DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
July 9, 2026

Administrator
GOOD SAMARITAN SOCIETY - STILLWATER
1119 OWENS STREET NORTH
STILLWATER, MN 55082

RE: CCN: 245207
Cycle Start Date: June 4, 2026

Dear Administrator:

On July 7, 2026, the Minnesota Department of Health 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.

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

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July 9, 2026

Administrator
GOOD SAMARITAN SOCIETY - STILLWATER
1119 OWENS STREET NORTH
STILLWATER, MN 55082

Re: Reinspection Results
Event ID: 234553-H2

Dear Administrator:

On July 7, 2026 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on June 4, 2026. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

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Electronically delivered
June 10, 2026

Administrator
Good Samaritan Society - Stillwater
1119 OWENS STREET NORTH
STILLWATER, MN 55082

RE: CCN:245207
Cycle Start Date: June 4, 2026

Dear Administrator:

On June 4, 2026, a survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Lisa Krebs, Regional Operations Supervisor, Rapid Response
Health Regulation Division
Minnesota Department of Health
Rochester District Office
3425 40th Avenue NW, Suite 115
Rochester, MN 55901
Email: Lisa.Krebs@state.mn.us
Office (507) 206-2728

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

If substantial compliance with the regulations is not verified by September 4, 2026 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by December 4, 2026 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social

Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

INFORMAL DISPUTE RESOLUTION (IDR)

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

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

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

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

Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

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June 10, 2026

Administrator
Good Samaritan Society - Stillwater
1119 OWENS STREET NORTH
STILLWATER, MN 55082

Re: State Nursing Home Licensing Orders
Event ID: 234553-H1

Dear Administrator:

The above facility survey was completed on June 4, 2026 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

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

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the

statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

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

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

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

Lisa Krebs, Regional Operations Supervisor, Rapid Response
Health Regulation Division
Minnesota Department of Health
Rochester District Office
3425 40th Avenue NW, Suite 115
Rochester, MN 55901
Email: Lisa.Krebs@state.mn.us
Office (507) 206-2728

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

Please feel free to call me with any questions.

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245207	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/04/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Good Samaritan Society - Stillwater	**1119 OWENS STREET NORTH , STILLWATER, Minnesota, 55082**

(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
F0000	INITIAL COMMENTS On 6/2/26, 6/3/26 and 6/4/26, a standard abbreviated survey was conducted at your facility. 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: H52072624C (3024959 and 3024993) with deficiencies issued at F684 and F697. 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 that substantial compliance with the regulations has been attained.	F0000		06/19/2026
F0684 SS = D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and record review, the facility failed to assess, monitor, and provide appropriate clinical oversight of a urinary collection device used to manage chronic urinary incontinence for 1 of 1 resident (R1) reviewed for urinary incontinence.	F0684	F684 Quality of Care Resident R1 was the only resident with an external Geiserailie 3-piece urinary drainage system. R1 was hospitalized on 6/7/26 and returned from the hospital on hospice on 6/10/26 without the external drainage system. Facility completed a new urinary assessment for the indwelling catheter that had been placed during hospitalization. A facility wide audit was conducted on all residents currently using catheters for urinary drainage. No other resident was using an external drainage system or external catheter. All catheters were audited for appropriate assessments, monitoring and clinical oversight of the urinary device. Care plans were also reviewed and appropriate. A new procedure was completed based on manufacturing suggestions. RN/LPN were educated on its use, care, and maintenance as well	06/19/2026

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245207	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/04/2026

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F0684 SS = D	Continued from page 1 Findings include: R1's face sheet printed 6/3/26, identified diagnoses including chronic kidney disease stage 3, lymphedema (swelling caused by a buildup of fluid), chronic combined systolic and diastolic heart failure, chronic right-sided heart failure, benign prostatic hyperplasia (enlarged prostate) with urinary symptoms, localized edema (swelling), acute cystitis with hematuria (bladder infection with blood in the urine), and muscle weakness. R1's care area assessment (CAA) for urinary incontinence dated 2/5/26, identified urinary incontinence as an actual problem. The CAA identified R1 required assistance with toileting and was occasionally incontinent of urine. Contributing factors identified in the assessment included pain, restricted mobility, benign prostatic hyperplasia (enlarged prostate), congestive heart failure, use of diuretic medications, and opioid medications. The CAA further identified urinary incontinence placed R1 at risk for urinary tract infections, skin injury, loss of dignity, social isolation, and further functional decline. The assessment determined the issue would be addressed through care planning. R1's quarterly Minimum Data Set (MDS) dated 4/24/26, identified cognition was intact. The MDS further identified R1 was always incontinent of urine and received diuretic medication. R1's care plan identified a focus, revised 8/18/25, that R1 had a history of urinary tract infections (UTIs) and benign prostatic hyperplasia (enlarged prostate). The care plan goal directed staff to prevent skin breakdown related to incontinence and brief use. Interventions initiated 11/9/22, directed staff to encourage fluid intake during the morning and afternoon, limit fluids during the evening, avoid foods and beverages that may irritate the bladder, and monitor for signs and symptoms of a UTI, including pain, burning, blood in the urine, cloudy urine, decreased urine output, foul-smelling urine, fever, chills, changes in mental status, and changes in behavior. An additional intervention initiated and revised 8/18/25, identified R1 preferred use of a urinal, refused briefs, would request assistance as needed, and had PRN orders for a condom catheter. An additional care plan focus, revised 2/12/24, identified R1 had a self-care deficit related to a history of fractures, limited mobility, and pain. The care plan goal directed staff to maintain R1's current level of function with bed mobility, transfers, eating, dressing, toileting, and personal hygiene. An	F0684	Continued from page 1 as ongoing skin care checks. The IDT meetings will include a review of all urinary collection devices upon admission, quarterly, annually, and with any significant change in condition or implementation of new catheters. The DON or designee will conduct audits of all residents with external urinary drainage systems for cleanliness, correct application and fit, and updated care plans. Audits will be conducted weekly X 4 weeks, then monthly for 2 months. Results will be presented at QAPI monthly for 3 months to determine the need to increase or decrease until substantial compliance is achieved.	06/19/2026

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F0684 SS = D	Continued from page 2 intervention revised 11/15/24, directed staff to assist with toilet use by offering help to the bathroom and assistance with emptying the urinal upon arising, before and after meals, and at night. R1's Kardex dated 6/3/26, identified R1 preferred use of a urinal, refused briefs, and would request staff assistance as needed. The Kardex directed staff to assist with emptying the urinal and identified PRN condom catheter orders. The Kardex further directed staff to offer assistance with toileting and empty the urinal upon arising, before and after meals, and at night. R1's progress note dated 5/2/26 at 11:54 a.m., identified R1 required standby assistance to transfer to the toilet and extensive assistance with personal care and dressing. The note further identified R1 was unable to control his urine stream, was incontinent of urine, and left the urinal in his pants. R1's progress note dated 5/8/26 at 4:23 p.m., identified R1 reported constant urinary dribbling and stated he kept a urinal between his legs at all times because he was afraid of spilling urine. R1 further reported his penis was enlarged from having it in the urinal all the time. Staff educated R1 that he could rest in bed or a recliner and request assistance with the urinal before transferring to prevent spills. The note further identified R1 agreed to lie in bed and was later observed sleeping. R1's progress note dated 5/25/26 at 1:55 a.m., identified R1 returned from the hospital with a diagnosis of cystitis (bladder infection). The note further identified the provider recommended discontinuing use of the external condom catheter until the urinary infection was treated and cleared R1 to use a urinal. During a phone interview on 6/4/26 at 9:34 a.m., LPN-B stated the Geiserailie urinary collection device was first applied approximately two days before R1 was sent to the emergency department on 5/24/26 and was reapplied on 6/1/26. When asked what assessment she completed before directing staff to apply the device on 5/23/26, LPN-B stated, "I didn't do one, we were just trialing it." LPN-B acknowledged she did not document an assessment on 5/23/26 or when the device was reapplied on 6/1/26 and stated, "I didn't do a formal one." LPN-B further stated no assessments had been completed and no care directions had been developed regarding prevention of skin breakdown, reduction of infection risk, or monitoring for complications associated with device use. When	F0684		06/19/2026

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F0684 SS = D	Continued from page 3 asked how she determined the device was safe to continue using after the hospital documented penile edema and cystitis, LPN-B stated she was instructed by the interim director of nursing to continue the trial. When asked what findings would indicate the device was causing a complication, LPN-B stated, "I am not sure if he would have gotten a rash, infection..." Review of R1's toileting response history identified staff documented R1's urinary continence as "not rated due to use of an indwelling catheter" on 5/23/26 at 6:25 p.m., 5/24/26 at 5:59 a.m., 9:36 a.m., and 8:35 p.m., 6/1/26 at 7:17 p.m., and 6/3/26 at 5:59 a.m. The toileting response history further identified staff documented R1's urinary continence as "not rated due to condom catheter" on 6/3/26 at 2:05 p.m. and 9:35 p.m. R1's weekly skin checks dated 5/4/26, 5/11/26, 5/18/26, and 5/27/26, identified R1's skin was warm and dry, skin color was within normal limits, skin turgor was normal, and no external devices were present. The skin did not identify use of the urinary collection device or document assessment of the penile skin and surrounding tissue related to device use. In review of R1's record there was no indication a physician order had been obtained for the use of the Geiserailie device nor evident the care plan was revised. Further not evident of ongoing assessments and monitoring of device effectiveness and skin integrity. During an observation and interview on 6/2/26 at 3:48 p.m., R1 was observed seated in his wheelchair in his room. R1 stated, "I have a condom catheter. It's the penis and the thing that goes over it. It's not inside." Observation identified a drainage bag containing urine was positioned in a white pillowcase attached to the left side of the wheelchair. R1 stated he was unsure how often staff emptied the bag and reported staff changed the device when it needed to be changed. R1 stated staff were responsible for managing the device and he did not know how it worked. R1 denied having sores or pain to his penis. R1 stated the device was being used because urine would leak from the urinal and result in a wet bed. During an interview on 6/2/26 at 4:37 p.m., nurse practitioner (NP)-A stated R1 was using an external urinary collection device obtained by the facility. NP-A stated the device was not a condom catheter but consisted of a support garment with a plastic	F0684		06/19/2026

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F0684 SS = D	Continued from page 4 receptacle that fit over the penis and drained into a closed urinary drainage bag. NP-A stated use of the device allowed R1 to sleep in bed rather than in his wheelchair with a urinal positioned between his legs. NP-A further stated the device had recently been reordered after it was discarded during R1's recent hospital stay. When asked about skin concerns related to the device, NP-A stated she was not aware of any skin issues. NP-A stated she approved use of the device but had not written orders regarding use of the device, routine maintenance, cleaning procedures, skin integrity monitoring, or infection prevention measures. During an interview on 6/3/26 at 12:14 p.m., nursing assistant (NA)-A stated she had emptied the drainage bag but had not applied the device. NA-A stated she had not received instructions regarding changing, cleaning, maintenance, or skin assessment related to the device and was unaware of any procedures for monitoring complications. During an observation and interview on 6/3/26 at 12:40 p.m., R1 was observed lying in bed with NA-A present. R1 was using an external urinary collection device consisting of a Y-shaped collection cup positioned around the penis and connected to tubing and a drainage bag. The penis was observed within the collection cup. R1 stated staff did not change or clean the device and reported, “I have had it in for about 3 days.” The drainage bag was observed attached to a Velcro strap and placed inside a black bag hanging from the side of the bed. NA-A stated she believed the drainage bag was intended to be secured to R1’s leg; however, the tubing was too long. NA-A stated she initially hung the drainage bag from the side of the bed, later placed it on the bed, and was unsure how it should be positioned. NA-A further stated she obtained a Velcro strap from the supply room and used it to secure the drainage bag. The support garment surrounding the collection cup had dried urine staining and a urine odor. When the drainage bag was placed on the bed, R1 stated urine could “back flush” and requested the bag be hung over the side of the bed. NA-A complied and repositioned the drainage bag. During an interview on 6/3/26 at 1:02 p.m., NA-B stated staff were not provided instructions regarding cleaning, changing, or maintaining the urinary collection device. NA-B stated she checked the waistband for irritation but would need to remove the device to assess the penile skin and had not been directed to do so. NA-B further stated she was unaware of how often the device should be changed and had not received guidance regarding monitoring	F0684		06/19/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245207	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/04/2026

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F0684 SS = D	Continued from page 5 for complications. During an interview on 6/3/26 at 1:15 p.m., licensed practical nurse (LPN)-A stated she was unable to locate practitioner orders addressing use of the device and was not aware of its care or maintenance requirements. LPN-A stated there were no current orders directing staff to assess skin integrity related to device use and she was unsure whether staff were removing the device to perform skin assessments. During an interview on 6/3/26 at 3:21 p.m., the interim director of nursing (IDON) stated she initiated use of the Geiserailie three-piece urinary collection system for R1. IDON stated a physician or nurse practitioner order was not obtained prior to implementation of the device. The IDON further stated the care plan was not updated, no baseline assessment was completed prior to implementation, and no routine assessments were established after implementation. Staff were not provided training regarding application, cleaning, emptying, monitoring, or removal of the device and manufacturer instructions were not available. IDON stated there was no established process or frequency for assessment of R1's penis or foreskin while using the device. IDON further stated the nurse practitioner was notified after the device had already been implemented. IDON could not determine whether penile edema was present prior to implementation because assessments had not been completed or documented. During a phone interview on 6/4/26 at 10:05 a.m., the medical director verified a provider order was not obtained prior to implementation of the Geiserailie urinary collection device. The medical director stated the intervention should have been care planned and staff provided direction regarding application, monitoring, cleaning, and maintenance of the device. Nursing staff should have completed and documented baseline and ongoing assessments of the penis and foreskin. The medical director noted the emergency department documented distal penile edema and cystitis, although no obvious penile infection was identified. The medical director stated the skin should be assessed at least daily, the device should be changed daily, and distal penile edema should be reported to the provider. A provider order should be obtained prior to initiating any new urinary collection device. Facility undated policy, "Catheter Care," identified that urinary drainage systems should be maintained as a closed drainage system. The policy directed	F0684		06/19/2026

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F0684 SS = D	Continued from page 6 staff to secure the drainage bag with straps, observe the skin for irritation or changes and report concerns to the licensed nurse, empty the drainage bag routinely to prevent overfilling, and clean drainage bags according to established procedures. The policy further identified drainage bags should be cleaned with appropriate cleaning solutions and allowed to dry before reuse. The policy further identified staff were to observe the skin for irritation or changes and report concerns to the licensed nurse. Contrary to facility policy, staff did not routinely assess the skin, were not instructed regarding cleaning procedures, improvised methods for securing the drainage bag, and were unable to describe maintenance requirements for the urinary collection system.	F0684		06/19/2026
F0697 SS = D	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and record review, the facility failed to comprehensively assess pain, re-evaluate the effectiveness of the pain regimen, ensure accurate and complete documentation, and notify the physician of break through pain for 1 of 1 resident (R1) reviewed for pain management. Findings include: R1’s face sheet printed 6/3/26, identified diagnoses of pain in left elbow, generalized muscle weakness, cervical spinal stenosis (narrowing of the spinal canal in the neck), lumbar spinal stenosis (narrowing of the spinal canal in the lower back), low back pain, anxiety disorder, and major depressive disorder (depression). R1's Care Area Assessment (CAA) dated 2/5/26, identified pain as an actual problem and triggered due to a pain numeric intensity rating of 7/10. The CAA identified multiple diagnoses and conditions that could contribute to pain, including cardiac disease, pneumonia, gastroesophageal reflux disease	F0697	F697 Pain Management A comprehensive review of medications, pain and care plan interventions was completed for R1 by the physician to determine appropriate pharmacological and non-pharmacological pain management strategies. Physician increased pain medications on 6/5/26 which was effective. Resident was hospitalized for an unrelated issue on 6/7/26 and returned on 6/10/26 on hospice care. R1 pain is currently being re-assessed and care planned in the MDS significant change process with an ARD of 6/16/26 after his return from the hospital. The facility conducted a facility chart audit of all residents currently receiving pain medication or with a diagnosis of chronic pain. Audits verified that comprehensive pain assessments, reassessments of pain regimen efficacy, and physician notifications were accurately documented in the medical records. Any identified gaps were corrected immediately. The facility's pain management policy was reviewed. Licensed nursing staff (RNs/LPNs) were trained on facility pain management protocols, documentation requirements (pain assessments and effectiveness of PRN medications), and timely physician notification. The DON or designee will conduct random medical record audits using the facility's pain assessment on residents receiving pain medication or with a diagnosis of chronic pain per week for 4 weeks, and then on all residents receiving pain medication or with a diagnosis of chronic pain monthly for 2	06/19/2026

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F0697 SS = D	Continued from page 7 (GERD), arthritis, and dental problems. The CAA further identified pain could result in impaired ability to perform ADLs, reluctance to participate in therapy, poor healing, falls, and further functional and cognitive decline. The CAA identified pain would be addressed through care planning. R1's quarterly Minimum Data Set (MDS) dated 4/24/26, identified cognition was intact. The MDS indicated R1 received a scheduled pain medication regimen and did not receive non-pharmacological pain interventions during the 5-day look-back period. R1 reported experiencing pain frequently and rated his worst pain as 3/10. The MDS further identified pain occasionally made it difficult for R1 to sleep at night and occasionally limited day-to-day activities. R1 was independent with most activities of daily living (ADLs). R1's care plan dated 1/16/24, identified a focus that R1 had generalized chronic and acute pain related to multiple chronic conditions and diagnoses, including osteoarthritis. The care plan noted pain could affect R1's ability to perform activities of daily living ADL's and quality of life. Interventions initiated 9/23/22, directed staff to assess pain using the Numeric Pain Scale (0-10); monitor and record pain characteristics, including quality, severity, location, onset, duration, aggravating factors, and relieving factors; monitor and document side effects of pain medications; report changes in activity attendance patterns or refusal to attend activities related to signs, symptoms, complaints of pain, or discomfort; notify the health care provider if interventions were unsuccessful or if pain represented a significant change from R1's usual pain pattern; and provide R1 and family information regarding pain and pain management options. An additional intervention initiated 2/2/24, directed staff to attempt non-pharmacological pain management interventions, including ice packs. Although R1's care plan identified R1's chronic and acute pain and included interventions for assessment, monitoring, reporting, medication side effects, provider notification, and non-pharmacological interventions, the care plan did not address resident-specific pain management goal or desired outcome such as acceptable pian level or desired outcome. R1's physician order summary identified an order dated 10/25/22, for acetaminophen tablet 500 milligram (mg), give 2 tablets by mouth three times daily for pain. On 5/6/26, directed staff to administer oxycodone HCl (narcotic pain medication) oral tablet	F0697	Continued from page 7 months. Audit results will be reviewed at the monthly QAPI committee for 3 months to determine the need to increase or decrease until substantial compliance is achieved.	06/19/2026

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F0697 SS = D	Continued from page 8 5 mg, give 2.5 mg by mouth every six hours as needed for pain rated 2-5 and give 5 mg by mouth every six hours as needed for pain rated 6-10. An additional order dated 5/11/26, directed staff to administer gabapentin (medication for nerve pain) 300 mg, give 2 capsules by mouth three times daily (600 mg three times daily) for neuropathy. R1's May 2026 MAR, progress notes, and occupational therapy documentation dated between 5/11/26 and 5/21/26 were reviewed and identified R1 continued to report left arm pain that interfered with daily activities despite ongoing treatment. The MAR identified R1 received PRN oxycodone on 47 occasions between 5/7/26 and 5/31/26 for reported pain ratings ranging from 6/10 to 10/10. Follow-up documentation identified the medication was ineffective on 13 occasions and effectiveness was documented as unknown on four occasions. When oxycodone was documented as ineffective, follow-up pain ratings remained elevated at 6/10, 7/10, 8/10, 9/10, and 10/10. Record review did not identify documentation that nursing staff completed additional pain assessments, notified the provider that prescribed pain interventions were unsuccessful, or revised the pain management plan following the repeated ineffective medication administrations. Although R1's care plan directed staff to attempt non-pharmacological pain management interventions, record review identified limited documentation of non-pharmacological interventions being offered or implemented. The only documented intervention following an ineffective pain medication administration was application of a cold compress on 5/15/26. Record review did not identify consistent documentation of other interventions attempted or offered such as ice, positioning, bracing, sling use, activity modification, rest periods, or other measures to address R1's ongoing pain. R1's progress note dated 5/7/26 at 11:03 p.m., documented oxycodone 5 mg administered for pain rated 6-10/10. The effectiveness of the medication was documented as "Unknown." The note indicated R1 reported increased pain with repositioning in the wheelchair. Record review did not identify documentation of a follow-up pain assessment, evaluation of the effectiveness of the medication administration, or additional interventions to address the resident's reported increase in pain. R1's progress note 5/9/26 at 2:21 a.m., R1 received oxycodone 5 mg for pain rated 6-10/10. Follow-up documentation indicated the administration was ineffective, and R1 continued to report pain at a level	F0697		06/19/2026

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F0697 SS = D	Continued from page 9 of 6/10. R1's progress note dated 5/11/26 at 6:19 a.m., documented oxycodone 5 mg administered for pain rated 6-10/10. The effectiveness of the medication was documented as "Unknown." Record review did not identify documentation of a follow-up pain assessment or evaluation of the effectiveness of the medication administration. R1's physician visit dated 5/11/26, identified R1 was evaluated for left arm pain. The physician documented R1 reported pain at the level of the elbow that sometimes extended toward the hand and had been present for approximately one week. R1 denied chest pain, denied radiation from the shoulder to the elbow, and denied trauma. Physical examination identified left elbow pain on palpation of both the medial (inside) and lateral (outside) epicondyles (bony areas on each side of the elbow) and pain with resisted extension. The physician assessed bilateral epicondylitis (inflammation and irritation of the tendons attached to the elbow, commonly known as tennis elbow), discussed use of a counterforce brace, encouraged R1 to minimize use of the left hand, ordered a therapy consultation, and increased gabapentin to 600 mg three times daily. R1’s Occupational Therapy (OT) note dated 5/12/26, identified R1 reported constant left elbow pain rated 10/10, describing the pain as, "The whole elbow - it's in so much pain, you wouldn't believe it." OT documented the pain limited R1's quality of life and daily functional tasks. Following ultrasound treatment, R1 reported temporary improvement from 10/10 to 0/10; however, nursing staff reported severe pain returned within 20 minutes. R1's progress note 5/13/26 at 7:21 p.m., R1 received oxycodone 5 mg for pain rated 6-10/10. Follow-up documentation indicated the medication was ineffective, stating "pain still same," and R1 continued to report pain at 9/10. R1's progress note dated 5/14/26 at 2:22 p.m., documented oxycodone 5 mg administered for pain rated 6-10/10 was ineffective. Follow-up documentation identified R1 continued to report pain at a level of 6/10 following administration of the medication. R1’s OT note dated 5/14/26, identified R1 continued to report constant left elbow pain rated 10/10 at rest. OT documented the pain was tender to touch, limited quality of life and daily functional tasks, increased	F0697		06/19/2026

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F0697 SS = D	Continued from page 10 with reaching, and caused grimacing with elbow movement. R1 reported continued use of pain medication, topical cream, and ice packs with ongoing pain. R1's progress note dated 5/15/26 at 7:15 p.m., documented oxycodone 5 mg administered for pain rated 6-10/10 was ineffective. Follow-up documentation identified R1 continued to report pain at a level of 10/10 following administration of the medication. R1's progress note dated 5/20/26 at 12:13 p.m., documented oxycodone 5 mg administered for pain rated 6-10/10 was ineffective. Follow-up documentation identified R1 continued to report pain at a level of 10/10 following administration of the medication. R1's progress note dated 5/21/26 at 8:54 a.m., documented oxycodone 5 mg administered for pain rated 6-10/10 was ineffective. Follow-up documentation identified R1 continued to report pain at a level of 10/10 following administration of the medication. R1's OT note dated 5/21/26, identified R1 reported constant left elbow pain rated 10/10 that limited quality of life and daily functional tasks. The OT documented the left elbow was tender to touch and pain increased with reaching. Nursing staff reported R1 had received pain medication approximately 4.5 hours earlier and could receive additional pain medication every six hours. R1 reported the best his pain improved with medication was 6/10. OT provided a left-sided half lap tray and an ice pack for pain management. After approximately 10 minutes of using the lap tray, R1 reported pain improved from 10/10 to 6/10; however, the pain remained constant. Post-treatment documentation identified left elbow pain remained at 6/10. R1’s OT note dated 5/22/26, identified R1 stated, "my elbow hurts so much. I'm not doing anything with it today," and declined stretching and strengthening activities due to pain. R1's progress note dated 5/22/26 at 9:10 a.m., documented oxycodone 5 mg administered for pain rated 6-10/10 was ineffective. Follow-up documentation identified R1 continued to report pain at a level of 9/10 following administration of the medication. R1's progress note dated 5/23/26 at 1:16 a.m., documented oxycodone 5 mg administered for pain	F0697		06/19/2026

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F0697 SS = D	Continued from page 11 rated 6-10/10. The effectiveness of the medication was documented as "Unknown." Record review did not identify documentation of a follow-up pain assessment or evaluation of the effectiveness of the medication administration. In review of R1's record between 5/11/26 (increase of the gabapentin) through 6/3/26 there was no indication R1's pharmacological pain management regimen in conjunction with non-pharmacological interventions was re-evaluated for effectiveness. R1's progress note dated 5/24/26 at 8:57 a.m., documented oxycodone 5 mg administered for pain rated 6-10/10 was ineffective. Follow-up documentation identified R1 continued to report pain at a level of 6/10 following administration of the medication. R1's progress note dated 5/24/26 at 6:20 p.m., documented oxycodone 5 mg administered for pain rated 6-10/10 was ineffective. Follow-up documentation identified R1 continued to report pain at a level of 8/10 following administration of the medication. R1's progress note dated 5/24/26 at 10:15 p.m., identified R1 complained of severe left arm pain that was not relieved by PRN oxycodone, scheduled acetaminophen, or elevation of the arm. Due to persistent pain, the on-call provider ordered transfer to the emergency department for evaluation. R1's emergency department (ED) note dated 5/24/26, identified R1 was transferred to the emergency department for left arm pain. The emergency department provider documented R1 reported several days of non-traumatic left forearm and wrist pain and denied recent falls or trauma to the arm. Physical examination identified range of motion of the left shoulder, elbow, and wrist was intact with no significant tenderness, redness, or swelling. X-rays identified no acute fracture or dislocation of the left wrist or forearm. The emergency department provider documented R1's pain improved after receiving pain medication and discharged R1 back to the facility with a clinical impression of left arm pain. The ER visit did not include any new orders or treatment plan. R1's progress note dated 5/25/26 at 12:23 p.m., documented oxycodone 5 mg administered for pain rated 6-10/10 was ineffective. The note indicated R1 stated the pain level "didn't change much" following administration of the medication. Follow-up documentation identified R1 continued to	F0697		06/19/2026

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F0697 SS = D	Continued from page 12 report pain at a level of 10/10. R1's progress note dated 5/25/26 at 11:45 p.m., documented oxycodone 5 mg administered for pain rated 6-10/10. The effectiveness of the medication was documented as "Unknown." Record review did not identify documentation of a follow-up pain assessment or evaluation of the effectiveness of the medication administration. R1's progress note dated 5/26/26 at 1:21 a.m., documented oxycodone 5 mg administered for pain rated 6-10/10. The effectiveness of the medication was documented as "Unknown." Record review did not identify documentation of a follow-up pain assessment or evaluation of the effectiveness of the medication administration. R1's progress note dated 5/26/26 at 9:53 a.m., documented oxycodone 5 mg administered for pain rated 6-10/10 was ineffective. Follow-up documentation identified R1 continued to report pain at a level of 6/10 following administration of the medication. R1's OT note dated 5/26/26, identified R1 reported constant left elbow pain rated 10/10 at rest. Nursing staff reported R1 had recently been sent to the emergency department due to uncontrolled left upper extremity pain and returned to the facility with no changes to the pain management regimen. OT documented R1 continued to receive oxycodone and use ice packs for pain management. OT assessed the left upper extremity and applied kinesiology tape (a specialized elastic therapeutic tape used to provide support, reduce pain, and improve movement) to the elbow for lateral epicondylitis. Following the intervention, R1 reported immediate improvement in pain control and stated his pain decreased from 10/10 to 9/10. R1 described the pain as feeling like "when you hit your funny bone." OT further documented R1 actively participated in treatment and reported improved pain management with use of kinesiology tape. R1's progress note dated 5/26/26 at 11:23 p.m., documented oxycodone 5 mg administered for pain rated 6-10/10 was ineffective. Follow-up documentation identified R1 continued to report pain at a level of 7/10 following administration of the medication. R1's occupational therapy (OT) note dated 5/28/26, identified OT received an elbow brace and applied it after removing the kinesiology tape. OT documented no skin irritation was present. Upon application of	F0697		06/19/2026

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F0697 SS = D	Continued from page 13 the brace, R1 smiled and stated, "That feels good!" OT educated R1 regarding use of the brace and encouraged positioning that promoted elbow extension. OT also provided education to nursing staff regarding the purpose and use of the elbow brace. Nursing staff reported R1 had been spending more time resting in bed and a certified nursing assistant reported R1 had been "in a lot of pain earlier." OT requested an order for R1 to wear the left elbow brace as needed and for nursing staff to complete daily skin checks. R1's progress note dated 5/28/26 at 2:02 a.m., documented oxycodone 2.5 mg administered for pain rated 2-5. The effectiveness of the medication was documented as "Unknown." Record review did not identify documentation of a follow-up pain assessment or evaluation of the effectiveness of the medication administration. R1's progress note dated 5/31/26 at 1:39 p.m., documented oxycodone 5 mg administered for pain rated 6-10/10 was ineffective and lacked a follow up pain scale rating. R1's progress note dated 5/31/26 at 1:39 p.m., documented oxycodone 2.5 mg administered for pain rated 2-5 was ineffective. The note indicated R1 continued to rate the pain at 10/10 following administration of the medication. R1's medication administration record (MAR) dated 6/1/26 through 6/3/26 identified acetaminophen and gabapentin were administered as prescribed. Review of the MAR further identified R1 received PRN (as needed) oxycodone on seven occasions between 6/1/26 and 6/3/26 for reported pain ratings ranging from 6/10 to 10/10. Six of the seven administrations were for pain ratings of 7/10 or greater, including documented pain ratings of 9/10 and 10/10. Follow-up documentation identified the effectiveness of the medication was unknown on two occasions despite facility expectations to evaluate the effectiveness of pain management interventions. R1's OT note dated 6/1/26, identified R1 reported left elbow pain that "comes and goes" and rated the pain 7/10 at rest while lying in bed with the elbow extended. OT documented R1 was not feeling well and remained in bed for lunch. R1 reported increased left elbow pain rated 10/10 when sitting at the edge of the bed. OT further documented R1 was not wearing the prescribed elbow brace and staff were unable to locate it despite searching R1's room and contacting other staff. R1 agreed to application of kinesiology tape (a specialized elastic	F0697		06/19/2026

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F0697 SS = D	Continued from page 14 therapeutic tape used to provide support, reduce pain, and improve movement) to the left elbow and reported mild pain relief following the intervention. R1's progress note dated 6/1/26 at 8:46 p.m., documented oxycodone 5 mg administered for pain rated 6-10/10. The effectiveness of the medication was documented as "Unknown." The note further indicated R1 continued to complain of pain in the left arm following administration of the medication. Record review did not identify documentation of a follow-up pain assessment or evaluation of the effectiveness of the medication administration. During an observation and interview on 6/2/26 at 3:48 p.m., R1 was observed seated in a wheelchair in his room. During the interview, R1 suddenly bent to the left side, exhibited facial grimacing, moaning, and crying, and stated he was experiencing left elbow pain that radiated down his arm into his fingers. R1 rated his pain as 10/10 and later stated his pain was a "12." R1 stated staff should allow him to receive pain medication every four hours and reported staff had informed him it was too early for his next pain medication, and he would need to wait an additional two hours. R1 repeatedly stated staff were allowing him to suffer in pain and reported delays in receiving pain medication were worse on the evening shift. R1 was observed holding his left arm and hand, rocking back and forth, crying, and keeping his eyes closed while reporting pain. R1 described the pain as feeling like his "funny bone" had been hit. R1 stated the pain affected his sleep and had been present for years. R1 further stated acetaminophen helped his pain; however, he continued crying and stated he could not handle the pain. The surveyor left the room to notify nursing staff of R1's reported severe pain. During an interview on 6/2/26 at 4:03 p.m., registered nurse (RN)-A was informed R1 was experiencing pain rated as a "12" in the left elbow, was doubled over in pain, and was crying. When asked whether she would assess R1's pain, RN-A stated the provider was aware of R1's left elbow pain and confirmed R1 had reported pain levels as high as "12" out of 10 in the past. RN-A stated R1 received oxycodone 5 mg at 12:20 p.m. for left arm pain and could receive oxycodone every six hours as needed (PRN). RN-A stated R1 also received scheduled acetaminophen 1,000 mg three times daily. R1's left elbow pain was chronic, and staff utilized alternative pain management measures including ice packs, relaxation, distraction, and reminders not to rest his left arm on hard surfaces. RN-A stated R1 requested additional oxycodone at	F0697		06/19/2026

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0697 SS = D	Continued from page 15 approximately 3:00 p.m.; however, it was too early for another dose based on the physician's order. RN-A had no additional medication available to administer for pain at that time. RN-A would assess R1's pain and document the assessment in a progress note. When asked under what circumstances she would notify the provider regarding R1's ongoing severe pain, RN-A stated the provider was aware of the pain but did not identify any circumstances that would prompt additional provider notification. During an observation and interview on 6/2/26 at 4:13 p.m., R1 was observed seated in his wheelchair holding his left arm, moaning, and crying. At 4:14 p.m., RN-A entered the room and asked R1 whether he would like to lie down to help him relax. R1 declined and stated he wanted to remain up to eat supper. RN-A offered to adjust R1's ice pack; however, R1 stated the ice pack did not help his pain. RN-A did not ask R1 to rate his pain or otherwise assess the characteristics, location, severity, aggravating factors, or relieving factors associated with the pain and stated she could clearly see he was in pain. When asked how she would document her pain assessment, RN-A stated she could clearly observe R1 was experiencing pain. RN-A further stated the physician was aware of R1's pain and then exited the room. During the interview, R1 continued to cry and reported a constant burning pain that originated in his left elbow and radiated into his fingers, causing tingling in his thumb, index finger, and middle finger. R1 stated the pain occasionally lessened for a few minutes but quickly returned. R1 reported he had recently been evaluated at the hospital for the pain, but no cause had been identified. The pain also caused neck pain and sensitivity to touch. R1 reported the pain had worsened since admission to the facility and that pain medication provided only a few hours of relief. R1 repeatedly cried and stated he was tired of living with the pain, wanted pain relief, and felt his concerns were not resulting in adequate pain management. R1’s progress note dated 6/2/26 at 5:01 p.m., identified R1 was in excruciating pain prior to receiving PRN oxycodone. Staff applied Biofreeze (a cooling pain-relief product that works similarly to putting an ice pack on sore muscles or joints). and repositioned ice packs in addition to administering pain medication. Following intervention, R1 reported some relief and his pain score decreased to 3/10. During an interview on 6/2/26 at 4:37 p.m., nurse practitioner (NP)-A was notified by the surveyor that	F0697		06/19/2026

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F0697 SS = D	Continued from page 16 R1 was currently experiencing uncontrolled left elbow pain and was not due for another dose of oxycodone for approximately 1½ hours. NP-A stated she had been away the previous week, and the medical director had diagnosed R1 with lateral epicondylitis (tennis elbow) on 5/11/26. NP-A stated R1's pain was believed to be related to nerve impingement (pressure on a nerve) and associated swelling. R1 had previously been provided a sling, which R1 reported helped relieve the pain, but the sling had been lost and recently reordered. NP-A further stated R1 had a brace, and his gabapentin had been increased due to nerve pain. NP-A acknowledged she was aware of R1's left elbow pain and stated oxycodone was unlikely to fully relieve the condition. NP-A stated treatment options were becoming limited and future discussions could include whether hospice services and morphine should be considered for pain management. During an interview on 6/2/26 at 5:13 p.m., interim director of nursing (IDON)-A was informed R1 was currently experiencing uncontrolled left elbow pain, was crying and doubled over in pain, and was not due for another dose of oxycodone for approximately 1½ hours. IDON-A acknowledged awareness that R1 had been experiencing left elbow pain. R1's progress note dated 6/3/26 at 6:01 a.m., documented oxycodone 2.5 mg administered for pain rated 2-5. The effectiveness of the medication was documented as "Unknown." The note indicated R1 was "not giving me a number, just crying in pain." Record review did not identify documentation of a follow-up pain assessment or evaluation of the effectiveness of the medication administration. R1’s OT note dated 6/3/26, identified R1 was crying in pain while seated at the breakfast table. OT documented nursing staff were aware of the pain and educating R1 regarding when the next pain medication would be available. OT located R1's elbow brace, applied it, and R1 immediately stated, "that's already feeling better." OT continued to evaluate positioning devices and arm supports to improve R1's comfort and positioning. OT documented R1 declined additional interventions to the left upper extremity due to pain. Later that day, OT reviewed R1's pain management plan and educated R1 regarding additional positioning options. OT documented R1 continued to experience left elbow pain that limited positioning and participation in daily tasks. R1’s progress note dated 6/3/26 at 2:24 p.m.,	F0697		06/19/2026

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F0697 SS = D	Continued from page 17 identified R1 complained of left arm pain rated 8/10 and requested PRN oxycodone; however, staff documented it was too soon to administer the medication. R1 received scheduled gabapentin and a lidocaine patch and agreed to wait until the next PRN dose was available. At 10:40 a.m., R1 received oxycodone for pain rated 9/10. Follow-up assessment at noon identified pain remained at 6/10. R1's progress note dated 6/3/26 at 10:50 p.m., identified R1 reported pain rated 7/10 and received oxycodone 5 mg and an ice pack. Follow-up documentation identified the medication was effective; however, R1 reported only little relief and continued to report pain rated 6/10. During an interview on 6/3/26 at 12:14 p.m., nursing assistant (NA)-A stated R1 was previously largely independent with many activities and required minimal assistance; however, beginning in early to mid-May 2026, R1 developed significant left elbow pain and became weaker. NA-A reported R1 had experienced constant left elbow pain over the previous three weeks and frequently reported pain levels of 10/10 or 11/10. NA-A stated R1 was often observed crying, doubled over, and unwilling to be disturbed due to pain. NA-A further stated she had observed R1 doubled over in pain on multiple occasions and reported other residents had expressed concern regarding the severity of his pain. According to NA-A, R1's pain medication appeared to provide relief for the first few hours after administration; however, once the medication wore off, R1 would again be observed doubled over and writhing in pain. NA-A stated R1's pain was severe and needed to be better controlled. During an interview on 6/3/26 at 1:02 p.m., NA-B stated R1's left elbow pain began a couple of weeks earlier and had become more frequent over the previous several days. NA-B stated she observed R1 holding his elbow, groaning, crying, and requesting staff obtain a nurse because he was experiencing severe pain. NA-B stated she did not believe R1's pain was well controlled and had observed R1 experiencing significantly more pain than in the past. NA-B further stated R1 now required additional assistance with activities of daily living (ADLs) due to pain in his left arm. During an interview on 6/3/26 at 1:15 p.m., licensed practical nurse (LPN)-A stated R1 had developed left elbow pain several weeks earlier and was using a brace for treatment of tennis elbow. LPN-A stated today R1 received oxycodone 5 mg at 4:40 a.m. and began requesting additional pain medication at	F0697		06/19/2026

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F0697 SS = D	Continued from page 18 approximately 8:40 a.m. when he rated his pain as 8/10. LPN-A stated R1 received another dose of oxycodone at approximately 10:40 a.m. when he rated his pain as 9/10. LPN-A stated the medication reduced R1's pain temporarily; however, by approximately 12:55 p.m., R1 reported his pain had increased to 7/10. LPN-A stated R1 also received gabapentin, scheduled acetaminophen, and used a brace for pain management. LPN-A stated she did not believe R1's pain was well controlled and estimated the oxycodone provided relief for only about four hours despite being ordered every six hours as needed. LPN-A stated she was unaware of additional interventions available to address R1's pain other than oxycodone and ice packs. During an interview on 6/3/26 at 3:21 p.m., IDON stated R1 complained of left elbow pain rated 10/10 on 5/24/26. IDON-A stated the provider was notified, R1 received PRN oxycodone and acetaminophen, and was subsequently transferred to the emergency department due to uncontrolled pain. IDON acknowledged R1 had experienced increased left elbow pain, frequently cried due to pain, and stated the current pain management plan had not been effective. IDON-A further stated she would expect the provider to be notified when a resident's pain was not adequately controlled so the pain management plan could be reevaluated. During a phone interview on 6/4/26 at 9:34 a.m., LPN-B stated R1's left elbow pain began several weeks earlier, and staff observed R1 frequently resting his left elbow on hard surfaces while completing puzzles. LPN-B stated staff implemented multiple interventions, including a gel pad for the wheelchair armrest, an elbow compression brace, ice packs, a sling, occupational therapy (OT), and positioning interventions. LPN-B stated R1's gabapentin dose was increased on 5/11/26. LPN-B stated R1 would appear comfortable at times and then suddenly begin crying due to severe pain. LPN-B stated oxycodone did not provide significant relief for the nerve pain and staff frequently encouraged R1 to use ice packs, remove pressure from the elbow, and rest in bed, which appeared to lessen his pain. LPN-B stated R1 occasionally requested oxycodone before it was due and staff would offer non-pharmacological interventions until the medication could be administered. LPN-B stated R1's pain was generally worse during the daytime and evening hours and confirmed R1 would cry due to pain on occasion. During a phone interview on 6/4/26 at 10:05 a.m., the medical director stated R1 was evaluated on	F0697		06/19/2026

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F0697 SS = D	Continued from page 19 5/11/26 for left elbow pain and his gabapentin was increased to 600 mg three times daily. The medical director stated R1's examination was consistent with epicondylitis (inflammation of the tendons around the elbow) and multiple treatment interventions had been attempted, including gabapentin, oxycodone, occupational therapy, bracing, positioning interventions, and ultrasound therapy. The medical director stated occupational therapy had reported improvement with ultrasound treatment and an orthopedic consultation had recently been discussed during therapy rounds. When informed that R1 continued to experience severe breakthrough pain between medication doses, was observed bent over, crying, and moaning in pain, and reported pain radiating from his elbow into his hand with tingling of the thumb, index finger, and middle finger, the medical director stated nursing staff should complete a comprehensive pain assessment, document the findings, and notify the on-call provider when pain remained uncontrolled. The medical director stated the facility had 24-hour provider coverage available for consultation. The medical director further stated uncontrolled pain should be communicated through the nurse practitioner communication process and acknowledged she would expect additional notification if a resident was observed bent over, crying, and moaning in pain despite current interventions. The medical director stated additional treatment options could include increasing oxycodone from every six hours to every four hours as needed, steroid injections, or referral to an orthopedic specialist. During the interview, the medical director stated she will provide an order to change R1's oxycodone from every six hours as needed to every four hours as needed for pain. Facility policy entitled, "Pain Management - R/S, LTC, Therapy & Rehab," reviewed/revised 1/29/26, identified the licensed nurse would assess current pain levels; review the resident's response to medication interventions; work closely with the physician to develop an individualized pain management plan; continually monitor and observe the resident for success of the pain management plan; report to the prescriber as necessary to keep the resident comfortable; include the resident's goal for pain control in the care plan; and monitor and evaluate the effectiveness of the pain management plan. The policy further identified non-pharmacological interventions should be utilized and the care plan should be updated as needed to reflect current effective interventions. Facility policy was not followed when staff failed to	F0697		06/19/2026

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F0697 SS = D	Continued from page 20 adequately assess, monitor, evaluate, and revise R1's pain management plan despite ongoing reports of severe pain, ineffective interventions, and continued impairment in R1's comfort and functioning.	F0697		06/19/2026

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20000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 6/2/26, 6/3/26 and 6/4/26, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure, and the following licensing order(s) (was/were) issued. Please indicate in your electronic plan of correction you have reviewed these orders and identify the date when they will be completed. The following complaints were reviewed: H52072624C (3024959 and 3024993) with a licensing	20000		06/19/2026

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

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20000	Continued from page 1 order issued at 0830. Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor's findings are the Suggested Method of Correction and Time Period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	20000		06/19/2026
20830	Adequate and Proper Nursing Care; General CFR(s): MN Rule 4658.0520 Subp. 1 Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or	20830	Completed	06/19/2026

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20830	Continued from page 2 the resident prefers to remain in bed. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and record review, the facility failed to comprehensively assess pain, re-evaluate the effectiveness of the pain regimen, ensure accurate and complete documentation, and notify the physician of break through pain for 1 of 1 resident (R1) reviewed for pain management. Based on observation, interview, and record review, the facility failed to assess, monitor, and provide appropriate clinical oversight of a urinary collection device used to manage chronic urinary incontinence for 1 of 1 resident (R1) reviewed for urinary incontinence. Findings include: R1’s face sheet printed 6/3/26, identified diagnoses of pain in left elbow, generalized muscle weakness, cervical spinal stenosis (narrowing of the spinal canal in the neck), lumbar spinal stenosis (narrowing of the spinal canal in the lower back), low back pain, anxiety disorder, and major depressive disorder (depression). R1's Care Area Assessment (CAA) dated 2/5/26, identified pain as an actual problem and triggered due to a pain numeric intensity rating of 7/10. The CAA identified multiple diagnoses and conditions that could contribute to pain, including cardiac disease, pneumonia, gastroesophageal reflux disease (GERD), arthritis, and dental problems. The CAA further identified pain could result in impaired ability to perform ADLs, reluctance to participate in therapy, poor healing, falls, and further functional and cognitive decline. The CAA identified pain would be addressed through care planning. R1's quarterly Minimum Data Set (MDS) dated 4/24/26, identified cognition was intact. The MDS indicated R1 received a scheduled pain medication regimen and did not receive non-pharmacological pain interventions during the 5-day look-back period. R1 reported experiencing pain frequently and rated his worst pain as 3/10. The MDS further identified pain occasionally made it difficult for R1 to sleep at night and occasionally limited day-to-day activities. R1 was independent with most activities of daily living (ADLs). R1's care plan dated 1/16/24, identified a focus that R1 had generalized chronic and acute pain related to multiple chronic conditions and diagnoses, including	20830		06/19/2026

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20830	Continued from page 3 osteoarthritis. The care plan noted pain could affect R1's ability to perform activities of daily living ADL's and quality of life. Interventions initiated 9/23/22, directed staff to assess pain using the Numeric Pain Scale (0-10); monitor and record pain characteristics, including quality, severity, location, onset, duration, aggravating factors, and relieving factors; monitor and document side effects of pain medications; report changes in activity attendance patterns or refusal to attend activities related to signs, symptoms, complaints of pain, or discomfort; notify the health care provider if interventions were unsuccessful or if pain represented a significant change from R1's usual pain pattern; and provide R1 and family information regarding pain and pain management options. An additional intervention initiated 2/2/24, directed staff to attempt non-pharmacological pain management interventions, including ice packs. Although R1's care plan identified R1's chronic and acute pain and included interventions for assessment, monitoring, reporting, medication side effects, provider notification, and non-pharmacological interventions, the care plan did not address resident-specific pain management goal or desired outcome such as acceptable pian level or desired outcome. R1's physician order summary identified an order dated 10/25/22, for acetaminophen tablet 500 milligram (mg), give 2 tablets by mouth three times daily for pain. On 5/6/26, directed staff to administer oxycodone HCl (narcotic pain medication) oral tablet 5 mg, give 2.5 mg by mouth every six hours as needed for pain rated 2-5 and give 5 mg by mouth every six hours as needed for pain rated 6-10. An additional order dated 5/11/26, directed staff to administer gabapentin (medication for nerve pain) 300 mg, give 2 capsules by mouth three times daily (600 mg three times daily) for neuropathy. R1's May 2026 MAR, progress notes, and occupational therapy documentation dated between 5/11/26 and 5/21/26 were reviewed and identified R1 continued to report left arm pain that interfered with daily activities despite ongoing treatment. The MAR identified R1 received PRN oxycodone on 47 occasions between 5/7/26 and 5/31/26 for reported pain ratings ranging from 6/10 to 10/10. Follow-up documentation identified the medication was ineffective on 13 occasions and effectiveness was documented as unknown on four occasions. When oxycodone was documented as ineffective, follow-up pain ratings remained elevated at 6/10, 7/10, 8/10, 9/10, and 10/10. Record review did not identify	20830		06/19/2026

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20830	Continued from page 4 documentation that nursing staff completed additional pain assessments, notified the provider that prescribed pain interventions were unsuccessful, or revised the pain management plan following the repeated ineffective medication administrations. Although R1's care plan directed staff to attempt non-pharmacological pain management interventions, record review identified limited documentation of non-pharmacological interventions being offered or implemented. The only documented intervention following an ineffective pain medication administration was application of a cold compress on 5/15/26. Record review did not identify consistent documentation of other interventions attempted or offered such as ice, positioning, bracing, sling use, activity modification, rest periods, or other measures to address R1's ongoing pain. R1's progress note dated 5/7/26 at 11:03 p.m., documented oxycodone 5 mg administered for pain rated 6-10/10. The effectiveness of the medication was documented as "Unknown." The note indicated R1 reported increased pain with repositioning in the wheelchair. Record review did not identify documentation of a follow-up pain assessment, evaluation of the effectiveness of the medication administration, or additional interventions to address the resident's reported increase in pain. R1's progress note 5/9/26 at 2:21 a.m., R1 received oxycodone 5 mg for pain rated 6-10/10. Follow-up documentation indicated the administration was ineffective, and R1 continued to report pain at a level of 6/10. R1's progress note dated 5/11/26 at 6:19 a.m., documented oxycodone 5 mg administered for pain rated 6-10/10. The effectiveness of the medication was documented as "Unknown." Record review did not identify documentation of a follow-up pain assessment or evaluation of the effectiveness of the medication administration. R1's physician visit dated 5/11/26, identified R1 was evaluated for left arm pain. The physician documented R1 reported pain at the level of the elbow that sometimes extended toward the hand and had been present for approximately one week. R1 denied chest pain, denied radiation from the shoulder to the elbow, and denied trauma. Physical examination identified left elbow pain on palpation of both the medial (inside) and lateral (outside) epicondyles (bony areas on each side of the elbow) and pain with resisted extension. The physician assessed bilateral epicondylitis (inflammation and	20830		06/19/2026

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Good Samaritan Society - Stillwater	**1119 OWENS STREET NORTH , STILLWATER, Minnesota, 55082**

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20830	Continued from page 5 irritation of the tendons attached to the elbow, commonly known as tennis elbow), discussed use of a counterforce brace, encouraged R1 to minimize use of the left hand, ordered a therapy consultation, and increased gabapentin to 600 mg three times daily. R1's Occupational Therapy (OT) note dated 5/12/26, identified R1 reported constant left elbow pain rated 10/10, describing the pain as, "The whole elbow - it's in so much pain, you wouldn't believe it." OT documented the pain limited R1's quality of life and daily functional tasks. Following ultrasound treatment, R1 reported temporary improvement from 10/10 to 0/10; however, nursing staff reported severe pain returned within 20 minutes. R1's progress note 5/13/26 at 7:21 p.m., R1 received oxycodone 5 mg for pain rated 6-10/10. Follow-up documentation indicated the medication was ineffective, stating "pain still same," and R1 continued to report pain at 9/10. R1's progress note dated 5/14/26 at 2:22 p.m., documented oxycodone 5 mg administered for pain rated 6-10/10 was ineffective. Follow-up documentation identified R1 continued to report pain at a level of 6/10 following administration of the medication. R1's OT note dated 5/14/26, identified R1 continued to report constant left elbow pain rated 10/10 at rest. OT documented the pain was tender to touch, limited quality of life and daily functional tasks, increased with reaching, and caused grimacing with elbow movement. R1 reported continued use of pain medication, topical cream, and ice packs with ongoing pain. R1's progress note dated 5/15/26 at 7:15 p.m., documented oxycodone 5 mg administered for pain rated 6-10/10 was ineffective. Follow-up documentation identified R1 continued to report pain at a level of 10/10 following administration of the medication. R1's progress note dated 5/20/26 at 12:13 p.m., documented oxycodone 5 mg administered for pain rated 6-10/10 was ineffective. Follow-up documentation identified R1 continued to report pain at a level of 10/10 following administration of the medication. R1's progress note dated 5/21/26 at 8:54 a.m., documented oxycodone 5 mg administered for pain rated 6-10/10 was ineffective. Follow-up	20830		06/19/2026

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20830	Continued from page 6 documentation identified R1 continued to report pain at a level of 10/10 following administration of the medication. R1's OT note dated 5/21/26, identified R1 reported constant left elbow pain rated 10/10 that limited quality of life and daily functional tasks. The OT documented the left elbow was tender to touch and pain increased with reaching. Nursing staff reported R1 had received pain medication approximately 4.5 hours earlier and could receive additional pain medication every six hours. R1 reported the best his pain improved with medication was 6/10. OT provided a left-sided half lap tray and an ice pack for pain management. After approximately 10 minutes of using the lap tray, R1 reported pain improved from 10/10 to 6/10; however, the pain remained constant. Post-treatment documentation identified left elbow pain remained at 6/10. R1’s OT note dated 5/22/26, identified R1 stated, "my elbow hurts so much. I'm not doing anything with it today," and declined stretching and strengthening activities due to pain. R1's progress note dated 5/22/26 at 9:10 a.m., documented oxycodone 5 mg administered for pain rated 6-10/10 was ineffective. Follow-up documentation identified R1 continued to report pain at a level of 9/10 following administration of the medication. R1's progress note dated 5/23/26 at 1:16 a.m., documented oxycodone 5 mg administered for pain rated 6-10/10. The effectiveness of the medication was documented as "Unknown." Record review did not identify documentation of a follow-up pain assessment or evaluation of the effectiveness of the medication administration. In review of R1’s record between 5/11/26 (increase of the gabapentin) through 6/3/26 there was no indication R1’s pharmacological pain management regimen in conjunction with non-pharmacological interventions was re-evaluated for effectiveness. R1's progress note dated 5/24/26 at 8:57 a.m., documented oxycodone 5 mg administered for pain rated 6-10/10 was ineffective. Follow-up documentation identified R1 continued to report pain at a level of 6/10 following administration of the medication. R1's progress note dated 5/24/26 at 6:20 p.m., documented oxycodone 5 mg administered for pain rated 6-10/10 was ineffective. Follow-up	20830		06/19/2026

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20830	Continued from page 7 documentation identified R1 continued to report pain at a level of 8/10 following administration of the medication. R1's progress note dated 5/24/26 at 10:15 p.m., identified R1 complained of severe left arm pain that was not relieved by PRN oxycodone, scheduled acetaminophen, or elevation of the arm. Due to persistent pain, the on-call provider ordered transfer to the emergency department for evaluation. R1's emergency department (ED) note dated 5/24/26, identified R1 was transferred to the emergency department for left arm pain. The emergency department provider documented R1 reported several days of non-traumatic left forearm and wrist pain and denied recent falls or trauma to the arm. Physical examination identified range of motion of the left shoulder, elbow, and wrist was intact with no significant tenderness, redness, or swelling. X-rays identified no acute fracture or dislocation of the left wrist or forearm. The emergency department provider documented R1's pain improved after receiving pain medication and discharged R1 back to the facility with a clinical impression of left arm pain. The ER visit did not include any new orders or treatment plan. R1's progress note dated 5/25/26 at 12:23 p.m., documented oxycodone 5 mg administered for pain rated 6-10/10 was ineffective. The note indicated R1 stated the pain level "didn't change much" following administration of the medication. Follow-up documentation identified R1 continued to report pain at a level of 10/10. R1's progress note dated 5/25/26 at 11:45 p.m., documented oxycodone 5 mg administered for pain rated 6-10/10. The effectiveness of the medication was documented as "Unknown." Record review did not identify documentation of a follow-up pain assessment or evaluation of the effectiveness of the medication administration. R1's progress note dated 5/26/26 at 1:21 a.m., documented oxycodone 5 mg administered for pain rated 6-10/10. The effectiveness of the medication was documented as "Unknown." Record review did not identify documentation of a follow-up pain assessment or evaluation of the effectiveness of the medication administration. R1's progress note dated 5/26/26 at 9:53 a.m., documented oxycodone 5 mg administered for pain rated 6-10/10 was ineffective. Follow-up documentation identified R1 continued to report pain	20830		06/19/2026

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20830	Continued from page 8 at a level of 6/10 following administration of the medication. R1's OT note dated 5/26/26, identified R1 reported constant left elbow pain rated 10/10 at rest. Nursing staff reported R1 had recently been sent to the emergency department due to uncontrolled left upper extremity pain and returned to the facility with no changes to the pain management regimen. OT documented R1 continued to receive oxycodone and use ice packs for pain management. OT assessed the left upper extremity and applied kinesiology tape (a specialized elastic therapeutic tape used to provide support, reduce pain, and improve movement) to the elbow for lateral epicondylitis. Following the intervention, R1 reported immediate improvement in pain control and stated his pain decreased from 10/10 to 9/10. R1 described the pain as feeling like "when you hit your funny bone." OT further documented R1 actively participated in treatment and reported improved pain management with use of kinesiology tape. R1's progress note dated 5/26/26 at 11:23 p.m., documented oxycodone 5 mg administered for pain rated 6-10/10 was ineffective. Follow-up documentation identified R1 continued to report pain at a level of 7/10 following administration of the medication. R1's occupational therapy (OT) note dated 5/28/26, identified OT received an elbow brace and applied it after removing the kinesiology tape. OT documented no skin irritation was present. Upon application of the brace, R1 smiled and stated, "That feels good!" OT educated R1 regarding use of the brace and encouraged positioning that promoted elbow extension. OT also provided education to nursing staff regarding the purpose and use of the elbow brace. Nursing staff reported R1 had been spending more time resting in bed and a certified nursing assistant reported R1 had been "in a lot of pain earlier." OT requested an order for R1 to wear the left elbow brace as needed and for nursing staff to complete daily skin checks. R1's progress note dated 5/28/26 at 2:02 a.m., documented oxycodone 2.5 mg administered for pain rated 2-5. The effectiveness of the medication was documented as "Unknown." Record review did not identify documentation of a follow-up pain assessment or evaluation of the effectiveness of the medication administration. R1's progress note dated 5/31/26 at 1:39 p.m., documented oxycodone 5 mg administered for pain	20830		06/19/2026

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20830	Continued from page 9 rated 6-10/10 was ineffective and lacked a follow up pain scale rating. R1's progress note dated 5/31/26 at 1:39 p.m., documented oxycodone 2.5 mg administered for pain rated 2-5 was ineffective. The note indicated R1 continued to rate the pain at 10/10 following administration of the medication. R1's medication administration record (MAR) dated 6/1/26 through 6/3/26 identified acetaminophen and gabapentin were administered as prescribed. Review of the MAR further identified R1 received PRN (as needed) oxycodone on seven occasions between 6/1/26 and 6/3/26 for reported pain ratings ranging from 6/10 to 10/10. Six of the seven administrations were for pain ratings of 7/10 or greater, including documented pain ratings of 9/10 and 10/10. Follow-up documentation identified the effectiveness of the medication was unknown on two occasions despite facility expectations to evaluate the effectiveness of pain management interventions. R1's OT note dated 6/1/26, identified R1 reported left elbow pain that "comes and goes" and rated the pain 7/10 at rest while lying in bed with the elbow extended. OT documented R1 was not feeling well and remained in bed for lunch. R1 reported increased left elbow pain rated 10/10 when sitting at the edge of the bed. OT further documented R1 was not wearing the prescribed elbow brace and staff were unable to locate it despite searching R1's room and contacting other staff. R1 agreed to application of kinesiology tape (a specialized elastic therapeutic tape used to provide support, reduce pain, and improve movement) to the left elbow and reported mild pain relief following the intervention. R1's progress note dated 6/1/26 at 8:46 p.m., documented oxycodone 5 mg administered for pain rated 6-10/10. The effectiveness of the medication was documented as "Unknown." The note further indicated R1 continued to complain of pain in the left arm following administration of the medication. Record review did not identify documentation of a follow-up pain assessment or evaluation of the effectiveness of the medication administration. During an observation and interview on 6/2/26 at 3:48 p.m., R1 was observed seated in a wheelchair in his room. During the interview, R1 suddenly bent to the left side, exhibited facial grimacing, moaning, and crying, and stated he was experiencing left elbow pain that radiated down his arm into his fingers. R1 rated his pain as 10/10 and later stated his pain was a "12." R1 stated staff should allow	20830		06/19/2026

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20830	Continued from page 10 him to receive pain medication every four hours and reported staff had informed him it was too early for his next pain medication, and he would need to wait an additional two hours. R1 repeatedly stated staff were allowing him to suffer in pain and reported delays in receiving pain medication were worse on the evening shift. R1 was observed holding his left arm and hand, rocking back and forth, crying, and keeping his eyes closed while reporting pain. R1 described the pain as feeling like his "funny bone" had been hit. R1 stated the pain affected his sleep and had been present for years. R1 further stated acetaminophen helped his pain; however, he continued crying and stated he could not handle the pain. The surveyor left the room to notify nursing staff of R1's reported severe pain. During an interview on 6/2/26 at 4:03 p.m., registered nurse (RN)-A was informed R1 was experiencing pain rated as a "12" in the left elbow, was doubled over in pain, and was crying. When asked whether she would assess R1's pain, RN-A stated the provider was aware of R1's left elbow pain and confirmed R1 had reported pain levels as high as "12" out of 10 in the past. RN-A stated R1 received oxycodone 5 mg at 12:20 p.m. for left arm pain and could receive oxycodone every six hours as needed (PRN). RN-A stated R1 also received scheduled acetaminophen 1,000 mg three times daily. R1's left elbow pain was chronic, and staff utilized alternative pain management measures including ice packs, relaxation, distraction, and reminders not to rest his left arm on hard surfaces. RN-A stated R1 requested additional oxycodone at approximately 3:00 p.m.; however, it was too early for another dose based on the physician's order. RN-A had no additional medication available to administer for pain at that time. RN-A would assess R1's pain and document the assessment in a progress note. When asked under what circumstances she would notify the provider regarding R1's ongoing severe pain, RN-A stated the provider was aware of the pain but did not identify any circumstances that would prompt additional provider notification. During an observation and interview on 6/2/26 at 4:13 p.m., R1 was observed seated in his wheelchair holding his left arm, moaning, and crying. At 4:14 p.m., RN-A entered the room and asked R1 whether he would like to lie down to help him relax. R1 declined and stated he wanted to remain up to eat supper. RN-A offered to adjust R1's ice pack; however, R1 stated the ice pack did not help his pain. RN-A did not ask R1 to rate his pain or otherwise assess the characteristics, location,	20830		06/19/2026

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20830	Continued from page 11 severity, aggravating factors, or relieving factors associated with the pain and stated she could clearly see he was in pain. When asked how she would document her pain assessment, RN-A stated she could clearly observe R1 was experiencing pain. RN-A further stated the physician was aware of R1's pain and then exited the room. During the interview, R1 continued to cry and reported a constant burning pain that originated in his left elbow and radiated into his fingers, causing tingling in his thumb, index finger, and middle finger. R1 stated the pain occasionally lessened for a few minutes but quickly returned. R1 reported he had recently been evaluated at the hospital for the pain, but no cause had been identified. The pain also caused neck pain and sensitivity to touch. R1 reported the pain had worsened since admission to the facility and that pain medication provided only a few hours of relief. R1 repeatedly cried and stated he was tired of living with the pain, wanted pain relief, and felt his concerns were not resulting in adequate pain management. R1’s progress note dated 6/2/26 at 5:01 p.m., identified R1 was in excruciating pain prior to receiving PRN oxycodone. Staff applied Biofreeze (a cooling pain-relief product that works similarly to putting an ice pack on sore muscles or joints). and repositioned ice packs in addition to administering pain medication. Following intervention, R1 reported some relief and his pain score decreased to 3/10. During an interview on 6/2/26 at 4:37 p.m., nurse practitioner (NP)-A was notified by the surveyor that R1 was currently experiencing uncontrolled left elbow pain and was not due for another dose of oxycodone for approximately 1½ hours. NP-A stated she had been away the previous week, and the medical director had diagnosed R1 with lateral epicondylitis (tennis elbow) on 5/11/26. NP-A stated R1's pain was believed to be related to nerve impingement (pressure on a nerve) and associated swelling. R1 had previously been provided a sling, which R1 reported helped relieve the pain, but the sling had been lost and recently reordered. NP-A further stated R1 had a brace, and his gabapentin had been increased due to nerve pain. NP-A acknowledged she was aware of R1's left elbow pain and stated oxycodone was unlikely to fully relieve the condition. NP-A stated treatment options were becoming limited and future discussions could include whether hospice services and morphine should be considered for pain management. During an interview on 6/2/26 at 5:13 p.m., interim director of nursing (IDON)-A was informed R1 was	20830		06/19/2026

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20830	Continued from page 12 currently experiencing uncontrolled left elbow pain, was crying and doubled over in pain, and was not due for another dose of oxycodone for approximately 1½ hours. IDON-A acknowledged awareness that R1 had been experiencing left elbow pain. R1's progress note dated 6/3/26 at 6:01 a.m., documented oxycodone 2.5 mg administered for pain rated 2-5. The effectiveness of the medication was documented as "Unknown." The note indicated R1 was "not giving me a number, just crying in pain." Record review did not identify documentation of a follow-up pain assessment or evaluation of the effectiveness of the medication administration. R1's OT note dated 6/3/26, identified R1 was crying in pain while seated at the breakfast table. OT documented nursing staff were aware of the pain and educating R1 regarding when the next pain medication would be available. OT located R1's elbow brace, applied it, and R1 immediately stated, "that's already feeling better." OT continued to evaluate positioning devices and arm supports to improve R1's comfort and positioning. OT documented R1 declined additional interventions to the left upper extremity due to pain. Later that day, OT reviewed R1's pain management plan and educated R1 regarding additional positioning options. OT documented R1 continued to experience left elbow pain that limited positioning and participation in daily tasks. R1's progress note dated 6/3/26 at 2:24 p.m., identified R1 complained of left arm pain rated 8/10 and requested PRN oxycodone; however, staff documented it was too soon to administer the medication. R1 received scheduled gabapentin and a lidocaine patch and agreed to wait until the next PRN dose was available. At 10:40 a.m., R1 received oxycodone for pain rated 9/10. Follow-up assessment at noon identified pain remained at 6/10. R1's progress note dated 6/3/26 at 10:50 p.m., identified R1 reported pain rated 7/10 and received oxycodone 5 mg and an ice pack. Follow-up documentation identified the medication was effective; however, R1 reported only little relief and continued to report pain rated 6/10. During an interview on 6/3/26 at 12:14 p.m., nursing assistant (NA)-A stated R1 was previously largely independent with many activities and required minimal assistance; however, beginning in early to mid-May 2026, R1 developed significant left elbow pain and became weaker. NA-A reported R1 had	20830		06/19/2026

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20830	Continued from page 13 experienced constant left elbow pain over the previous three weeks and frequently reported pain levels of 10/10 or 11/10. NA-A stated R1 was often observed crying, doubled over, and unwilling to be disturbed due to pain. NA-A further stated she had observed R1 doubled over in pain on multiple occasions and reported other residents had expressed concern regarding the severity of his pain. According to NA-A, R1's pain medication appeared to provide relief for the first few hours after administration; however, once the medication wore off, R1 would again be observed doubled over and writhing in pain. NA-A stated R1's pain was severe and needed to be better controlled. During an interview on 6/3/26 at 1:02 p.m., NA-B stated R1's left elbow pain began a couple of weeks earlier and had become more frequent over the previous several days. NA-B stated she observed R1 holding his elbow, groaning, crying, and requesting staff obtain a nurse because he was experiencing severe pain. NA-B stated she did not believe R1's pain was well controlled and had observed R1 experiencing significantly more pain than in the past. NA-B further stated R1 now required additional assistance with activities of daily living (ADLs) due to pain in his left arm. During an interview on 6/3/26 at 1:15 p.m., licensed practical nurse (LPN)-A stated R1 had developed left elbow pain several weeks earlier and was using a brace for treatment of tennis elbow. LPN-A stated today R1 received oxycodone 5 mg at 4:40 a.m. and began requesting additional pain medication at approximately 8:40 a.m. when he rated his pain as 8/10. LPN-A stated R1 received another dose of oxycodone at approximately 10:40 a.m. when he rated his pain as 9/10. LPN-A stated the medication reduced R1's pain temporarily; however, by approximately 12:55 p.m., R1 reported his pain had increased to 7/10. LPN-A stated R1 also received gabapentin, scheduled acetaminophen, and used a brace for pain management. LPN-A stated she did not believe R1's pain was well controlled and estimated the oxycodone provided relief for only about four hours despite being ordered every six hours as needed. LPN-A stated she was unaware of additional interventions available to address R1's pain other than oxycodone and ice packs. During an interview on 6/3/26 at 3:21 p.m., IDON stated R1 complained of left elbow pain rated 10/10 on 5/24/26. IDON-A stated the provider was notified, R1 received PRN oxycodone and acetaminophen, and was subsequently transferred to the emergency department due to uncontrolled pain. IDON	20830		06/19/2026

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20830	Continued from page 14 acknowledged R1 had experienced increased left elbow pain, frequently cried due to pain, and stated the current pain management plan had not been effective. IDON-A further stated she would expect the provider to be notified when a resident's pain was not adequately controlled so the pain management plan could be reevaluated. During a phone interview on 6/4/26 at 9:34 a.m., LPN-B stated R1's left elbow pain began several weeks earlier, and staff observed R1 frequently resting his left elbow on hard surfaces while completing puzzles. LPN-B stated staff implemented multiple interventions, including a gel pad for the wheelchair armrest, an elbow compression brace, ice packs, a sling, occupational therapy (OT), and positioning interventions. LPN-B stated R1's gabapentin dose was increased on 5/11/26. LPN-B stated R1 would appear comfortable at times and then suddenly begin crying due to severe pain. LPN-B stated oxycodone did not provide significant relief for the nerve pain and staff frequently encouraged R1 to use ice packs, remove pressure from the elbow, and rest in bed, which appeared to lessen his pain. LPN-B stated R1 occasionally requested oxycodone before it was due and staff would offer non-pharmacological interventions until the medication could be administered. LPN-B stated R1's pain was generally worse during the daytime and evening hours and confirmed R1 would cry due to pain on occasion. During a phone interview on 6/4/26 at 10:05 a.m., the medical director stated R1 was evaluated on 5/11/26 for left elbow pain and his gabapentin was increased to 600 mg three times daily. The medical director stated R1's examination was consistent with epicondylitis (inflammation of the tendons around the elbow) and multiple treatment interventions had been attempted, including gabapentin, oxycodone, occupational therapy, bracing, positioning interventions, and ultrasound therapy. The medical director stated occupational therapy had reported improvement with ultrasound treatment and an orthopedic consultation had recently been discussed during therapy rounds. When informed that R1 continued to experience severe breakthrough pain between medication doses, was observed bent over, crying, and moaning in pain, and reported pain radiating from his elbow into his hand with tingling of the thumb, index finger, and middle finger, the medical director stated nursing staff should complete a comprehensive pain assessment, document the findings, and notify the on-call provider when pain remained uncontrolled. The medical director stated the facility had 24-hour	20830		06/19/2026

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20830	Continued from page 15 provider coverage available for consultation. The medical director further stated uncontrolled pain should be communicated through the nurse practitioner communication process and acknowledged she would expect additional notification if a resident was observed bent over, crying, and moaning in pain despite current interventions. The medical director stated additional treatment options could include increasing oxycodone from every six hours to every four hours as needed, steroid injections, or referral to an orthopedic specialist. During the interview, the medical director stated she will provide an order to change R1's oxycodone from every six hours as needed to every four hours as needed for pain. Facility policy entitled, "Pain Management - R/S, LTC, Therapy & Rehab," reviewed/revised 1/29/26, identified the licensed nurse would assess current pain levels; review the resident's response to medication interventions; work closely with the physician to develop an individualized pain management plan; continually monitor and observe the resident for success of the pain management plan; report to the prescriber as necessary to keep the resident comfortable; include the resident's goal for pain control in the care plan; and monitor and evaluate the effectiveness of the pain management plan. The policy further identified non-pharmacological interventions should be utilized and the care plan should be updated as needed to reflect current effective interventions. Facility policy was not followed when staff failed to adequately assess, monitor, evaluate, and revise R1's pain management plan despite ongoing reports of severe pain, ineffective interventions, and continued impairment in R1's comfort and functioning. Suggested Method of Correction: The facility could ensure residents experiencing pain are assessed, reassessed, and managed in accordance with practitioner orders and individualized care plans, with emphasis on timely identification and management of breakthrough or uncontrolled pain. Licensed nursing staff could be educated on proper pain assessment and reassessment, including required post-intervention evaluation, accurate documentation of pain characteristics and response to interventions, and the requirement to promptly notify the practitioner when pain is not effectively controlled or when prescribed interventions are ineffective or repeatedly unsuccessful. The facility could implement audits of residents receiving pharmacological pain management, including PRN	20830		06/19/2026

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20830	Continued from page 16 opioid use, to verify that pain reassessments are completed and documented after medication administration, that effectiveness of interventions is consistently evaluated and recorded, and that practitioner notification occurs when pain remains uncontrolled or persistent despite interventions. Audit results could be reviewed through the Quality Assurance and Performance Improvement (QAPI) process to identify trends, ensure corrective actions are effective, and sustain ongoing compliance. Time allowed for correction: 21 days. Findings include: R1's face sheet printed 6/3/26, identified diagnoses including chronic kidney disease stage 3, lymphedema (swelling caused by a buildup of fluid), chronic combined systolic and diastolic heart failure, chronic right-sided heart failure, benign prostatic hyperplasia (enlarged prostate) with urinary symptoms, localized edema (swelling), acute cystitis with hematuria (bladder infection with blood in the urine), and muscle weakness. R1's care area assessment (CAA) for urinary incontinence dated 2/5/26, identified urinary incontinence as an actual problem. The CAA identified R1 required assistance with toileting and was occasionally incontinent of urine. Contributing factors identified in the assessment included pain, restricted mobility, benign prostatic hyperplasia (enlarged prostate), congestive heart failure, use of diuretic medications, and opioid medications. The CAA further identified urinary incontinence placed R1 at risk for urinary tract infections, skin injury, loss of dignity, social isolation, and further functional decline. The assessment determined the issue would be addressed through care planning. R1's quarterly Minimum Data Set (MDS) dated 4/24/26, identified cognition was intact. The MDS further identified R1 was always incontinent of urine and received diuretic medication. R1's care plan identified a focus, revised 8/18/25, that R1 had a history of urinary tract infections (UTIs) and benign prostatic hyperplasia (enlarged prostate). The care plan goal directed staff to prevent skin breakdown related to incontinence and brief use. Interventions initiated 11/9/22, directed staff to encourage fluid intake during the morning and afternoon, limit fluids during the evening, avoid foods and beverages that may irritate the bladder, and monitor for signs and symptoms of a UTI, including pain, burning, blood in the urine, cloudy urine, decreased urine output, foul-smelling urine,	20830		06/19/2026

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20830	Continued from page 17 fever, chills, changes in mental status, and changes in behavior. An additional intervention initiated and revised 8/18/25, identified R1 preferred use of a urinal, refused briefs, would request assistance as needed, and had PRN orders for a condom catheter. An additional care plan focus, revised 2/12/24, identified R1 had a self-care deficit related to a history of fractures, limited mobility, and pain. The care plan goal directed staff to maintain R1's current level of function with bed mobility, transfers, eating, dressing, toileting, and personal hygiene. An intervention revised 11/15/24, directed staff to assist with toilet use by offering help to the bathroom and assistance with emptying the urinal upon arising, before and after meals, and at night. R1's Kardex dated 6/3/26, identified R1 preferred use of a urinal, refused briefs, and would request staff assistance as needed. The Kardex directed staff to assist with emptying the urinal and identified PRN condom catheter orders. The Kardex further directed staff to offer assistance with toileting and empty the urinal upon arising, before and after meals, and at night. R1's progress note dated 5/2/26 at 11:54 a.m., identified R1 required standby assistance to transfer to the toilet and extensive assistance with personal care and dressing. The note further identified R1 was unable to control his urine stream, was incontinent of urine, and left the urinal in his pants. R1's progress note dated 5/8/26 at 4:23 p.m., identified R1 reported constant urinary dribbling and stated he kept a urinal between his legs at all times because he was afraid of spilling urine. R1 further reported his penis was enlarged from having it in the urinal all the time. Staff educated R1 that he could rest in bed or a recliner and request assistance with the urinal before transferring to prevent spills. The note further identified R1 agreed to lie in bed and was later observed sleeping. R1's progress note dated 5/25/26 at 1:55 a.m., identified R1 returned from the hospital with a diagnosis of cystitis (bladder infection). The note further identified the provider recommended discontinuing use of the external condom catheter until the urinary infection was treated and cleared R1 to use a urinal. During a phone interview on 6/4/26 at 9:34 a.m., LPN-B stated the Geiserailie urinary collection device was first applied approximately two days before R1 was sent to the emergency department on 5/24/26 and was reapplied on 6/1/26. When asked	20830		06/19/2026

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20830	Continued from page 18 what assessment she completed before directing staff to apply the device on 5/23/26, LPN-B stated, "I didn't do one, we were just trialing it." LPN-B acknowledged she did not document an assessment on 5/23/26 or when the device was reapplied on 6/1/26 and stated, "I didn't do a formal one." LPN-B further stated no assessments had been completed and no care directions had been developed regarding prevention of skin breakdown, reduction of infection risk, or monitoring for complications associated with device use. When asked how she determined the device was safe to continue using after the hospital documented penile edema and cystitis, LPN-B stated she was instructed by the interim director of nursing to continue the trial. When asked what findings would indicate the device was causing a complication, LPN-B stated, "I am not sure if he would have gotten a rash, infection..." Review of R1's toileting response history identified staff documented R1's urinary continence as "not rated due to use of an indwelling catheter" on 5/23/26 at 6:25 p.m., 5/24/26 at 5:59 a.m., 9:36 a.m., and 8:35 p.m., 6/1/26 at 7:17 p.m., and 6/3/26 at 5:59 a.m. The toileting response history further identified staff documented R1's urinary continence as "not rated due to condom catheter" on 6/3/26 at 2:05 p.m. and 9:35 p.m. R1's weekly skin checks dated 5/4/26, 5/11/26, 5/18/26, and 5/27/26, identified R1's skin was warm and dry, skin color was within normal limits, skin turgor was normal, and no external devices were present. The skin did not identify use of the urinary collection device or document assessment of the penile skin and surrounding tissue related to device use. In review of R1’s record there was no indication a physician order had been obtained for the use of the Geiserailie device nor evident the care plan was revised. Further not evident of ongoing assessments and monitoring of device effectiveness and skin integrity. During an observation and interview on 6/2/26 at 3:48 p.m., R1 was observed seated in his wheelchair in his room. R1 stated, "I have a condom catheter. It's the penis and the thing that goes over it. It's not inside." Observation identified a drainage bag containing urine was positioned in a white pillowcase attached to the left side of the wheelchair. R1 stated he was unsure how often staff emptied the bag and reported staff changed the device when it needed to be changed. R1 stated staff were	20830		06/19/2026

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20830	Continued from page 19 responsible for managing the device and he did not know how it worked. R1 denied having sores or pain to his penis. R1 stated the device was being used because urine would leak from the urinal and result in a wet bed. During an interview on 6/2/26 at 4:37 p.m., nurse practitioner (NP)-A stated R1 was using an external urinary collection device obtained by the facility. NP-A stated the device was not a condom catheter but consisted of a support garment with a plastic receptacle that fit over the penis and drained into a closed urinary drainage bag. NP-A stated use of the device allowed R1 to sleep in bed rather than in his wheelchair with a urinal positioned between his legs. NP-A further stated the device had recently been reordered after it was discarded during R1's recent hospital stay. When asked about skin concerns related to the device, NP-A stated she was not aware of any skin issues. NP-A stated she approved use of the device but had not written orders regarding use of the device, routine maintenance, cleaning procedures, skin integrity monitoring, or infection prevention measures. During an interview on 6/3/26 at 12:14 p.m., nursing assistant (NA)-A stated she had emptied the drainage bag but had not applied the device. NA-A stated she had not received instructions regarding changing, cleaning, maintenance, or skin assessment related to the device and was unaware of any procedures for monitoring complications. During an observation and interview on 6/3/26 at 12:40 p.m., R1 was observed lying in bed with NA-A present. R1 was using an external urinary collection device consisting of a Y-shaped collection cup positioned around the penis and connected to tubing and a drainage bag. The penis was observed within the collection cup. R1 stated staff did not change or clean the device and reported, “I have had it in for about 3 days.” The drainage bag was observed attached to a Velcro strap and placed inside a black bag hanging from the side of the bed. NA-A stated she believed the drainage bag was intended to be secured to R1’s leg; however, the tubing was too long. NA-A stated she initially hung the drainage bag from the side of the bed, later placed it on the bed, and was unsure how it should be positioned. NA-A further stated she obtained a Velcro strap from the supply room and used it to secure the drainage bag. The support garment surrounding the collection cup had dried urine staining and a urine odor. When the drainage bag was placed on the bed, R1 stated urine could “back flush” and requested the bag be hung over the side of the bed. NA-A	20830		06/19/2026

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20830	Continued from page 20 complied and repositioned the drainage bag. During an interview on 6/3/26 at 1:02 p.m., NA-B stated staff were not provided instructions regarding cleaning, changing, or maintaining the urinary collection device. NA-B stated she checked the waistband for irritation but would need to remove the device to assess the penile skin and had not been directed to do so. NA-B further stated she was unaware of how often the device should be changed and had not received guidance regarding monitoring for complications. During an interview on 6/3/26 at 1:15 p.m., licensed practical nurse (LPN)-A stated she was unable to locate practitioner orders addressing use of the device and was not aware of its care or maintenance requirements. LPN-A stated there were no current orders directing staff to assess skin integrity related to device use and she was unsure whether staff were removing the device to perform skin assessments. During an interview on 6/3/26 at 3:21 p.m., the interim director of nursing (IDON) stated she initiated use of the Geiserailie three-piece urinary collection system for R1. IDON stated a physician or nurse practitioner order was not obtained prior to implementation of the device. The IDON further stated the care plan was not updated, no baseline assessment was completed prior to implementation, and no routine assessments were established after implementation. Staff were not provided training regarding application, cleaning, emptying, monitoring, or removal of the device and manufacturer instructions were not available. IDON stated there was no established process or frequency for assessment of R1’s penis or foreskin while using the device. IDON further stated the nurse practitioner was notified after the device had already been implemented. IDON could not determine whether penile edema was present prior to implementation because assessments had not been completed or documented. During a phone interview on 6/4/26 at 10:05 a.m., the medical director verified a provider order was not obtained prior to implementation of the Geiserailie urinary collection device. The medical director stated the intervention should have been care planned and staff provided direction regarding application, monitoring, cleaning, and maintenance of the device. Nursing staff should have completed and documented baseline and ongoing assessments of the penis and foreskin. The medical director noted the emergency department documented distal penile	20830		06/19/2026

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20830	Continued from page 21 edema and cystitis, although no obvious penile infection was identified. The medical director stated the skin should be assessed at least daily, the device should be changed daily, and distal penile edema should be reported to the provider. A provider order should be obtained prior to initiating any new urinary collection device. Facility undated policy, "Catheter Care," identified that urinary drainage systems should be maintained as a closed drainage system. The policy directed staff to secure the drainage bag with straps, observe the skin for irritation or changes and report concerns to the licensed nurse, empty the drainage bag routinely to prevent overfilling, and clean drainage bags according to established procedures. The policy further identified drainage bags should be cleaned with appropriate cleaning solutions and allowed to dry before reuse. The policy further identified staff were to observe the skin for irritation or changes and report concerns to the licensed nurse. Contrary to facility policy, staff did not routinely assess the skin, were not instructed regarding cleaning procedures, improvised methods for securing the drainage bag, and were unable to describe maintenance requirements for the urinary collection system. Suggested Method of Correction: The facility could assess residents utilizing urinary collection devices to ensure appropriate practitioner involvement, assessment, monitoring, and documentation. The facility could establish procedures for the implementation, care planning, monitoring, assessment of skin integrity and device-related complications, safe use, cleaning, maintenance, and replacement of urinary collection devices and educate staff on those procedures. The facility could review residents utilizing similar devices to ensure appropriate oversight is in place and conduct audits to verify compliance with assessment, monitoring, care, and documentation requirements. Time allowed for correction: 21 days.	20830		06/19/2026