m., 11:34 a.m. and 12:40 p.m. R31 was lying in bed with lights off, curtains open and no TV or music on in room. When interviewed on 5/01/25, at 1:31 p.m. TMA-A stated R31 loved bingo and was very religious. TMA-A stated R31's daughter would take her out to have nails done. When interviewed on 5/01/25, at 2:13 p.m. registered nurse (RN)-A stated she hadn't seen	F 679		

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F 679	Continued From page 42 R31 do any activities, went out with daughter one to two times a week. R36 R36's admission MDS dated 3/25/25, indicated R36 had severe cognitive impairment and required extensive assistance with ADLs. R36's diagnoses included hyperkalemia, dementia, hypertension, hyperlipidemia, urine retention, and weakness. R36's care plan indicated R36 was independent with his activity choices. He enjoyed watching TV, tinkering around, reading, using his cell phone, being outside in his free time and was open to invites to facility group activities. R36 was noted to have a supportive family. The goal statement indicated R36 would remain independent with daily activity choices, express satisfaction with his current activity level through positive statements and continued daily activities of choice. R36's care plan interventions included invite and encourage to participate in facility group activities he may enjoy, with staff targeting church, sports events, gardening, music, and socials/special events. Staff were to offer to assist to and from activities as needed. Additional interventions included staff were to provide with a monthly activity calendar for his room and offer to assist him as needed. Staff were also directed to provide facility updates, notify of upcoming special events, and to offer supplies for in-room activities, such as reading materials and a deck of cards.	F 679		

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F 679	Continued From page 43 R36's TR Evaluation and Social History assessment dated 3/20/25, indicated R36 enjoyed cards, games, exercises, sports with basketball being named as a favorite, music, reading, all kinds of music, TV, spiritual and religious activities, wheeling around outdoors, trips/shopping, gardening, conversing with others, independent activities, and group activities. R36's Daily Activity Attendance was not found within the electronic medical record. Upon request from the activity staff, handwritten attendance sheets were provided. Although R36's care plan indicated R36 enjoyed watching TV, tinkering around, reading, using his cell phone, being outside in his free time; and R36's TR Evaluation assessment indicated R36 enjoyed cards, games, exercises, sports with basketball being named as a favorite, music, reading, all kinds of music, TV, spiritual and religious activities, wheeling around outdoors, trips/shopping, gardening, conversing with others, independent activities, and group activities a review of R36's Daily Activity Attendance records lacked indication of participation in any of these activities in March or April. When observed on 4/28/2, at 1:47 p.m. R36 was lying in bed with lights off, no TV or radio on in room. At 2:29 p.m. bingo was in the chapel, R36 was lying in bed with lights off and no TV or music on. When observed on 4/29/25, at 11:16 a.m. R36 was sitting in his wheelchair in common area. At 12:50 p.m. R36 was observed wheeling his wheelchair from the dining room. At 3:50 p.m.	F 679		

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F 679	Continued From page 44 R36 was lying in bed, light off with no TV or radio on. On 4/29/25, at 3:08 p.m. a review was completed of the April Activity Calendar. It was noted there were no weekend activities identified, and the calendar identified activities on those days to be "Independent Leisure". A review of the Activity Calendar identified the latest activity starts at 3:45 p.m. on Tuesdays for Bible Study. There were no craft activities identified on the April Activity Calendar. When observed on 4/30/25, at 8:09 a.m. R36 was being assisted by staff to the dining room. At 12:11 p.m. R36 was sitting in the dining room for lunch. At 1:58 p.m. R36 was lying in bed, lights off and no TV or radio on. At 2:57 p.m. R36 was lying in bed, lights off with no TV or radio on. When interviewed on 4/30/25, at 9:58 a.m. activities director (AD) stated the staff who managed the activities kept a tracking record for each resident. AD stated she was unsure as to when/if they were scanned into the EMR, although did have the handwritten records in her drawer in binders for each month since October of 2024. AD stated the residents were asked at Resident Council meetings as to which activities they would like to have done. AD stated she received activity ideas from other therapeutic recreation directors. AD stated there were staff for weekend activities, however, the activities are not placed on the calendar. AD stated residents are informed of weekend activities on Fridays when they passed out the calendar for the weekend. AD affirmed there were no evening activities, and added, "unless CNA staff try to do something with them." AD stated she was unsure	F 679		

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F 679	Continued From page 45 if CNA's did this. When observed on 5/01/25, at 9:13 a.m., 10:18 a.m., and 11:36 a.m. R36 was lying on his bed with lights off and no TV or radio on in room. When interviews on 5/01/25, at 1:16 p.m. TMA-A stated R36 was a pleasantly confused man. TMA-A stated when there was a memory care unit there had been many more activities provided throughout the day to stimulate the residents. When interviewed on 5/01/25, at 1:55 p.m. RN-A stated was harder for R36 to participate in activities, R36 required someone to sit with him during the activities to help him participate. A facility policy was requested for activities program development and implementation, but was identified as not available.	F 679		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to ensure the hospice	F 684	Submission of this Response and Plan of Correction is not a legal admission that a	6/6/25

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F 684	Continued From page 46 plan of care had been integrated with the facility care plan for 1 of 1 resident (R2), identified to receive hospice services. Findings include: R2's 3/21/25, significant change Minimum Data Set (MDS) identified her cognition was severely impaired, and was dependent on staff for activities of daily living (ADL)s. R2 had diagnoses of anemia (low levels of red blood cells (which carry oxygen to the tissues) which causes weakness and fatigue), hypertension (high blood pressure), arthritis (inflammation of the joints), neuropathy (nerve pain which can lead to pain, weakness, or numbness), and urinary retention, . A review of R2's current care plan identified R2 was on hospice, however, lacked indication as to what services hospice provided during their visits to the facility. Although the facility care plan directed staff to refer to Hospice plan of care and visit schedule, the medical record lacked this information for staff reference. During interview on 5/1/25 at 8:54 a.m., hospice nurse (HN)-A stated R2 was enrolled in Hospice on 3/20/24 with the diagnosis of senile degeneration of the brain. HN-A stated R2's hospice plan of care identified R2 received the following services: nursing services twice weekly, and as needed and aide services twice a week. R2 also received the following services monthly: massage therapy, social services, music therapy, chaplain visit, and volunteer visits. HN-A stated R2's service plan was evaluated on an ongoing basis for any needed changes regarding services provided and frequency of visits and was revised as needed.	F 684	deficiency exists or that this Statement of Deficiency was correctly cited and is also not to be construed as an admission of fault by the facility, the Administrator or any employees, agents or other individuals who draft or may be discussed in this Response and Plan of Correction. In addition, preparation and submission of this Plan of Correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in the allegations. Accordingly, the Facility has prepared and submitted this Plan of Correction prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission of a Plan of Correction within ten (10) days of the survey as a condition to participate in Title 18 and Title 19 programs. This Plan of Correction is submitted as the facilitys credible allegation of compliance. F684 s/s D - The process for satisfying this requirement has been reviewed and revised as needed, to ensure the hospice and facility plan of care are integrated. - All current alike residents, receiving hospice services, have been identified and had the potential to be affected if this requirement is not met. No further non-compliance was identified. - R2’s hospice plan of care was placed into the appropriate binder at the nursing station, so staff have access to it.	

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F 684	Continued From page 47 During interview and record review on 5/1/25 at 1:07 p.m., with registered nurse (RN)-A of the Hospice Care Binder for R2. RN-A stated she was unable to locate the hospice care plan within the binder. A review of the electronic facility care plan lacked incorporation of hospice services provided, other than to refer staff to Hospice plan of care. RN-A stated she was unsure of what process was used for referencing the care plan, however, stated she would follow up on this. On 5/1/25 at 3:38 p.m., the care plan process was reviewed with the director of nursing (DON) and corporate nurse (CN)-B. DON stated R2 was now enrolled in Hospice, which was going well. DON stated she was unaware the hospice care plan was not in the Hospice binder and would follow up on that. DON acknowledged the hospice care plan was to be available for reference as identified in the facility care plan for services. A review of the Hospice-Nursing Facility Services Agreement, dated 9/15/14, signed only by the Hospice agent, indicated the Hospice Plan of Care was a written plan of care established, maintained, reviewed and modified, at intervals identified by the Hospice and the Facility. The agreement indicated the Hospice Care Plan included the following: identification of services provided to meet the needs of hospice patient, and the needs of her family; a statement of scope and frequency of both hospice and facility services, measurable outcomes which were anticipated from implementation and coordination of the plan of care; drugs and treatments necessary to meet the needs of the resident; medical supplies needed; and documentation of	F 684	- Appropriate staff have been re-educated to the process of how and where the hospice plan of care can be found. - Audits will be completed three (3) times per week for two (2) weeks; two (2) times per week for two (2) weeks; one (1) time per week for one (1) week; and monthly thereafter for one (1) month. Audit results will be reviewed at QAPI, with any deficient practice corrected at the time of occurrence. -Director of Nursing or designee is responsible party. -Corrective action will be completed on or before 6/6/25.	

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F 684	Continued From page 48 participation of the hospice patient, or representatives' level of understanding of the plan of care. The agreement outlined the facility shall comply with the Hospice Patient's Plan of Care.	F 684		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to implement appropriate monitoring of wanderguard function for 1 of 1 residents (R32) reviewed for elopement. Additionally, the facility failed to assure proper ongoing storage and use for e-cigarette (inhaled nicotine) device were implemented for 1 of 5 residents (R9) reviewed for smoking. In addition, the facility failed to provide supervision in the dining room during meal for 1 of 1 residents (R30) reviewed for safety while eating. Findings include: R32 R32's annual assessment of 12/13/24, indicated R32 had moderate cognitive impairment. R32's quarterly Minimum Data Set (MDS) dated 3/27/25, indicated R32 did not display episodes of inattention, disorganized thinking, or altered level	F 689	Submission of this Response and Plan of Correction is not a legal admission that a deficiency exists or that this Statement of Deficiency was correctly cited and is also not to be construed as an admission of fault by the facility, the Administrator or any employees, agents or other individuals who draft or may be discussed in this Response and Plan of Correction. In addition, preparation and submission of this Plan of Correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in the allegations. Accordingly, the Facility has prepared and submitted this Plan of Correction prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission of a Plan of Correction within	6/6/25

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F 689	Continued From page 49 of consciousness. The MDS also indicated R32 did not display physical or verbal symptoms directed toward others, or behavior symptoms not directed at others such as pacing. R2 was identified as having impairment of both lower extremities and noted to use a wheelchair for mobility. R32 was identified as receiving assistance with mobility. R32's medical diagnoses included acute kidney failure, cancer, hypertension (high blood pressure), seizure disorder or epilepsy, and reduced mobility. R32's care plan last revised 4/18/25, indicated R32 was at risk for elopement due to cognitive status. The care plan identified interventions to redirect tend to be effective and R32's Wanderguard was in place to left wrist. The care plan directed staff to monitor wanderguard for proper functioning. The care plan lacked direction how the staff were to assess for proper functioning. The care plan directed staff to answer door alarms promptly. R32's progress noted dated 10/11/24, R32 was noted by another resident to be exiting the therapy room entrance at 7:54 p.m. Resident was found near the door, and had his wheelchair tire stuck in the mulch. A review of the alarm codes indicated the alarm had initially sounded at 7:46 p.m. and then again at 7:54 when the staff assisted R32 into the facility. A nursing assessment was completed with no harm identified. R32's Wanderguard placement was checked for function, with no concerns identified. The facility also verified the function of other Wanderguards for Arial system functioning. Resident was identified to be at risk for elopement effective 10/5/23. Staff were aware to monitor for wandering. Wanderguard was in place	F 689	ten (10) days of the survey as a condition to participate in Title 18 and Title 19 programs. This Plan of Correction is submitted as the facilitys credible allegation of compliance. F689 s/s D -The process for satisfying this requirement has been reviewed and revised as needed to ensure resident wanderguards are monitored for function; there is proper storage of e-cigarettes; and there is appropriate supervision of residents eating in the dining room. -Alike residents residing in the facility have the potential to be affected if this requirement is not met. -R32 was reviewed for a functional wanderguard with no known issues. -R9 was reviewed and appropriately assessed for safe smoking and storage per policy. -R30 was reviewed for safe eating. -All alike residents were reviewed for similar concerns and no further non-compliance was identified. -Staff have been re-educated to the requirement and need to ensure wanderguards are working in accordance with manufacturer’s recommendations. Completed utilizing Monarch Healthcare Management Elopement Policy. -Staff have been reeducated to the requirement and need assess and properly store resident smoking materials. Completed utilizing Monarch Healthcare Management Smoking Policy. -Staff have been reeducated on appropriate supervision of residents	

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F 689	Continued From page 50 on the left wrist. Wanderguard was to be monitored for proper functioning. A further review of R32's record indicated a prior elopement in January of 2024. At that time, staff increased frequency of monitoring of Wanderguard function and wandering of R32. The record reflected no episodes where resident had exited facility. R32's Elopement Risk Evaluation completed 3/26/25, indicated R32 had a history of wandering/attempts to leave the building and was able to self-propel his wheelchair. The assessment identified R32 does exhibit pacing or agitated behavior and had a history of elopement from the facility. The assessment indicated R32 had a cognitive deficit. The resident was identified as taking a medication which may cause confusion. The score of this assessment was 6. A score of 4 or greater was indicative of the potential for elopement. The assessment indicated implementation of an Elopement Risk Care Plan within the document. On 4/29/25 at 11:38 a.m., a purple binder, titled Elopement at Risk, was observed at the nurse's station and was reviewed. Within the binder, the residents at risk for elopement were identified with a listing updated 4/15/25, with a copy of their face sheet and diagnosis listing. In addition, there was a document titled "Elopement at Risk Weekly IDT (Interdisciplinary Team) Review". This was completed from 8/21/24 through 2/28/25, with no further documents to identify review beyond that date. Additionally, a document titled "Placing a Wanderguard-The Process" was noted. The document indicated: If a resident was agitated/trying to wander was at risk for elopement the following needed to be completed	F 689	during meal times. Completed utilizing Monarch Healthcare Management's policy on dining room supervision. -Monitoring to assure compliance will include, but is not limited to, audits completed three (3) times per week for two (2) weeks; two (2) times per week for four (4) weeks; and monthly thereafter for one (1) month. Audit results will be reviewed at QAPI. Any deficient practice will be identified and corrected at the time of occurrence. -Director of Nursing or designee is responsible party. -Corrective action will be completed on or before 6/6/25.	

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F 689	Continued From page 51 ASAP (As soon as possible): Complete Elopement form (undated) Place Wanderguard (These are located in the small room behind the nurse's station). Place orders in PCC (Point Click Care-electric medical record) to monitor for placement and functioning of wanderguard every day, every shift. Document in progress notes where the wanderguard was placed, and why. Writer [sic] residents name in Elopement at Risk binder. Place Face Sheet in Elopement at Risk binder. Notify Responsible Party. Notify Administrator) and DON (Director of Nursing). Update physician. A review of the treatment administration record (TAR) for R32 was completed both for behavior monitoring and wandering. The resident was not identified as pacing in hallways, wandering, door checking, or exit seeking. In addition to monitoring for wandering, it also identified: "Change Wanderguard per manufactures guidelines every evening shift" with a start date of 4/4/2025. This had been signed off from 4/4/25 through 4/30/25 with a check, however, no guidelines were in place to identify specifically what was being completed. Monitor placement and function of wanderguard (placed on left ankle) every shift, effective 4/3/25. Although staff were directed to monitor placement and function of the wanderguard, the TAR lacked direction as to how this was to be done. On 4/30/25 at 12:03 p.m., DON stated staff check the Wanderguard for functioning by taking residents near the exits to see if they alarm.	F 689		

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F 689	Continued From page 52 When questioned in clarification, DON stated she was unsure of the process and would follow up to assure the appropriate information was relayed. On 4/29/25 at 12:14 p.m., registered nurse (RN)-A stated she was unsure what the directions meant to monitor placement and function meant and would clarify with the DON. Upon review of the TAR, it was noted RN-A had signed off on the TAR that this was administered/completed by RN-A on multiple shifts. On 4/30/25 at 12:59 p.m., the corporate maintenance director (CMD) stated facility maintenance (FM) director checked the function of the Wanderguard at the exit doors weekly. A request was made for the manufacturer manual for the process of monitoring the system, and CMD stated this would be provided. CMD stated the nursing staff should be checking the function of the Wanderguards with the use a small monitoring box to assess function. CMD had located the tester and stated this would be kept in the supply closet with the Wanderguard supplies. During interview on 4/30/25 at 1:38 p.m., with RN-C and trained medical assistant (TMA)-B, RN-C stated if the Wanderguard alarmed, the staff were responsible to check the alarm to determine the reason it was triggered. RN-C stated staff were to reference the Elopement at Risk binder to see who had Wanderguards in place. RN-C stated staff were to always to check the residents who had Wanderguards in place if the alarm went off. RN-C was unaware of where the test machine was located. Previously she had not been able to find the device, and stated today was the first she had seen the monitor. RN-C stated some people say if they hear the alarm	F 689		

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F 689	Continued From page 53 beeping when the resident is by the elevator, that is how they are checking it. The TAR was reviewed with RN-C in regards to the directions to change Wanderguards per manufacturer guidelines every night with no further direction. RN-C stated she was unsure of the policy, but stated this was not typically scanned daily. TMA-B stated this was the responsibility of the charge nurse and did not perform the task. Upon review of the document for instruction sheet for application of the Wanderguard in the Elopement at Risk binder, although it indicated to check the function of the Wanderguard, it lacked instruction as to how staff were to check functioning. On 4/30/25 at 1:59 p.m., DON stated the standard orders identified at this time included to check the function of the Wanderguard alarm daily. DON stated staff were to check for placement of the Wanderguard alarm every shift. DON acknowledged the policy in the binder did not reflect this process. When asked about the TAR directions to "change Wanderguard as per manufacturer's instructions", DON had no further information. The facility policy, titled Elopement Policy, last reviewed June of 2023 identified upon admission, each resident was assessed for elopement risk. The policy identified all residents were to be reassessed quarterly, annually, and as needed for significant change. Although the policy directed staff to observe each resident's bracelet alarm brace for placement each shift, it lacked any direction as to when the alarm was to be placed and what guidelines were to be used to determine this. The policy further indicated the	F 689		

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F 689	Continued From page 54 facility was to establish a process to check bracelet alarm/device batteries according to manufacturer's directions, however, it lacked indication as to what that was. The policy further directed staff to document bracelet alarm/device was in place and functioning but lacked direction as to how to verify function. A request was made for the manufacturer manual, and it was not provided. R9 R9's quarterly MDS dated 4/11/25, indicated R9 was alert and oriented and readily able to communicate her needs. The MDS lacked any indication of behavioral concerns. R9 was able to complete activities of daily living (ADL's) independently, with the exception of bathing and toileting needs. R9's medical diagnoses included anemia (low levels of healthy red blood cells to carry oxygen), depression (a mood disorder with symptoms of sadness), chronic obstructive pulmonary disease with acute exacerbation (a persistent respiratory disease that may cause long-term, progressive lung damage), nicotine dependence, and history of cerebral infarction (stroke) without residual deficits (last effects related to the stroke). R9's care plan last revised on 4/24/25, identified R9 currently smoked at this facility. The goal was identified for R9 to continue to smoke safely through the next review date (identified as 7/10/25). The care plan directed staff to educate R9 regarding the potential danger of butane lighters. The care plan identified the resident was deemed to be independent with smoking per smoking evaluation, and had been deemed safe to store/handle their own smoking materiel's. The	F 689		

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F 689	Continued From page 55 care plan directed staff to complete a smoking evaluation per facility policy and as needed (PRN). R9's Quarterly Smoking Assessment dated 4/21/25, identified R9 as a smoker. The assessment identified R9 preferred to smoke morning, afternoon, and evenings. R9 was determined able to light own cigarettes, and was deemed safe to store/handle own cigarette lighter. The assessment identified R9 would store smoking materiel's in her room. The assessment did identify the use of e-cigarettes and identified R9 was safe to use device. The summary and interventions also identified R9 was noted to smoke e-cigarettes and was aware these were not to be used in the facility and must be used in the designated area. The assessment also identified staff were to continue to monitor quarterly and PRN. During initial interview on 4/28/25 at 1:04 p.m., R9 was observed to have two e-cigarettes/vapes sitting on her bedside table. R9 stated she did not use the e-cigarettes, and stated she only used them outside. During conversation, R9 reached over and grabbed a vape and inhaled, releasing smoke stream toward surveyor, as smoke also flowed out of e-cigarette. R9 stated she didn't usually vape in room. R9 stated she kept her own cigarettes locked in the drawer of her bedside stand. During follow up interview on 4/29/25 at 12:33 p.m., R9 was observed resting on her bed. R9 continued to have two e-cigarettes/vapes sitting on her bedside table. R9 stated she only used them outside. When asked about use yesterday, R9 stated that was related to her hip pain, and	F 689		

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F 689	Continued From page 56 stated it was difficult to move her hip to get up and go outside. On 5/01/25 at 10:59 a.m., DON was made aware of R9 using e-cigarette inside facility on 4/28/25. DON stated a smoking assessment had been recently completed. The smoking assessment indicated that R9 was able to safely smoke and manage own supplies. DON stated the smoking policy was also reviewed with R9 at the time the smoking assessment was completed. DON stated she would be removing items from resident and would be following up on the situation. The facility policy, titled Resident Smoking Policy, last reviewed 10/2024, identified it was the the intent of the policy to outline the procedure for safe resident smoking including evaluation of residents for determination of who were capable of smoking independently, and if safe, allowed to smoke in a designated smoking area. The policy identified all smoking devices, including electronic devices, will be lit/used in designated areas only. The policy went on to further identify those residents found not to be in compliance may lose smoking privileges. The policy identified privileges can be re-evaluated upon resident request. R30 R30's quarterly minimum data set (MDS) dated 3/25/25, indicated R30 had moderate cognitive impairment and required extensive assistance with activities of daily living (ADL's), however, R30 was independent with eating after staff set up meal. R30's care plan dated 4/19/24, indicated R30 had	F 689		

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F 689	Continued From page 57 potential for altered nutrition status due to history of malnutrition, dementia, pneumonia and cancer. Interventions included ok for soft bread per facility bread policy, speech therapy to consult as needed and diet as ordered. R30's order summary report report dated 5/1/25, indicated regular diet International Dysphagia Diet Standardization Initiative (IDDSI) level six (soft and bite size food texture modification), thin liquids consistency. OK for soft breads. On 4/28/25 at 1:50 p.m., R30 was observed in the dining room eating, no staff were observed within site of R30. R30 was eating a whole chicken sandwich on a hamburger bun. R30 was observed alone in dining room until 2:05 p.m., when an unidentified staff member entered and sat with resident. On 4/28/25 at 6:05 p.m., R30 was eating a cheese quesidilla cut into quarters, no staff were in the dining room, R30 and two other residents remained in the dining room. At 6:08 p.m., three unidentified staff entered the dining room, one removed a medication cart, two staff assisted two other residents out of the dining room. Director of nursing (DON) entered dining room, remained in view of R30. On 5/01/25 at 9:41 a.m., R30 was eating alone in the dining room, no staff in view. At 9:53 a.m., unidentified staff member entered removed plate from in front of R30. When interviewed on 5/01/25 at 10:57 a.m., therapy program manager stated R30 had a history of pocketing food (holding food in the mouth without swallowing it), history of dysphagia	F 689		

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F 689	Continued From page 58 (difficulty swallowing) and difficulty chewing. R30 was being seen by speech therapy. R30's food should be cut into bite size pieces, R30 should not have a whole chicken sandwich due to difficulty chewing. When interviewed on 5/01/25 at 11:27 a.m., dietary manager (DM) stated IDDSI level six was soft and bite size food, items should be cut into thumbnail size pieces, soft and squishy. R30 should not have been given a whole chicken sandwich. When interviewed on 5/01/25 at 1:31 p.m., trained medication aid (TMA)-A stated R30 was a slow eater, staff should be in the dining room for safety if resident required an altered diet due to risk of choking. When interviewed on 5/01/25 at 2:13 p.m., registered nurse (RN)-A stated someone should be in the dining room at all times when residents were eating for safety. When interviewed on 5/01/25 at 4:00 p.m., director of nursing (DON) stated R30 doesn't chose to leave the dining room, R30 may need to be moved to his room to finish eating. DON then stated upon further thought, R30 cannot be moved to his room, the expectation would be that someone would be there while he is eating. Facility policy Dining Room Supervision dated 8/26/20, indicated the dining room would be supervised while residents were eating.	F 689		
F 698 SS=D	Dialysis CFR(s): 483.25(l)	F 698		6/6/25

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F 698	Continued From page 59 §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to consistently communicate with dialysis department, and follow through on directions for 1 of 1 residents (R141) reviewed for dialysis Findings include: R141 was admitted to the facility on 4/16/25. R141's brief interview for mental status assessment completed on 4/17/25, indicated he was cognitively intact. R141's diagnoses upon admission to the facility included end stage renal (kidney) disease, congestive heart failure, diabetes (a condition where the body has problems with regulating blood glucose (sugar), and post surgical treatment of left foot. A provider visit note of 4/18/25, identified: R141 was admitted following recent hospitalization for surgery to his left foot. The note also identified R141 had been hospitalized for nausea and vomiting after dialysis, with hypotension (low blood pressure) during dialysis, dark stools requiring EGD (a scope to view digestive system) (showing gastroparesis), and mild hypoglycemia (low blood sugars). R141's 48-hour care plan, completed 4/16/25, indicated R141 received a diabetic diet. It also identified R141 was at risk for complications to	F 698	Submission of this Response and Plan of Correction is not a legal admission that a deficiency exists or that this Statement of Deficiency was correctly cited and is also not to be construed as an admission of fault by the facility, the Administrator or any employees, agents or other individuals who draft or may be discussed in this Response and Plan of Correction. In addition, preparation and submission of this Plan of Correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in the allegations. Accordingly, the Facility has prepared and submitted this Plan of Correction prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission of a Plan of Correction within ten (10) days of the survey as a condition to participate in Title 18 and Title 19 programs. This Plan of Correction is submitted as the facilitys credible allegation of compliance. F698 s/s D -The process for satisfying this requirement has been reviewed and	

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F 698	Continued From page 60 dialysis. The care plan directed staff to send communication folder to dialysis with each run. R141 was scheduled for hemodialysis on Monday, Wednesday, and Friday. During interview on 4/29/25 at 11:20 a.m., R141 stated stated he had been receiving dialysis for approximately two years. R141 stated his fistula (site used to complete dialysis process) was on his left arm. R141 requested interview be complete as had many concerns to deal with. On 4/29/25 at 11:36 a.m., no dialysis binder for R141 was noted at nurses' station. On 4/29/25 at 3:39 p.m., registered nurse (RN)-B stated dialysis information was reviewed upon the resident's return to the facility following dialysis. He stated if there were follow up, that would be reviewed/implemented. Once this was completed, it was placed in the bin for processing by the Health Information Manager (HIM). During interview on 4/29/25 at 4:25 p.m., HIM stated the facility process included use of a Dialysis Center Communication Record. This document was sent with resident to dialysis and the staff would provide information prior to leaving for dialysis, and then review the information upon return. The current process was to send this information in an envelope and review upon it's return. A request was made for all of the documents since R141's admission 4/16/25. On 4/30/25 at 8:50 a.m., information provided by HIM, The Dialysis Center Communication Record was provided from 4/21/25, 4/23/25, and 4/25/25. Although the HIM provided the information faxed from the Dialysis Center from the runs of 4/18/25	F 698	revised as needed, to ensure there is consistent communication with the Dialysis center and follow through on directions. - All residents residing in the facility who received dialysis services have the potential to be affected if this requirement is not met. - The plan of care for R141 was reviewed and revised as needed to ensure there was no harm or lasting effects. - All alike residents were reviewed for similar concerns and no further non-compliance was identified. - The facility will follow the agreement with the Dialysis center to ensure communication and collaboration. -Staff have been re-educated to the requirement and need to review the dialysis communication form upon return from the dialysis center. Completed utilizing Monarch Healthcare Management dialysis record form. - Audits will be completed three (3) times per week for two (2) weeks; two (2) times per week for two (2) weeks; one (1) time per week for one (1) week; and monthly thereafter for one (1) month. Audit results will be reviewed at QAPI, with any deficient practice corrected at the time of occurrence. - Director of Nursing or designee is responsible party. -Corrective action will be completed on or before 6/6/25.	

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F 698	Continued From page 61 and 4/28/25, the Dialysis Center Communication Record was not available. HIM stated the information had not been returned to the facility from the family members who assisted with transport. A review of the Dialysis Center Communication Record from 4/21/25, indicated the following information under the New Order/Changes to orders: Please give the pt (patient) his morning Midodrine one hour before Dialysis. Midodrine is used to treat low blood pressure (hypotension). A review of the Dialysis Center Communication Record from 4/25/25, indicated resident's Dialysis run (length of time the process was completed) was cut due to late arrival and low blood pressure (76/40). A review of R141's April 2025 medication administration record (MAR) indicated orders in place for the following: Midodrine HCL oral tablet. Give one tablet by mouth every Monday, Wednesday, and Friday related to end stage renal disease. The directions stated to give prior to dialysis, however, did not specify a time frame. The Communication Record clearly stated one hour before Dialysis. In addition to the lack of clear directions, the time frame identified in the MAR only indicated AM, which is a window of time when the morning medications can be given. On 4/30/25 at 10:22 a.m., RN-C stated R141 was to receive the Midodrine on the days he received Dialysis. RN-C stated on the days he goes to Dialysis, he leaves at 11:00 a.m., and that is the time they would give it. Upon review of the time of administration being AM versus a specific time, RN-C stated that may have been confusing as	F 698		

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F 698	Continued From page 62 trained medical assistant (TMA) and they were the ones who gave the morning medications. RN-C stated the time of the medication administration needed to be changed to more clearly reflect when it was to be given. On 4/30/25, at 1:09 p.m. a call was placed to the Dialysis Center to inquired or orders for Midodrine. Upon speaking with Dialysis Clinical Manager (DCM), she verified the Midodrine was to have been given one hour before Dialysis. DCM stated the medication needed to be administered between one half to one hour prior to Dialysis because that is how long it takes to be effective. DCM stated R141 had informed him the facility had been giving it with his breakfast and that would not be effective. The Midodrine should be given just as R141 left for Dialysis. During interview on 4/30/25 at 1:30 p.m., TMA-A stated upon review of the MAR for R141, and the order for Midodrine TMA-A would probably send it with him, depending what time he goes. It just says give prior to Dialysis in this order. TMA then went on to stated she would ask her nurse on duty that day. During interview on 5/01/25 at 10:53 a.m., the director of nursing stated the time for medications assigned to be given "AM" allowed the medications to be given between 5:30 a.m. and 10:00 a.m. DON stated the order should have been more concise to clearly reflect when the medication should be given, as one hour before Dialysis did not correlate with the administration to be given "AM" as that was time frame of 5:30 a.m. to 10:00 a.m. DON stated upon review of the Dialysis Communication Record, the receiving nurse should sign off as having reviewed and	F 698		

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F 698	Continued From page 63 processed any orders, and indicated "1st." A second nurse should then review and indicate "2nd." This should be completed before the information is processed by HIM. A request was made for the policies related to communications with Dialysis, and no additional policy was received outside of the undated Dialysis Center Communication Record document. A review was made of the Long Term Care Facility Outpatient Dialysis Services Care Coordination Agreement, signed 12/5/24. Within this document, listed under Obligations of Operator's Long Term Care Facility, it identified under Preparation of Residents: Long Term Care Facility shall ensure that each Resident is prepared to spend the extended length of time at Dialysis Facility, as necessary for the administration of Resident's prescribed treatment, and has received proper nourishment and any necessary medications before arriving at the Dialysis Facility.	F 698		
F 740 SS=D	Behavioral Health Services CFR(s): 483.40 §483.40 Behavioral health services. Each resident must receive and the facility must provide the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Behavioral health encompasses a resident's whole emotional and mental well-being, which includes, but is not limited to, the prevention and treatment of mental and substance use disorders.	F 740		6/6/25

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F 740	Continued From page 64 This REQUIREMENT is not met as evidenced by: Based on observations, interviews and document review, the facility failed to ensure resident medical social services were provided for 2 of 2 residents (R8 and R14) whose room odors permeated the surrounding halls. This had the potential to affect residents in surrounding rooms, visitors and facility staff. Findings include: R8 In review of R8's Diagnosis Report (print date 4/30/25) documented the diagnoses of morbid obesity with alveolar hyperventilation (a condition where the lungs don't move enough air in and out, leading to a buildup of carbon dioxide (hypercapnia) and a decrease in oxygen levels in the blood, and type 2 diabetes. R8's 5-day minimum data set (MDS - post hospitalization), dated 2/12/25, indicated R8 was independent with self cares, requiring partial/moderate assistance with toileting and substantial/maximal assistance with showering/bath. In review of R8's Brief Interview for Mental Status (BIMS), resident was assessed to be cognitively intact. During screening interview on 4/28/25 at 2:12 p.m., there was a distinct urine and other odors to R8's room, however, R8 stated it was due to being toileted after an incontinent bowel movement. R8 stated the only concern he had at the time was having to wait 10-15 minutes to have his call light answered. On 4/29/25 at approximately 9:30 a.m., noted a	F 740	Submission of this Response and Plan of Correction is not a legal admission that a deficiency exists or that this Statement of Deficiency was correctly cited and is also not to be construed as an admission of fault by the facility, the Administrator or any employees, agents or other individuals who draft or may be discussed in this Response and Plan of Correction. In addition, preparation and submission of this Plan of Correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in the allegations. Accordingly, the Facility has prepared and submitted this Plan of Correction prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission of a Plan of Correction within ten (10) days of the survey as a condition to participate in Title 18 and Title 19 programs. This Plan of Correction is submitted as the facility's credible allegation of compliance. F740 s/s D -The process for satisfying this requirement has been reviewed and revised as needed, to ensure medical social services are provided to residents whose odors affect surrounding areas. -All residents and visitors of the facility can potentially be affected if this requirement is not met. -R8 and R14 have been offered	

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F 740	Continued From page 65 strong almost necrotic odor (a foul-smelling odor that often arises from the breakdown of dead tissue and bacterial activity within the wound) emanating from R8's room. R8 was noted to be sitting in his wheel chair, reading papers on his tray table. R8 was asked about the odor, to which he stated he had not yet done his morning cares. Throughout the day of 4/29/25, the strong odor continued to be noted when passing R8's room. In review of R8's assessment, entitled: Target Behavior Form - V5 (dated 3/26/25) documented the following: IDT (interdisciplinary team) Review of behavior in the past quarter "refusal of treatments, refusal of cares, scooting around facility in wheelchair without shoes, Inappropriate/Rude Comments, & Gestured Communication" In the section of the assessment of "Potential causes or identified patterns related to behavior", documented "resident may feel shame related to care support from staff, unaccepting of change. Under the assessment section of "Recommendations" document: "Non-Pharm Recommendations: Redirection, 2: Ambulate, 3: Offer Activity, 4: offer refused cares several times, 5: Reposition, 6: Toileting, 7: Provide 1:1 [one to one visits], 8: Offer food/fluids, 9: Offer pain relief" as well as "Pharmacy Recommendations: Administer medications/treatments as ordered" In review of R8's care plan - "Psychosocial Well-Being" (last revised 1/28/25) documented: "Resident is at risk for alteration in psychosocial well-being related to adjustment to placement...". Social services documented the interventions of "1. will monitor safety concerns and evaluate [as	F 740	psychiatric services and referred to both the Ombudsmans office and Polaris Pharmacy for medication review. -Odor originating from R8 and R14 has been addressed by both facility nursing staff and environmental services. -All Yona Healthcare employees have been reeducated to the requirement using Yona Healthcare Policy and Procedure. -All staff have been educated to the requirement using Monarch Healthcare policy and procedure on ADL care . -Nursing staff and Yona Healthcare employees are trained and expected to address odors, in order to promote a clean and homelike environment for all occupants of the facility. -Monitoring to assure compliance will include, but is not limited to, audits completed three (3) times per week for two (2) weeks; two (2) times per week for four (4) weeks; and monthly thereafter for one (1) month. Audit results will be reviewed at QAPI. Any deficient practice will be identified and corrected at the time of occurrence. -Environmental Services Director, Director of Nursing, and/or designee is responsible party. -Corrective action will be completed on or before 6/6/25.	

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F 740	Continued From page 66 needed]: smoking, elopement, suicide risk, etc.., 2. will monitor and respond to unmet needs, and 3. will monitor mood state, refer [as needed]." In further review of R8's care plan - "Vulnerable Adult" (last reviewed 1/28/25) documented: "Resident is categorically a vulnerable adult while resident resides in a Skilled Nursing Facility. Resident is at risk for decreased cognition and physical abilities...". The interventions included, "Monitor for signs of emotional distress or mood and behavior changes." A review of the social services progress notes, from admission on 7/17/24, through 4/29/25, lacked evidence the social worker was either aware of R8's care needs or failed to document and/or address the odor matter. During interview on 4/30/25 at 1:02 p.m., the corporate licensed social worker (CLSW) and covering licensed social worker (LSW)-A stated the facility currently does not have a LSW or a LSW designee currently, and between the two of them, they have been filling the social worker needs of the residents residing in the facility. CLSW stated she had spoken with R8 yesterday about the odor. R8 told her he doesn't want women helping him, and the facility currently doesn't have male nursing assistants. R8 told her once he is out of here he will clean himself better. Services through Associated Clinic of Psychology (ACP) were offered yesterday after this was brought to her attention. However R8 declined. No further interventions were documented by the social service department. R14	F 740		

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F 740	Continued From page 67 In review of R14's Diagnosis Report (print date 4/30/25) documented the diagnoses of Neuromuscular dysfunction of bladder, lumbar spina bifida with hydrocephalus (a birth defect where the spine and spinal cord don't close completely, is often associated with hydrocephalus, a condition where excess fluid accumulates in the brain) and morbid obesity. R14's significant change minimum data set (MDS), dated 3/25/25, indicated R14 was cognitively intact and required supervision and touch assistance with verbal cueing for all activities of daily living (ADLs). On 4/28/24 at 1: 00 p.m., outside R14's room, a strong odor of urine was noted. It also emanated from R14's room. It was also noted the door to R14's room was closed. The odor could be noted into the adjacent dayroom and within approximately 6 feet of the joining hall of rooms. On 4/28/25 at 1:13 p.m., After entering R14's room, the odor of urine became even more apparent. Inside the room, R14 was laying on her bed. Against the window was was a bariatic commode, the curtains were all pulled and lights were out. While being interviewed, R14 was asked about the odor in the room. R14 stated the odor in the room is from her, and stated she did not notice it, "I have the scent sticks that cover and absorb." R14 stated housekeeping cleans her room at least weekly, adding she did not like to be disturbed. R14 stated she was working on writing fantasy series of books and needed to concentrate. R14 stated she toileted herself, only asking staff to assist when she was tired. In review of R14's assessment, entitled: Target	F 740		

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F 740	Continued From page 68 Behavior Form - V5 (dated 11/11/24) the following was documented: - "Resident will refuse to get out of be when needing the [bathroom] and will soil the bed through her brief and ask for bed changes when it starts bothering her. She also declines any assistance with shaving her face as it : doesn't bother" her." - Under the section of "Potential causes or identified patterns related to behavior" documented "Adjustment to new and temporary placement and this time of the year may cause mood or behavior concerns but also may be her baseline." - Under the section of "Non-Pharm Recommendations documented "continue to support residents, listen to any concerns and feelings and provide activities / socialization. Continue to encourage resident to get out of bed during the day." In review of R14's care plan - "Mood and Behavior" (last revised 9/10/24) documented: "Resident is at risk for [alterations] in mood and behavior related to adjustment to placement...resident will refuse to get out of bed when needing the [bathroom] and also declines any assistance shaving." Interventions include: "1. MDS section [depression / PHQ-9 (an assessment used to determine issues of depression) will be conducted per regulations and [as needed], 2. monitor and document mood state/behaviors upon occurrence, 3. redirect [as needed], and 4. provide emotional support, validation and comfort measure [as needed]."	F 740		

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F 740	Continued From page 69 In review of the social services progress notes, from admission on 9/05/24, through the last noted dated 3/25/25, notes lacked evidence the social worker was either aware of R14's care needs or failed to document and/or address the odor matter. A review of R14's care conference form (3/28/2025 IDT (Interdisciplinary Team) Care Conference Form V-5), a quarterly care conference, documented no mention of strong urine odors, only that R14 would be offered baths twice a week. During interview on 4/30/25 at 1:02 p.m., the corporate licensed social worker (CLSW) and covering licensed social worker (LSW)-A stated the facility currently did not have a LSW or a LSW designee currently, and between the two of them, they had been filling the social worker needs of the residents residing in the facility. CLSW stated, after review of R14's chart, R14 had previously declined referral to ACP. No further interventions were documented by the social service department. The Facility's "Facility Assessment" (last updated 7/22/24), indicated the ability to care for "Psychiatric/Mood Disorders", which included "psychosis (hallucinations, delusions, etc.), impaired cognition, mental disorder, depression, bipolar disorder (i.e., mania, depression, schizophrenia, post-traumatic stress disorder, anxiety disorder, behavior that needs interventions, failure to thrive, personality disorder." Policies for social services assessment and intervention for resident behavior and	F 740		

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F 740	Continued From page 70 management was requested, however not received.	F 740		
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported;	F 880		6/6/25

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F 880	Continued From page 71 (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to perform hand hygiene and change gloves appropriately for 1 of 1 residents (R2) observed for personal cares. In addition, the facility failed to develop a trending and tracking program system for monitoring residents who showed signs of illness, but were	F 880	Submission of this Response and Plan of Correction is not a legal admission that a deficiency exists or that this Statement of Deficiency was correctly cited and is also not to be construed as an admission of fault by the facility, the Administrator or any employees, agents or other	

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F 880	Continued From page 72 not on an antibiotic, these practices had the potential to affect all 37 residents currently residing in the facility. Findings Include: R2's 3/21/25, significant change Minimum Data Set (MDS) identified her cognition was severely impaired, and she was dependent on staff for activities of daily living (ADL)s. R2 had diagnoses of anemia (low levels of red blood cells (which carry oxygen to the tissues) which causes weakness and fatigue), hypertension (high blood pressure), arthritis (inflammation of the joints), neuropathy (nerve pain which can lead to pain, weakness, or numbness), and urinary retention. R2's care plan initiated 2/24/25, identified R2 had enhanced barrier precautions (EBP) in place due to use of an indwelling catheter. Enhanced barrier precautions was a risk-based approach to personal protective equipment (PPE) use designed to reduce the spread of multi-drug-resistant organisms (MDROs-super bugs which were difficult to treat with antibiotics) which involved the use of gown and gloves during high-contact resident care activities for residents at high risk of colonization with an MDRO. The care plan directed staff to follow the EBP and to don/doff (apply and remove) PPE per EBP when providing high contact cares. The care plan directed staff to perform peri-cares every morning, evening, and as needed. The staff were directed to perform Foley catheter care per policy. R2's care plan also identified R2 had self-care deficit due to weakness and directed staff to provide assistance of one with dressing and personal hygiene.	F 880	individuals who draft or may be discussed in this Response and Plan of Correction. In addition, preparation and submission of this Plan of Correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in the allegations. Accordingly, the Facility has prepared and submitted this Plan of Correction prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission of a Plan of Correction within ten (10) days of the survey as a condition to participate in Title 18 and Title 19 programs. This Plan of Correction is submitted as the facility's credible allegation of compliance. F880 s/s F -The process for satisfying this requirement has been reviewed and revised as needed, to ensure staff use proper hand hygiene during nursing cares and establish a tracking program for monitoring residents who show signs of illness but were not on an antibiotic. -Residents residing in this facility who have care provided by nursing staff have the potential to be affected if proper hand hygiene and a tracking program for monitoring illness of those not on an antibiotic is not performed. -R2 has been assessed without any ill side effects to the non-compliance. -All staff have received re-education on appropriate hand hygiene practice utilizing the Monarch Healthcare Management	

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F 880	Continued From page 73 On 4/30/25 at 7:32 a.m., R2 was observed resting on her bed, with head of the bed elevated 30 degree angle. Resident was observed to be in bed clothes, under covers, and was awake at this time. On 4/30/25 at 7:40 a.m., certified nursing assistant (CNA)-A greeted R2 from the door way, performed hand hygiene with alcohol based rub, and placed gown and gloves prior to entering the room. After gathering R2's clothing, towels and washcloths, CNA-A proceeded with personal cares. CNA-A removed the blanket from R2 and proceeded to place R2's pants on. CNA-A ran the catheter bag and tubing through the pants leg, and placed the catheter bag on the bed. CNA-A removed R2's gown and proceeded to wash R2's underarms, and then proceeded to wash under R2's breasts. After R2 was washed, CNA-A proceeded to apply powder under R2's breasts, and deodorant on under R2's arms. R2 was then dressed in a t-shirt. CNA-A proceeded to remove brief and completed pericare, with the use of a fresh washcloth. CNA-A completed catheter care by wiping down catheter tubing from meatus (opening of the urinary system) down the catheter tube. Following completion of pericares and catheter cares, R2 was assisted to reposition to replace the incontinence brief. Once brief was placed, CNA-A reached into her pocket to use her walkie talkie to summon assistance. Of note, during the observation of personal cares, initial gloves have not been removed, nor was hand hygiene performed. CNA-A's walkie talkie was returned to uniform pocket, behind gown, and CNA-A continued with cares. CNA-A was unsure if anyone heard request for assistance, stepped over to door, and opened door, looked down hallways, closed door and returned to cares. At	F 880	policy on Hand Hygiene. -All nursing staff have received education on the need to monitor and track infections for all residents utilizing the Monarch Healthcare Management policy on Infection Prevention. -Monitoring to assure compliance will include, but is not limited to, audits completed three (3) times per week for two (2) weeks; two (2) times per week for four (4) weeks; and monthly thereafter for one (1) month. Audit results will be reviewed at QAPI. Any deficient practice will be identified and corrected at the time of occurrence. -Director of Nursing or designee is responsible party. -Corrective action will be completed on or before 6/6/25.	

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F 880	Continued From page 74 this time, original gloves remain and hand hygiene had not been performed. While waiting for assist of staff, CNA-A proceed to wash R2's face with a fresh washcloth, taking care to wash from the inner corner of the eye outward. While providing care, CNA-A noted R2's mouth was very dry. While waiting for assistance, CNA-A proceeded to straighten up the room. CNA-A noted skin protector on bedside table, commented it was hers, and placed back in her pocket, moving gown aside. At this time, original gloves remain in place and no hand hygiene has been performed. At 7:59 a.m., CNA-D arrived to assist. Once hand hygiene was performed, gown and gloves applied, R2 was turned to complete pulling up of pants, and place sling for transfer. R2 was assisted by two staff to transfer into her chair with the use of a mechanical lift and sling. Once transfer was completed, CNA-D removed gown and gloves, performed hand hygiene and left the room. Resident was adjusted in chair so she was well supported. CNA-A proceeded to make R2's bed, and then provided a blanket to R2's lap. CNA-A continued to have initial gloves in place, with no hand hygiene performed. CNA-A proceeded to comb R2's hair. CNA-A then performed oral hygiene with toothbrush and toothpaste. R2 was provided a small amount of water to rinse mouth and stated teeth felt better once brushed. CNA-A proceed to remove original gown and gloves. CNA-A then placed portable liquid oxygen on the chair, and placed the nasal cannula into nostrils. CNA-A performed hand hygiene upon exit of room, using an alcohol based rub. During interview on 4/30/25 at 8:14 a.m., with CNA-A stated that she used gloves with personal cares. CNA-A was aware of the use of gown and	F 880		

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F 880	Continued From page 75 gloves for EBP with R2. Gloves were placed upon entrance to each room for provision of cares. CNA-A stated when providing cares, she did change gloves throughout cares if they became visibly soiled, and stated "if there was poop on them. Then I change them." CNA-A confirmed she did not change gloves throughout the provision of cares with R2. During interview of 4/30/25 at 3:46 p.m., the director of nursing (DON) stated staff were to perform hand hygiene prior to entering all rooms. DON expected staff to assist residents with personal hygiene by going from the cleanest to the dirtiest areas. DON stated if for some reason the staff needed to perform more personal cares before completing more "clean" cares, staff were to remove gloves, perform hand hygiene, and place new gloves. DON stated it was her expectation to perform hand hygiene as outlined, even if gloves were not visibly soiled. On 5/1/25 at 9:14 a.m., registered nurse (RN)-A stated hand hygiene was to be completed before and after providing care to any resident. RN-A stated hand hygiene was to be performed with any cares and identified hand hygiene should be completed before entering any room. RN-A stated the order of the bed bath performed was for the staff to start with the face first, and make your way down to the arms, stomach, legs, and finishing with peri area. RN-A stated gloves should be changed following pericare, and hand hygiene performed before going to any other areas of care. Policies were requested for performance of bedbaths, and completion of hand hygiene with cares, but not received.	F 880		

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F 880	Continued From page 76 Infection Control: The facilities infection control logs were reviewed from January 2025 through March 2025. April 2025 infection control log was requested; however, this was not provided. The facility provided documents with the month and year written along the top of the first page. The headings on the document included; unit, name, room number, admit date, infection present on admission (yes or no), existing infection from previous month (yes or no), infection type, body system of infection, diagnosis, surveillance definition (yes or no), symptoms, onset date, device type(s), date(s) of insertion, date(s) of removal, device days, infection risk factors, diagnostic test performed (yes or no), test date, type of test, specimen source, results (organism colony count for urine), antibiotic resistant organism (yes or no), antibiotic name, class, other medications not listed, dose, route, frequency, provider, antimicrobial prescription origin, antibiotic start date, antibiotic end date, total days of therapy, meets criteria (yes or no), antibiotic reassessment performed, other antimicrobial prescribed name, other antimicrobial's prescribed class, transition based precautions required (yes or no) if yes specify, and date symptoms resolved. January 2025 infection log identified six-line entries for resident infections carried over from December 2024. There were 22 entries of infections during the month of January. Seven-line entries addressed respiratory tract infections which were treated with antibiotic	F 880		

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F 880	Continued From page 77 therapy, with two lines contributed to one resident. Eight-line entries addressed urinary tract infections (UTI) which were treated with antibiotic therapy, with two residents having had two-line entries each. Four-line entries addressed skin infections which were treated with antibiotic therapy with two entries contributed to one resident. One-line entry addressed gastrointestinal (GI) which was treated with antibiotic therapy. One-line entry addressed eye infection treated with antibiotic therapy, and one-line entry addressed shingles treated with antibiotic therapy. There were no viral, fungal, yeast or viral illnesses identified, only illnesses that were treated with antibiotics. February 2025 infection log identified 30-line entries for the month. Ten-line entries addressed UTI treated with antibiotic therapy, with two residents that contributed to two lines each. Twelve-line entries addressed respiratory illness treated with antibiotic therapy, of which two residents contributed to three entries each and two residents contributed to two entries each. Four-line entries were contributed to one resident treated with antibiotic therapy for graft versus host disease. four-line entries addressed cellulitis (bacterial infection of the skin and underlying tissues) treated with antibiotic therapy. There were no viral, fungal, yeast or viral illnesses identified, only illnesses that were treated with antibiotics. March 2025 infection log identified four-line entries carried over from February 2025. thirteen lines were entered for March infections. One-line entry identified the infection type of prophylaxis antibiotic (preventative). Three-line entries addressed skin treated with antibiotic therapy,	F 880		

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F 880	Continued From page 78 with two entries contributed to one resident. Two-line entries addressed GI treated with antibiotic therapy. Two-line entries addressed respiratory treated with antibiotic therapy, both contributed to one resident. Four-line entries addressed UTI treated with antibiotic therapy. One entry addressed hepatic encephalopathy (brain dysfunction caused by liver dysfunction) treated with antibiotic therapy. There were no viral, fungal, yeast illnesses identified, only illnesses that were treated with antibiotics. However, the facility did complete a Minnesota Department of Health (MDH) line listing for norovirus (very contagious virus that causes vomiting and diarrhea) outbreak that affected 29 residents. When interviewed on 4/30/25 at 3:40 p.m., director of nursing/infection preventionist (DON) stated resident infections and symptom tracking were completed on clinical DON update for morning meeting on weekdays with Mondays looking at the past weekend. There was no spreadsheet or log of symptom tracking for potential infections that did not require antibiotic therapy. Infection log was completed as infections were identified with a full review at the end of the month. On 5/01/25 at 8:13 a.m., DON provided clinical DON update before morning meeting for April 2025. Pages identified date with table for infections with headings of Resident, infection type, antibiotic, dates of treatment, MeGeers (a set of definitions used to identify and track healthcare-associated infections in long-term care facilities) and 72-hour antibiotic time out, added to infection tracking, and follow up. Review identified three residents with UTI treated with	F 880		

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	245459	A. BUILDING _____ B. WING _____	C 05/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GARDENS AT WINSTED LLC	551 FOURTH STREET NORTH WINSTED, MN 55395

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F 880	Continued From page 79 antibiotic therapy, one resident with cellulitis treated with antibiotic therapy. One resident with a nail infection treated with antibiotic therapy, and one resident with osteomyelitis (bone infection) treated with antibiotic therapy. No infections listed indicated they were added to infection tracking log. There was no April 2025 infection tracking log provided. There were no viral, fungal, yeast or viral illnesses identified, only illnesses that were treated with antibiotics. Facility Infection Prevention and Control Program policy dated 11/6/24, indicated surveillance tools were used to recognize the occurrence of infections, detected unusual pathogens with infection control implications. Data gathered during surveillance was used to oversee infections and spot trends. However, the policy did not address tracking symptoms and/or illnesses that did not require antibiotic therapy.	F 880		
F 883 SS=D	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and	F 883		6/6/25

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F 883	Continued From page 80 (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by:	F 883		

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F 883	Continued From page 81 Based on interview and document review, the facility failed to ensure 1 of 5 residents (R5) reviewed for immunizations were offered and/or provided the pneumococcal vaccine series as recommended by the Centers for Disease Control (CDC) to help reduce the risk of associated infection(s). Findings include: A CDC Pneumococcal Vaccine Timing for Adults feature, dated 10/24, identified various tables when each (or all) of the pneumococcal vaccinations should be obtained. This identified when an adult over 50 years old had received the complete series (i.e., PPSV23 and PCV13; see below) then the patient and provider may choose to administer Pneumococcal 20-valent Conjugate Vaccine (PCV20) for patients who had received Pneumococcal 13-valent Conjugate Vaccine (PCV13) at any age and Pneumococcal Polysaccharide Vaccine 23 (PPSV23) at or after 50 years old. R5's face sheet dated 5/1/25, indicated she was 79 years old. The immunization record dated 5/1/25, indicated R5 received the following pneumococcal vaccinations: PPSV23 on 10/25/19, she also received a PCV13 on 6/1/16. R5's electronic medical record (EMR) indicated an order dated 1/30/25 to administer PCV20, however, review of R5's medication administration record (MAR) lacked evidence of R5 being administered PCV20. Physician visit record shared clinical decision-making dated 4/3/25 indicated R5's provider recommended R5 to be administered PCV 21, however, R5's MAR failed to indicate R5 was administered PCV 21.	F 883	Submission of this Response and Plan of Correction is not a legal admission that a deficiency exists or that this Statement of Deficiency was correctly cited and is also not to be construed as an admission of fault by the facility, the Administrator or any employees, agents or other individuals who draft or may be discussed in this Response and Plan of Correction. In addition, preparation and submission of this Plan of Correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in the allegations. Accordingly, the Facility has prepared and submitted this Plan of Correction prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission of a Plan of Correction within ten (10) days of the survey as a condition to participate in Title 18 and Title 19 programs. This Plan of Correction is submitted as the facilitys credible allegation of compliance. F883 s/s D -The process for satisfying this requirement has been reviewed and revised as needed, to ensure residents are provided and offered the pneumococcal vaccine series as recommended by the CDC. -Unvaccinated residents have the potential to be affected if this regulation is not met. -R5’s was provided the pneumococcal vaccine.	

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F 883	Continued From page 82 When interviewed on 4/30/25 at 3:46 p.m., director of nursing/infection preventionist (DON/IP) stated "we need to administer that one". Consents were redone this month, the immunization was ordered and has been delivered but was not given. facility Pneumococcal Policy dated 1/24 indicated Consent will be obtains and the pneumococcal vaccination will be administer per physician order and will be documented in the residents medical record.	F 883	- All alike residents were reviewed for similar concerns and no further non-compliance was identified. -Future vaccine series will be offered as required, in accordance with recommendations by the CDC. -All necessary staff received education regarding the requirement to offer all residents the pneumococcal vaccine series in accordance with CDC recommendations. -Compliance audits will be completed three (3) times weekly for two (2) weeks, two (2) times weekly for two (2) weeks, one (1) time weekly for two (2) weeks, and monthly thereafter for one (1) month. Audit results will be reviewed at QAPI. Any deficient practice will be identified and corrected at the time of occurrence. -Director of Nursing or designee is responsible party. -Corrective action will be completed on or before 06/06/2025.	

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

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 04/30/2025. At the time of this survey, The Gardens At Winsted was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		05/23/2025

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 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.

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K 000	Continued From page 1 Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. The Gardens at Winsted consists of the original 1960 building. It is two-stories in height, has no basement, is fully fire sprinkler protected, and was determined to be of Type I(332) construction. In 2011, an addition was added and is a one-story in height, has no basement, is fully fire sprinkler protected, and was determined to be of Type II(111) construction. The facility has a fire alarm system with full corridor smoke detection and spaces open to the corridors that is monitored for automatic fire department notification.	K 000		

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K 000	Continued From page 2 The facility has a capacity of 65 beds and had a census of 36 at the time of the survey. The requirements at 42 CFR, Subpart 483.70(a), are NOT MET as evidenced by:	K 000		
K 321 SS=F	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322)	K 321		6/6/25

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K 321	Continued From page 3 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain hazardous area enclosures per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.2.1, 19.3.2.1.3, and 19.3.6.3.5. These deficient findings could have a patterned impact on the residents within the facility. Findings include: 1. On 04/30/2025 between 8:45 and 11:15 AM, it was revealed by observation that following rooms were being used to store combustible items and did not have a self-closing device on the door: Room 100, and Room 112. 2. On 04/30/2025 between 8:45 and 11:15 AM, it was revealed by observation that the door to the Level 1 Utility Room did not latch when closed. 3. On 04/30/2025 between 8:45 and 11:15 AM, it was revealed by observation that the door for the medical gas supply room in the 200 wing by rooms 216 and 218 did not latch when closed using the self-closing device. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 321	Submission of this Response and Plan of Correction is not a legal admission that a deficiency exists or that this Statement of Deficiency was correctly cited and is also not to be construed as an admission of fault by the facility, the Administrator or any employees, agents or other individuals who draft or may be discussed in this Response and Plan of Correction. In addition, preparation and submission of this Plan of Correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in the allegations. Accordingly, the Facility has prepared and submitted this Plan of Correction prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission of a Plan of Correction within ten (10) days of the survey as a condition to participate in Title 18 and Title 19 programs. This Plan of Correction is submitted as the facility's credible allegation of compliance. K321 s/s F -During the walk-through it was observed that there were three rooms being utilized on the first floor to store combustibles without automatic door closers on the doors. It was also noted that one utility room door did not close and latch. -In the event of an emergency, occupants of this compartment may have the potential to be affected if this regulation is	

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K 321	Continued From page 4	K 321	not met. -Maintenance Supervisor has been re-educated to the requirement utilizing this regulation. -Maintenance Supervisor removed the combustible materials and corrected the door that did not latch appropriately. -Audits will be completed weekly for four (4) weeks, and monthly thereafter for two (2) months. Any deficient practice will be immediately corrected, and results will be reported to QAPI. -Maintenance Director or Designee is responsible party -Corrective action will be completed on or before 6/6/25.	
K 351 SS=E	Sprinkler System - Installation CFR(s): NFPA 101 Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1)	K 351		6/6/25

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K 351	Continued From page 5 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to install fire sprinkler systems per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.5.1, and 9.7.1.1(1), and NFPA 13 (2010 edition), Standard for the Installation of Sprinkler Systems, section 7.2.6.2.1. These deficient findings could have a widespread impact on residents within the facility. Findings include: On 04/30/2025 between 8:45 and 11:15 AM, it was revealed by observation that the two air compressors for the two dry pipe sprinkler systems in the building were wired to a switch that was not locked in the "ON" position preventing the power from being turned off to the air compressors. An interview with the Maintenance Director verified these deficient findings at the time of discovery.	K 351	Submission of this Response and Plan of Correction is not a legal admission that a deficiency exists or that this Statement of Deficiency was correctly cited and is also not to be construed as an admission of fault by the facility, the Administrator or any employees, agents or other individuals who draft or may be discussed in this Response and Plan of Correction. In addition, preparation and submission of this Plan of Correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in the allegations. Accordingly, the Facility has prepared and submitted this Plan of Correction prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission of a Plan of Correction within ten (10) days of the survey as a condition to participate in Title 18 and Title 19 programs. This Plan of Correction is submitted as the facility's credible allegation of compliance. K351 s/s E -During the walk-through it was observed that there were two air compressors for two dry pipe sprinkler systems wired to a switch that was not locked in the "on" position. -In the event of an emergency, occupants of this compartment may have the potential to be affected if this regulation is not met.	

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K 351	Continued From page 6	K 351	-Maintenance Supervisor has been re-educated to the requirement utilizing this regulation. -Maintenance Supervisor applied a lock to the switch so it cannot be switched to the “off” position. -Audits will be completed weekly for four (4) weeks, and monthly thereafter for two (2) months. Any deficient practice will be immediately corrected, and results will be reported to QAPI. -Maintenance Director or Designee is responsible party -Corrective action will be completed on or before 6/6/25.	
K 353 SS=D	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced	K 353		6/6/25

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THE GARDENS AT WINSTED LLC	**551 FOURTH STREET NORTH** **WINSTED, MN 55395**

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K 353	Continued From page 7 by: Based on observation and staff interview, the facility failed to inspect and maintain the fire sprinkler system per NFPA 101 (2012 edition), Life Saftey Code, section 9.7.5, and NFPA 25 (2011 edition), Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, section 5.2.2.2. These deficient findings could have a patterned impact on residents within the facility. Findings include: On 04/30/2025 between 8:45 and 11:15 AM, it was revealed by observation that there were wires resting on top of the sprinkler pipe in the Lower Level Phone Room and Pump Room. An interview with the Maintenance Director verified these deficient findings at the time of discovery.	K 353	Submission of this Response and Plan of Correction is not a legal admission that a deficiency exists or that this Statement of Deficiency was correctly cited and is also not to be construed as an admission of fault by the facility, the Administrator or any employees, agents or other individuals who draft or may be discussed in this Response and Plan of Correction. In addition, preparation and submission of this Plan of Correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in the allegations. Accordingly, the Facility has prepared and submitted this Plan of Correction prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission of a Plan of Correction within ten (10) days of the survey as a condition to participate in Title 18 and Title 19 programs. This Plan of Correction is submitted as the facility's credible allegation of compliance. K353 s/s D -During the walk-through it was observed that there was a wire resting on top of the sprinkler pipe located in the lower-level phone room and pump room. -In the event of an emergency, occupants of this compartment may have the potential to be affected if this regulation is not met. -Maintenance Supervisor has been re-educated to the requirement utilizing	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245459	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**04/30/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 353	Continued From page 8	K 353	this regulation. -Maintenance Supervisor removed the line and corrected the issue. -Audits will be completed weekly for four (4) weeks, and monthly thereafter for two (2) months. Any deficient practice will be immediately corrected, and results will be reported to QAPI. -Maintenance Director or Designee is responsible party -Corrective action will be completed on or before 6/6/25.	
K 363 SS=D	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors	K 363		6/6/25

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	245459	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**04/30/2025**

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K 363	Continued From page 9 meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain corridor doors per NFPA 101 (2012 edition), Life Safety Code, section 19.3.6.3.5. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 04/30/2025 between 8:45 and 11:15 AM, it was revealed by observation that the Chapel door did not latch when it was released from its magnetic hold-open device. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 363	Submission of this Response and Plan of Correction is not a legal admission that a deficiency exists or that this Statement of Deficiency was correctly cited and is also not to be construed as an admission of fault by the facility, the Administrator or any employees, agents or other individuals who draft or may be discussed in this Response and Plan of Correction. In addition, preparation and submission of this Plan of Correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in the allegations. Accordingly, the Facility has prepared and submitted this Plan of Correction prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission of a Plan of Correction within ten (10) days of the survey as a condition to participate in Title 18 and Title 19	

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K 363	Continued From page 10	K 363	programs. This Plan of Correction is submitted as the facility's credible allegation of compliance. K363 s/s D - The process for satisfying this requirement has been reviewed and revised as needed to ensure the chapel doors close and latch when released. -In the event of an emergency, all occupants within this compartment had the potential to be affected. - The maintenance Supervisor was re-educated to the requirement upon finding the identified area during the walk through. - The Chapel door was immediately repaired and corrected. - Audits will be completed to ensure compliance with this requirement. Audit results will be reviewed at QAPI. Any deficient practice will be identified and corrected at the time of occurrence. -Maintenance Director or designee is responsible party. -Corrective action will be completed on or before 6/6/25.	