DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Submitted

December 10, 2025

Administrator
Valley View Manor HCC
200 EAST NINTH AVENUE
LAMBERTON, MN 56152

RE: CCN: 245378
Cycle Start Date: November 19, 2025

Dear Administrator:

On November 19, 2025, 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.

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

REMOVAL OF IMMEDIATE JEOPARDY

On November 17, 2025, the situation of immediate jeopardy to potential health and safety cited at F689 was removed. However, continued non-compliance remains at the lower scope and severity of D.

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy(ies) listed below to the CMS location for imposition. The CMS location concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

• Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective December 25, 2025.

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

The CMS location will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective December 25, 2025, (42 CFR 488.417 (b)). They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective December 25, 2025, (42 CFR 488.417 (b)).

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $13,343; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

Therefore, your agency is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective November 19, 2025. This prohibition is not subject to appeal. Under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

SUBSTANDARD QUALITY OF CARE

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

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

Federal law, as specified in the Act at Sections 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, Valley View Manor HCC is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective November 19, 2025. This prohibition remains in effect for the specified period even though substantial compliance is attained. Under Public Law 105-15 (H. R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable plan of correction (ePOC) for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

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

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

DEPARTMENT CONTACT

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

Lisa Krebs, Regional Supervisor, Federal 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 their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by May 19, 2026 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

APPEAL RIGHTS DENIAL OF PAYMENT

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file

electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

tamika.brown@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
202-795-7490

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown at (312) 353-1502. Information may also be emailed to tamika.brown@cms.hhs.gov.

APPEAL RIGHTS NURSE AIDE TRAINING PROHIBITION

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

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

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division

330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201

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

INFORMAL DISPUTE RESOLUTION (IDR)

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

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

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

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

Feel free to contact me if you have questions.

Sincerely,



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

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December 10, 2025

Administrator
Valley View Manor HCC
200 EAST NINTH AVENUE
LAMBERTON, MN 56152

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

Dear Administrator:

The above facility survey was completed on November 19, 2025 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 Supervisor, Federal 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.

Sincerely,



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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245378	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 11/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Valley View Manor Hcc	200 EAST NINTH AVENUE , LAMBERTON, Minnesota, 56152

(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 11/7/25, 11/12/25, 11/13/25, 11/14/25, 11/17/25, 11/18/25, and 11/19/25 a standard abbreviated survey was completed at your facility by surveyors from the Minnesota Department of Health (MDH). The facility was not found NOT to be in compliance with the requirements of 42 CFR Part 483, Subpart B, requirements for Long Term Care Facilities. The survey resulted in an immediate jeopardy (IJ) to resident health and safety. An IJ at F689 that began on 10/20/25, when The IJ began on 10/20/25 after R2 had a fall that resulted in head laceration, the facility failed to complete a comprehensive analysis and implement appropriate interventions which resulted in and/or could have mitigated the risk of subsequent falls. The administrator and director of nursing (DON) were notified of the IJ on 11/13/25 at 4:01p.m. The immediate jeopardy was removed on 11/17/25 at 4:45 p.m., The above findings constituted Substandard Quality of Care and an extended survey was conducted on 11/14/25 and 11/17/25. The following complaints were reviewed: H53787182C (2661210) and H53787703C (2668560) with a deficiencies cited at F689 at IJ, F605, F867, F656, F657, F658, F684, F686, F842, F849, and F609. 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		12/25/2025
F0605 SS = D	Right to be Free from Chemical Restraints CFR(s): 483.10(e)(1),483.12(a)(2),483.45(c)(3)(d)(e)	F0605	R2 has since passed away. All current residents who are on psychotropic medications, their orders and care plans were reviewed and updated as needed. Future	12/25/2025

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See 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: 245378	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 11/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Valley View Manor Hcc	200 EAST NINTH AVENUE , LAMBERTON, Minnesota, 56152

(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
F0605 SS = D	Continued from page 1 §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any . . . chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must-. . . §483.12(a)(2) Ensure that the resident is free from . . . chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. . . . . §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and	F0605	Continued from page 1 residents who are prescribed psychotropic medications, non pharmalogical interventions will be identified and implemented, will have non pharmalogical interventions attempted prior to psychotropic administration and target behaviors identified per facility policy. Licensed nurses, nurse aides, and the IDT team will be in-serviced on the entire Antipsychotic Therapy policy with emphasis on what antipsychotics are not used for and to utilize non-pharmalogical interventions before a psychotropic is administered. Director of Nursing is responsible for compliance. Audits on non-pharmalogical intervention established upon admission and non-pharmalogical attempts prior to PRN antipsychotic medication being used will begin weekly x 2 weeks then monthly to ensure sustained compliance. Audit results will be reviewed by the Administrator, and the Administrator will take audit results to QAPI for review and recommendation. Compliance: 12/25/2025	

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F0605 SS = D	Continued from page 2 (iv) Hypnotic. §483.45(d) Unnecessary drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- (1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. §483.45(e) Psychotropic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that-- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for	F0605		

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F0605 SS = D	Continued from page 3 the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review the facility failed ensure residents were free from chemical restraints by not identifying duplicative antipsychotic therapy without appropriate indications, failed to identify target behaviors, failed to develop individualized non-pharmacological interventions, and failed to attempt and/or offer non-pharmacological interventions prior to the administration of as needed (PRN) doses of antipsychotic medications for 1 of 1 resident (R2) who had verbal and physical behaviors towards staff reviewed for falls. Findings include: Antipsychotic medications are a class of drugs used to treat psychosis—conditions where a person has difficulty distinguishing reality, often involving delusions, hallucinations, paranoia, or disorganized thinking According to the Food and Drug Administration (FDA) the package insert for Seroquel (quetiapine) carries boxed warnings for increased mortality in elderly patients with dementia-related psychosis and suicidal thoughts/behaviors in children, adolescents, and young adults. Seroquel (quetiapine) has a rapid onset for sedation (within hours), but its therapeutic effects on mood, psychosis, or depression typically take days to weeks to become noticeable, with full benefit often requiring several weeks. Its half-life is about 6–7 hours (immediate-release and extended-release), meaning it takes roughly 30–35 hours for full elimination from the body. According to the FDA Haldol (Haloperidol Lactate) the package insert for Haldol has a boxed warning for increased mortality in elderly patients with dementia-related psychosis. Its half-life is about 14–37 hours orally. The onset of action varies: oral onset is 2–6 hours. Falls risk in elderly due to sedation and blood pressure changes. R2's face sheet dated 11/14/25, identified R2 had	F0605		

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F0605 SS = D	Continued from page 4 diagnoses of Alzheimer's disease (a progressive brain disorder that slowly destroys memory and thinking skills) and vascular dementia severe with anxiety (an advanced stage of cognitive decline caused by blood vessel damage in the brain). R2's Annual Minimum Data Set (MDS) dated 11/6/25, indicated R2 had severe cognitive impairment and required supervision/touching assistance for transfers. During the assessment period R2 had physical behavior symptoms towards others 1-3 days, verbal behavior symptoms directed towards others 4-6 days, other behavioral symptoms not directed towards others (e.g., physical symptoms such as hitting or scratching self, pacing, rummaging, sexual acts, disrobing in public, or verbal symptoms like screaming, disruptive sounds) occurred 4-6 days , and was taking an anti-psychotic (a class of psychiatric medications used to manage symptoms of psychosis, such as hallucinations, delusions, and paranoia). R2's psychotropic medication management focus care plan dated 2/3/25, identified goal will be free from medication side effects. Interventions were as followed: -Consult pharmacist to review medications-target behaviors: hallucinations, delusions, agitation, excessive worrying, pacing (anti-psychotic), insomnia, sad/depressed mood, sexual behaviors (anti-depressant). -Non-pharmacological interventions that were identified were not individualized and/or person centered. Interventions included reassure and redirect resident, engage resident in a meaningful activity, conversation, or television show of his interest, offer snack, offer restroom, one to one. R2's behavior focus care plan dated 3/18/25, identified R2 had vascular dementia with severe anxiety. Goal to have fewer episodes of socially inappropriate behaviors weekly. Interventions were as followed: -observe behavior episodes and attempt to determine underlying cause, consider location, time of day, persons involved, and situations. -provide a program of activities that is of interest and accommodates resident status or call family to come for a visit if available and other interventions fail. R2's geriatric psychiatry follow-up note dated	F0605		

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F0605 SS = D	Continued from page 5 10/16/25, indicated the facility requested an earlier appointment for increasing behaviors. Facility and family could not identify any stressors or environmental changes that could impact R2's behaviors. Reviewed dementia and its inevitable progression to moderate to severe dementia, which may require escalation of medication to manage symptoms. Suggested initiating discussions with palliative care if R2 required medication increase. R2's record was reviewed from 6/24/25 through 11/13/25 and identified R2 had a been first prescribed scheduled Seroquel on 6/24/25; a PRN (as needed) dose was added on 7/19/25. Further review from 10/30/25 through 11/13/25 revealed R2 continued on scheduled Seroquel in addition to PRN doses available and then Haldol (Haloperidol Lactate) was prescribed for PRN doses (in addition to Serequel) when R2 was admitted to hospice which was duplicative antipsychotic therapy. During review of the R2's medication administration records (MAR), in conjunction with progress notes, and Behavior Monitoring and Intervention Reports (BMIR) there was no indication target behaviors were identified for the determination of which medication (Seroquel versus Haldol) should be used, nor evident non-pharmacological interventions were developed, offered or attempted prior to the administration of an as needed antipsychotic medication. Of mention R2's record also identified R2 had 5 falls (11/4/25, 11/7/25, 11/9/25, 11/10/25, and 11/11/25) when both medications were used on the same days. The records from 10/30/25 through 11/13/25 identified the following: R2's progress note dated 10/30/25, identified nurse practitioner attempted to remove staples to back of head, however, R2 was "not having it." R2's nurse practitioner progress noted dated 10/30/25, identified R2 was seen for an acute visit for staple removal to the back of the head from a recent fall. Only able to remove one staple today and recommend contact psychiatrist today to request consideration of a PRN medication to help with aggravation and restlessness today. R2's progress note dated 11/1/25, identified R2 was admitted to hospice services on 10/31/25 and received an order for Haldol 2 mg/ml-administer 2.5 mg prior to staple removal and then ok to use every 4 hours PRN if other medications are not managing agitation. Change	F0605		

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F0605 SS = D	Continued from page 6 PRN Seroquel to 25 mg three times per day for unmanaged agitation. During an interview on 11/13/25 at 10:23 a.m., consulting pharmacist (C-Pharm) stated having a Haloperidol and Seroquel order would be considered duplicate therapy since they both are in the same drug class (anti-psychotics). This had the potential to cause increase in falls, drowsiness, orthostatic hypotension, and dizziness. C-Pharm was not aware R2 had received this duplicate drug and if she had known she would have asked for the Haloperidol to be discontinued. R2's BMIR on 11/1/25 included behaviors of agitation, restlessness, insomnia, experiencing something not there and refusing cares at 6:21 a.m. and 7:59 p.m., however, was given a PRN Seroquel at 10:32 p.m. which was 2 hours and 33 minutes after the documented behavior. R2's progress note dated 11/2/25 at 10:43 a.m., identified R2 was in a good mood and had staples removed from back of head. R2's BMIR on 11/2/25 did not identify R2 demonstrated any behaviors, however, R2's MAR identified Haldol was given 2:00 p.m. R2's BMIR on 11/3/25 did not identify R2 demonstrated any behaviors, however, R2's MAR identified Seroquel was given 12:01a.m. R2's progress note dated 11/5/25 at 3:18 p.m., identified a new order from hospice to start Haloperidol (Haldol) 2 mg/ml: 0.5 ml every 4 hours if needed for agitation or hallucinations. R2's MAR identified Haldol was given at 9:31 a.m., 1:37 p.m. and 8:37 p.m. R2's progress note dated 11/5/25 at 9:36 p.m., identified R2 was in and out of resident rooms. Is redirected and becomes aggressive towards staff. R2 grabbed this nurse arm and proceeded to shove nurse, even with Haldol on board and remains resistive with cares. R2 BMIR on 12/5/25 included behaviors of grabbing others, pushing others, cursing at others, express frustration with others, screaming at others, agitated, anxious/restless, neglecting self-care, and refusing care at 10:07 p.m. R2's MAR then identified R2 was administered Seroquel at 11:27 p.m.	F0605		

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F0605 SS = D	Continued from page 7 R2's MAR on 11/6/25 identified Haldol was given at 3:28 a.m.,11:03 a.m. and 2:34 p.m., however, R2's BMIR did not identify a behavior of being agitated, anxious/restless, experiencing something not there, refusing care until 10:23 p.m. Progress note dated 11/6/25 at 10:51 p.m., identified R2 became very loud throughout the shift, especially when staff try to assist R2. R2 was given a PRN Seroquel. R2's BMIR on 11/7/25 did not identify R2 demonstrated any behaviors, however, R2's MAR identified Haldol was given at 12:16 p.m. and Seroquel was given 3:54 p.m. R2's BMIR on 11/9/25 included behaviors of cursing and screaming, neglecting self-care and agitation observed at 3:30 a.m. R2's MAR on 11/9/25 identified Haldol was administered at 10:04 a.m., approximately 5 ½ hours after the behaviors at 3:30 a.m. R2's BMIR also included behaviors of cursing and screaming, neglecting self-care and agitation observed at 1:59 p.m., and 9:44 p.m., however, PRN Seroquel was administered at 10:26 p.m., which was approximately 45 minutes after the last the behavior. R2's BMIR on 11/10/25 did not identify R2 demonstrated any behaviors, however, R2 was administered Haldol at 1:25 a.m.,10:07 a.m., and 11:42 p.m. and Seroquel was given at 4:50 a.m. During an interview on 11/18/25 at 11:22 a.m., registered nurse (RN)-B stated she administered R2 a PRN dose of Haldol on 11/10/25 at 11:42 p.m. R2 had been attempting to self-transfer while seated in his wheelchair. RN-B stated she instructed staff to attempt to take R2 to the bathroom. R2 used the toilet, however, R2 refused to stand up from the toilet and began striking out at staff. RN-B stated staff then attempted to use a stand-aid (a medical device that helps individuals with limited mobility to stand up and move positions) to get R2 to agree to get off the toilet, but R2 began hitting, pinching, and yelling at staff. RN-B stated she then gave R2 a dose of Haldol to "get him to settle down and "get him to cooperate" as he was hitting the staff and not agreeing to get off the toilet. RN-B stated she had not tried any other non-pharmacological interventions or assessed if R2 was in pain and offered pain medication first instead of trying an antipsychotic first. During a interview on 11/14/25 at 10:44 a.m., C-Pharm	F0605		

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F0605 SS = D	Continued from page 8 stated Haldol could be used as a chemical restraint if used in the “wrong way”. Haldol can cause side effects such as lethargy and sedation in which could cause a resident to have an increase in falls. R2’s PRN antipsychotic administrations records were reviewed with C-Pharm. C-Pharm stated prior to any PRN psychotropic being administered, a non-pharmacological interventions would have to be attempted and this would need to be documented in the resident’s medical record. Administering a medication to have a resident to “cooperate” would be considered use of a chemical restraint and should not been used in that way. R2’s BMIR on 11/11/25 did not identify R2 demonstrated any behaviors, however, R2’s MAR identified Haldol was given at 11:05 a.m. and Seroquel was given 11:33 p.m. R2’s progress notes dated 11/11/25 at 2:06 p.m., identified R2 was up and restless and was given as needed and scheduled medication to help with restlessness. During an interview on 11/12/25 at 2:11p.m., hospice registered nurse (HRN)-G stated when she performed a routine visit for R2 on 11/12/25, she discovered that R2 had both Haldol and Seroquel PRN orders. HRN-G further stated that this was a “red flag” because of the duplicate drugs, and she had contacted the physician to see if the Haldol PRN could be discontinued. HRN-G stated Haldol PRN is normally part of the hospice standing orders and was unsure what was the rationale it was added in addition to the Seroquel PRN. R2’s hospice progress note dated 11/12/25 at 3:12p.m., identified R2 had four falls since last week and staff had been using PRN Haldol and PRN Seroquel in addition to the scheduled Seroquel and was there a reason a reason both anti-psychotics prescribed. Both medications indicated use for anxiety, agitation (Haldol also notes delirium and Seroquel indicates hallucinations). R2’s hospice progress noted dated 11/13/25 at 8:45 a.m., indicated the Haldol order was to be given prior to suture removal and nursing staff stated when R2 received the Haldol, R2 responded very well and took the remainder of his medications that R2 had previously been refusing. Physician ordered to remove Haldol off R2’s medication list. During a interview on 11/14/25 at 10:44 a.m., C-Pharm stated Haldol could be used as a chemical restraint if used in the “wrong way”. Haldol can cause side effects such as lethargy and sedation in which could cause a	F0605		

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F0605 SS = D	Continued from page 9 resident to have an increase in falls. R2's PRN antipsychotic administrations records were reviewed with C-Pharm. C-Pharm stated prior to any PRN psychotropic being administered, a non-pharmacological interventions would have to be attempted and this would need to be documented in the resident's medical record. Administering a medication to have a resident to "cooperate" would be considered use of a chemical restraint and should not been used in that way. During an interview on 11/12/25 at 12:34 p.m., nursing assistant (NA)-F stated when R2 got agitated with NA's, "we would just get the nurse to give him some Haldol to mellow him out, so he does not yell so much." During an interview on 11/19/25 at 3:32 pm., RN-G stated a residents have the right to be treated with dignity and respect, including to be free from chemical restraints. H-RN stated if her family member had been administered a PRN anti-psychotic like Haldol to get her "to cooperate or "settle her down" without trying some sort of non-pharmacological intervention prior she would be "appalled" that that happened her family member. During an interview on 11/12/25 at 10:16 a.m., licensed practical nurse (LPN)-A stated Haloperidol was ordered for R2 as a "pain medication" and Seroquel was ordered as an "anti-anxiety" medication. If R2 is having pain, we can give him the Haloperidol. LPN-A then obtained a drug reference book and identified that Haloperidol and Seroquel were both an anti-psychotic medication and that would be considered a duplicate therapy. LPN-A stated if she noted a duplicate therapy in a resident's chart, she would not contact the provider, because this would be up to the discretion of the physician to make that determination if they needed it. LPN-A did not identify a concern that R2 had this duplicate therapy of Haloperidol and Seroquel. LPN-A was unable to articulate what the possible side effects of these medications were and had to reference the drug reference book to identify drowsiness, dizziness, and increase in falls as some of the listed side effects. LPN-A stated that she was unaware if a non-pharmacological intervention needed to be tried before administering an as needed antipsychotic. R2's as needed Seroquel and Haloperidol was ordered for agitation, so if R2 was agitated we would administer this to him to "settle down". During an interview on 11/12/25 at 11:47 a.m., interim assistant director of nursing (I-ADON) stated R2 had an order for Haldol and Seroquel PRN to be given for agitation, he was unaware of the drug class (a group of	F0605		

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F0605 SS = D	Continued from page 10 medications that share similar chemical structures and act through the same mechanism) that Haldol and Seroquel were in, nor the side effects of either of the medications. I-ADON then proceeded to "Google" Haldol and Seroquel and then stated they were both considered anti-psychotic medications and that the Haldol and Seroquel had been ordered by the hospice agency and he would not have gotten clarification to see if hospice wanted a duplicate therapy, because "the doctor must have wanted it for R2." I-ADON was not aware if a non-pharmacological intervention needed to be attempted prior to administering a PRN antipsychotic or where that would be documented. I-ADON stated both Seroquel and Haloperidol could cause sedation, lethargy (a state of unusual drowsiness), and dizziness when administered and if it was used in the incorrect way it could be considered a chemical restraint. During an interview on 11/19/25 at 3:18 p.m., medical director (MD) stated R2's Haloperidol was only initially ordered as a one-time dose to give prior to the provider removing the sutures on the back of the head. The as needed every 4-hour dose was only supposed to be given as a last resort if no other medication were effective and was unaware that R2 had received multiple doses of this medication and had now discontinued the as needed Haloperidol to "clean up" his record. During an interview on 11/12/25 at 5:11 p.m., director of nursing (DON) stated R2 had been followed by psychiatry and had an order for Seroquel scheduled and PRN for agitation and hallucinations, however R2 was admitted to hospice on 10/31/25 when a PRN order for Haldol was also added to R2's orders. DON stated Haldol and Seroquel PRN would be a duplication of therapy since both medications are in the same drug class and should have not had both orders at the same time. DON stated the facility should have called and got clarification from the physician that ordered the PRN Haldol to see if this was supposed to be in R2's orders. DON further stated staff are supposed to document and attempt a non-pharmacological intervention prior to administering any PRN psychotropic medications. DON reviewed R2's progress notes from 11/1/25 to 11/12/25 and did not identify any documentation of a non-pharmacological intervention prior to administration of the PRN Haldol or Seroquel. During an interview on 11/18/25 at 2:45 p.m., administrator stated all PRN psychotropics should have a documented non-pharmacological intervention prior to the medication to being administered and should never be given out of convenience.	F0605		

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F0605 SS = D	Continued from page 11 Review of the facility's Anti-psychotic Medication Use policy undated, identified residents will not receive medications that are not clinically indicated to treat a specific condition. Policy Interpretation and Implementation were as follow: 1. A psychotropic medication is any mediation that affects brain activity associated with mental processes and behavior. 2. Drugs in the following categories are considered psychotropic medications and are subject to prescribing, monitoring, and review requirements specific to psychotropic medications: a. Anti-psychotics. b. Anti-depressants. c. Anti-anxiety medications; and d. Hypnotics. 3. Residents, families, and/or the representative are involved in the medication management process. Psychotropic medication management includes: a. indications for use. b. dose (including duplicate therapy); c. duration. d. adequate monitoring for efficacy and adverse consequences; and e. preventing, identifying, and responding to adverse consequences. 4. Residents who have not used psychotropic medications are not prescribed or given these medications unless the medication is determined to be necessary to treat a specific condition that is diagnosed and documented in the medical record. 5. Use of psychotropic medications (other than antipsychotics) are not increased when efforts to decrease antipsychotic medications are being implemented. 6. Medications not classified as anti-psychotic, anti-depressant, anti-anxiety, and hypnotic medication are not prescribed or administered as a substitution	F0605		

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F0605 SS = D	Continued from page 12 for another psychotropic medication unless there is a documented clinical indication consistent with clinical standard of practice. 7. Categories of medications which affect brain activity such as antihistamines, anti-cholinergic medications, and central nervous system medications that are prescribed as a substitute for or an adjunct to a psychotropic medication are monitored and managed as psychotropic medications. 8. Consideration of the use of any psychotropic medication is based on comprehensive review of the resident. This includes evaluation of the resident's signs and symptoms in order to identify underlying causes. 9. Use of psychotropic medications may be considered appropriate in specific circumstances. These include: a. acute or emergency situations. b. enduring conditions; and/or c. new admissions where the resident is already on a psychotropic medication. 10. Non-pharmacological approaches are used (unless contraindicated) to minimize the need for medications, permit the lowest possible dose, and allow for discontinuation of medications when possible. 11. Residents on psychotropic medications receive gradual dose reductions (coupled with non-pharmacological interventions), unless clinically contraindicated, in an effort to discontinue these medications. 12. Psychotropic medications are not prescribed or given on a PRN basis unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record. a. PRN orders for psychotropic medications are limited to 14 days. (1) For psychotropic medications that are NOT antipsychotics: If the prescriber or attending physician believes it is appropriate to extend the PRN order beyond 14 days, he or she will document the rationale for extending the use and include the duration for the PRN order.	F0605		

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F0605 SS = D	Continued from page 13 (2) For psychotropic medications that ARE antipsychotics: PRN orders cannot be renewed unless the attending physician or prescriber evaluates the resident and documents the appropriateness of the medication. 13. If psychotropic medications are identified as possibly causing or contributing to adverse consequences, the prescriber will determine whether the medication(s) should be continued and document the rationale for this decision. Review of the facility's Anti-Psychotic Medication Use Policy undated, identified antipsychotic medications may be considered for residents with dementia but only after medical, physical, functional, psychological, emotional psychiatric, social and environmental causes of behavioral symptoms have been identified and addressed. Antipsychotic medications will be prescribed at the lowest possible dosage for the shortest period and are subject to gradual dose reduction and re-review. Antipsychotic medications will not be used if the only symptoms are one or more of the following: a. Wandering. b. Poor self-care. c. Restlessness. d. Impaired memory. e. Mild anxiety. f. Insomnia. g. Inattention or indifference to surroundings. h. Sadness or crying alone that is not related to depression or other psychiatric disorders. i. Fidgeting. j. Nervousness; or k. Uncooperativeness.	F0605		
F0609 SS = D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4)	F0609	R5 has since been discharged from the facility. As of this writing, there have been no reportable incidents that have occurred. Future suspected allegations of abuse of unknown origin will be reported to the State	12/25/2025

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F0609 SS = D	Continued from page 14 §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review the facility failed to ensure that alleged violations involving abuse/neglect were reported to the administrator and to the State Agency (SA) timely, in accordance with established policies for 1 of 1 resident (R5) reviewed for injury of unknown origin. Findings include: R5's face sheet dated 11/19/25, identified diagnoses malignant neoplasm of the of ovary and malignant neoplasm of the thyroid gland (cancer of the thyroid gland), and morbid obesity. R5's Admission Minimum Data Set (MDS) dated 11/4/25, identified R5 had no skin issues, was frequently incontinent of bowel, and was cognitively intact. R5's skin focus care plan dated 10/31/25, identified R5 was at risk for impaired skin integrity related to morbid obesity and lack of mobility.	F0609	Continued from page 14 Agency per facility policy. Facility staff will be in-serviced on Abuse, Neglect, Misappropriation Reporting and Investigating with emphasis on item #1 that all suspected allegations of abuse including injuries of unknown source must be reported to the state agency immediately per facility policy. Social Service Designee is responsible for compliance. Audits on reporting allegations to the state agency timely will begin 1x week for 2 weeks then monthly to ensure sustained compliance. Audit results will be reviewed by the Administrator, and the Administrator will take audit results to QAPI for review and recommendation. Compliance: 12/25/2025	

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F0609 SS = D	Continued from page 15 During an interview on 11/18/25 at 12:24 p.m., hospice registered nurse (H-RN) stated that as a hospice nurse she is a contracted staff that provided extra support to residents in the facility while under hospice care. H-RN performed a routine visit for R5 on 11/13/25 when R5 informed her she had been sitting in feces for a long time and staff would not assist her with changing her brief or clean her up, and that she had not received a shower since she was admitted to the nursing home. H-RN also observed a large open blister on R5's right lower leg with a large purple discoloration on the back of her leg, of which to her appeared to be a large bruise. H-RN stated she had asked the interim assistant director of nursing (I-ADON) if he was aware of how R5 obtained the bruise and blister, however, was told he did not know anything about it. H-RN stated normally she would report this type of concerns of neglect and injury of unknow origin to the director of nursing (DON) and/or the administrator, however, the DON was busy with another resident, so she did not report this information to her or the administrator. During an interview on 11/19/25 at 2:44p.m., the administrator stated hospice agency staff were considered contracted staff and need to follow the same policies and procedures for reporting as the staff in the facility. If any staff, including contracted staff became aware of an allegation of neglect they would report this immediately the DON or the administrator, however, had not had any reports of allegation of neglect made by any contracted staff. Review of the facility Hospice Services Agreement dated 2/24, identified that hospice should report all alleged violations involving mistreatment, neglect, or verbal, mental, sexual, and physical abuse including injuries of unknown source, and misappropriation of patient property by anyone unrelated to the hospice to the facility administrator within 24 hours of the hospice becoming aware of the alleged violation. During an interview on 11/21/25 at 4:20 p.m., clinical director of hospice (CD-H) stated she was unaware if the hospice agency would follow the facility's reporting policy and was unaware if they had received the facility reporting policy. CD-H was unaware the hospice services agreement dated 2/24, identified that if hospice received an allegation this would need to be reported immediately to the facility administrator. Review of the facility's Abuse, Neglect, Exploitation or Misappropriation-Reporting and Investigating Policy undated, identified that if resident abuse, neglect, exploitation, misappropriation of resident property or	F0609		

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F0609 SS = D	Continued from page 16 injury of unknown source is suspected, the suspicion must be reported immediately to the administrator, director of nursing and the other officials according to state law.	F0609		
F0656 SS = D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.	F0656	R2 has since passed away. All current residents who have behaviors, their care plans were reviewed and updated as needed. Future residents who trigger in Section 9 of the CAA, their care plans will be implemented with target behavior and individualized interventions per policy. The IDT team will be in-serviced on the Comprehensive Care Plan Policy with emphasis on item #1 which instructs the IDT team, in conjunction with the resident and family, will develop a comprehensive, person-centered care plan for each resident. Director of Nursing is responsible for compliance. Audits on CAA area #9 for behaviors and person center interventions will begin weekly x 2 weeks then monthly to ensure sustained compliance. Audit results will be reviewed by the Administrator, and the Administrator will take audit results to QAPI for review and recommendation. Compliance: 12/25/2025	12/25/2025

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F0656 SS = D	Continued from page 17 §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review the facility failed to develop a comprehensive person-centered behavior care plan with individualized interventions for behavior management for 1 of 1resident (R2) with Alzheimer's Disease. Findings include: R2's face sheet dated 11/14/25, identified diagnoses of Alzheimer's disease(a progressive neurological disorder and the most common cause of dementia), congestive heart failure (a chronic condition where the heart muscle cannot pump enough blood to meet the body's needs), diabetes mellitus (the body does not produce enough insulin), and chronic obstructive respiratory failure (when the airways that carry air to the lungs become narrow or damaged). R2's Significant Change Minimum Data Set (MDS) dated 11/6/25, identified R2 needed supervision/touching assistance for transfers, had severe cognitive impairment, had physical behavior symptoms towards others 1-3 days, verbal behavior symptoms directed towards others 4-6 days, but less than daily, and other behavioral symptoms not directed towards others (e.g., physical symptoms such as hitting or scratching self, pacing, rummaging, sexual acts, disrobing in public, or verbal symptoms like screaming, disruptive sounds) occurred 4-6 days, but less than daily, and was taking an anti-psychotic. R2's psychotropic medication management focus care plan dated 2/3/25, identified goal will be free from medication side effects. Interventions were as followed: -Consult pharmacist to review medications-target behaviors: hallucinations, delusions, agitation, excessive worrying, pacing (anti-psychotic), insomnia, sad/depressed mood, sexual behaviors (anti-depressant). -Non-pharmacological interventions-reassure and redirect resident, engage resident in a meaningful activity, conversation, or television show of his interest, offer snack, offer restroom, one to one.	F0656		

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F0656 SS = D	Continued from page 18 R2's behavior focus care plan dated 3/18/25, identified R2 had a behavior problem due to vascular dementia with severe anxiety. Goal to have fewer episodes of socially inappropriate socially inappropriate behaviors weekly. Interventions added 3/18/25 were as followed: -observe behavior episodes and attempt to determine underlying cause, consider location, time of day, persons involved, and situations. - provide a program of activities that is of interest and accommodates resident status or call family to come for a visit if available and other interventions fail. R2's behavior management focus care plan dated 8/12/25, identified goal to remain safe. Interventions were as followed: -ensure the safety of resident and others -evaluate elopement risk -monitor for cognitive factors that may contribute to new behavior. -monitor for environmental factors that may contribute to new behavior. -monitor for signs and symptoms of infection. -reorient resident to person, place, time, and situation. -utilize diversion techniques as needed. R2's outpatient geriatric psychiatry follow-up note dated 10/16/25, identified R2 was seen due to a requested appointment due to worsening behaviors at the skilled nursing facility. Encourage ongoing utilization of non-pharmacological interventions, such as environmental modifications, distractions, music, and relaxation activities to manage behaviors as well. R2's record did not identify a comprehensive assessment of R2's behaviors and individualized behavior interventions that are effective for R2. R2's progress note dated 11/2/25, identified R2 was agitated and would not/unable to follow directions, was sitting at the nurse's desk. R2 was given a sandwich and taken to his room and urinated on the floor in his room.	F0656		

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F0656 SS = D	Continued from page 19 R2's progress note dated 11/3/25, identified R2 was yelling and wandering into other resident's rooms, undressing in the hallways, swinging at staff and urinated on the wall in his room. Interventions attempted of redirection and family sitting with resident which was only effective for few minutes. R2's psychosocial quarterly progress note dated 11/4/25, identified R2 had dementia with behaviors and follow psychiatry. R2 does have behavioral issues including wandering, verbal and physical aggression and is resistive with taking medications and cares. R2's preferences evaluation progress note dated 11/5/25, identified R2 prefers country music, and it very important to him to be around animals such as pets, and favorite activities included watching television, visiting, looking at tractor and truck books and to go outside when the weather is nice. R2's care plan did not identify R2's preferences. R2's progress note dated 11/5/25, identified R2 was going in and out of resident rooms and when attempted redirection, R2 becomes aggressive towards staff and grabbed the nurse and attempted to "shove" staff. R2's progress note dated 11/9/25, identified R2 was yelling out at staff and other residents. R2's progress note dated 11/11/25, identified R2 was restless and was given as needed medication to help with restlessness. R2's progress note dated 11/12/25, identified R2 attempted to stand up from the wheelchair and as staff attempted to redirect R2 he became loud and agitated and urinated on the floor. During an interview on 11/7/25 at 3:38 p.m., nursing assistant (NA)-D) stated R2's behaviors had been getting "worse" over the past few weeks, however, was unable to articulate specific care plan non-pharmacological interventions for R2, that staff should be using to decrease R2's behaviors. NA-D stated that without having specific behavior interventions in his care plan would make it "very difficult" for unfamiliar staff to care for R2 and could make R2's behaviors "worse". During an interview on 11/7/25 at 4:00 p.m., NA-E stated R2 had some "good days and "bad days" due to his dementia, however, NA-E was unable to articulate what type of non-pharmacological interventions staff were supposed to use to help decrease R2's symptoms. NA-E	F0656		

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F0656 SS = D	Continued from page 20 was unable to identify any interventions on R2's care plan that would be effective in reducing his behaviors. During an interview on 11/7/25 at 4:13 p.m., director of nursing (DON) stated R2's care plan had not been created to include person-centered interventions to decrease his behaviors to give direction of staff to assist R2 with each identified and/or newly identified behaviors. DON stated she will be meeting with the team to add person-centered interventions on R2's care plan to reduce some of R2's behaviors. R2's behavior focus care plan had added Interventions added on 11/7/25, that included that R2's triggers include pain, having to use the bathroom, hallucinations, thinking he is working/you are an employee. R2 owned a backhoe company and farmed/worked with livestock. R2's behavior is deescalated by the following: 1) ensure that you have R2's attention by calmly but firmly saying his name-saying it multiple times may be required. 2) ensure you have eye contact 3) ask R2 is he needs to use the restroom 4) ask if R2 is hungry 5) offer R2 something to drink 6)ask R2 questions rather that giving commands 7) alert nurse to assess if as needed medications may be needed 8) talk mechanics, horses, farming with patient/ask questions about this topic. During an interview on 11/19/25 at 1:53 p.m., social services designee (SSD) stated that the facility does not analyze R2's behaviors to determine person centered behavior reduction interventions and ensure those interventions are placed in a resident's care plan. SSD stated since R2's care plan had included individualized behavior interventions on 11/7/25, she had already noticed a decrease in R2's behaviors. Review of the facility's Care Plan, Comprehensive Person-Centered Policy undated, indicated a comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. Policy Interpretation and Implementation were as followed:	F0656		

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F0656 SS = D	Continued from page 21 1. The interdisciplinary team (IDT), in conjunction with the resident and his/her family or legal representative, develops and implements a comprehensive, person-centered care plan for each resident. 2. The comprehensive, person-centered care plan is developed within seven (7) days of the completion of the required MDS assessment (Admission, Annual or Significant Change in Status), and no more than 21 days after admission. 3. The care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment. 4. If the participation of the resident and his/her resident representative in developing the resident's care plan is determined to not be practicable, an explanation is documented in the resident's medical record. The explanation should include what steps were taken to include the resident or representative in the process. 5. The comprehensive, person-centered care plan: 1. includes measurable objectives and timeframes. 2. describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, including: 1. services that would otherwise be provided for the above but are not provided due to the resident exercising his or her rights, including the right to refuse treatment. 2. any specialized services to be provided because of PASARR recommendations; and 3. which professional services are responsible for each element of care. 3. includes the resident's stated goals upon admission and desired outcomes. 4. builds on the resident's strengths; and 5. reflects currently recognized standards of practice for problem areas and conditions.	F0656		

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F0656 SS = D	Continued from page 22 6. Services provided for or arranged by the facility and outlined in the comprehensive care plan are: 1. provided by qualified persons. 2. culturally competent; and 3. trauma informed. 7. Care plan interventions are chosen only after data gathering, proper sequencing of events, careful consideration of the relationship between the resident's problem areas and their causes, and relevant clinical decision making. 8. When possible, interventions address the underlying source(s) of the problem area(s), not just symptoms or triggers. 9. Assessments of residents are ongoing, and care plans are revised as information about the residents and the residents' conditions change. 10. The interdisciplinary team reviews and updates the care plan: 1. when there has been a significant change in the resident's condition. 2. when the desired outcome is not met. 3. when the resident has been readmitted to the facility from a hospital stay; and 4. at least quarterly, in conjunction with the required quarterly MDS assessment. 11. The resident has the right to refuse to participate in the development of his/her care plan and medical and nursing treatments. Such refusals are documented in the resident's clinical record in accordance with established policies.	F0656		
F0657 SS = D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment.	F0657	R2 has since passed away. R6 care plan for falls and skin was reviewed and updated as needed. All current residents from survey exit until present, their fall incidents and skin documentation and care plans will be reviewed and updated as needed. Future residents who admit will have their care plans focus, goals and interventions thoroughly reviewed and updated per facility policy. The IDT team and licensed nurses will be in-serviced on the Comprehensive Care Plan Policy with emphasis on	12/25/2025

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F0657 SS = D	Continued from page 23 (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review the facility failed to revise the care plan for 2 of 3 residents (R2, R6) who were reviewed for falls and impaired skin integrity. Findings include: R2's face sheet dated 11/14/25, identified diagnoses of Alzheimer's disease(a progressive neurological disorder and the most common cause of dementia), congestive heart failure (a chronic condition where the heart muscle cannot pump enough blood to meet the body's needs), diabetes mellitus (the body does not produce enough insulin), and chronic obstructive respiratory failure (when the airways that carry air to the lungs become narrow or damaged). R2's Annual Minimum Data Set (MDS) dated 11/6/25, identified R2 used a wheelchair and needed supervision/touching assistance for transfers and ambulation, had one fall with no injury, one fall with minor injury since admission and had severe cognitive impairment. R2's functional performance focus care plan dated	F0657	Continued from page 23 updating resident care plans when there's a significant change, when the outcome is not met and when the resident has been readmitted to the facility from a hospital stay and at least quarterly with the required MDS assessment. Director of Nursing is responsible for compliance. Audits on care plan revisions will begin weekly x 2 weeks then monthly to ensure sustained compliance. Audit results will be reviewed by the Administrator, and the Administrator will take audit results to QAPI for review and recommendation. Compliance: 12/25/2025	

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F0657 SS = D	Continued from page 24 2/3/25, identified R2's care plan goal of to progress towards personal discharge goal during stay. Interventions were as followed: - Transfer - Independent / no set-up or physical help - Toilet use - Limited assist / two-person physical assist - Walk in corridor - Supervision / no set-up or physical help - Locomotion on Unit - Supervision / no set-up or physical - Locomotion off Unit - Supervision / no set-up or physical R2's fall focus care plan dated 2/3/25, identified R2 was at risk for falls as evident by scoring tool, antidepressant use, and wandering behaviors. R2's care plan goal was to be free from falls. Interventions included: -educate on the importance of maintaining a safe environment, free from potential fall hazards. -evaluate fall risk on admission and as needed; review medication for drugs that increase the risk for falls. -Intervention added on 5/12/25 to assist R2 with ambulation and transfers, utilizing therapy recommendations. During an observation on 11/12/25 at 10:25 a.m., R2 was seated in a wheelchair, propelling himself with his feet around the lobby. R2's care plan had not been revised to reflect R2 used a wheelchair. During an interview on 11/12/25 at 10:33 a.m., nursing assistant (NA)-A stated R2's care plan indicated R2 was independent with transfers, however, R2 had not been independent for "a while" due to being "unsteady" on his feet and had multiple falls. NA-A further stated R2 had been wheelchair while out of his room, however, R2's care plan had not been updated to reflect this change. In review of R2's care plan in conjunction with R2's fall record there was no indication R2's fall care plan goals were appropriate, and interventions were evaluated for effectiveness that would prevent or mitigate the risk for recurrent falls and/or the care	F0657		

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F0657 SS = D	Continued from page 25 plan was revised with new interventions based on R2's safety needs to prevent falls and falls with major injury. R2's fall incident report dated 10/20/25 at 1:46 a.m., identified R2 was found on the floor in his room with a 7-8 cm laceration on the back of his head and an abrasion on the right inner arm. R2 thought he was answering the phone. R2's fall incident report dated 11/4/25 at 8:45 a.m., identified R2 was found in his room kneeling and leaning on a chair in his room. R2's fall incident report dated 11/7/25 at 6:29 p.m., identified R2 was found lying on his face in his room at 5:50 p.m. R2's fall incident report dated 11/9/25 at 4:50 p.m., identified R2 was found sitting on the floor in his room next to his chair. R2 was trying to pick up specks on the floor and had been sitting in chair which is low to ground. R2's fall incident report dated 11/10/25 at 8:30 p.m., identified R2 was found sitting between chair and bedside table. R2's fall incident report dated 11/11/25 at 8:30 p.m., identified R2 was in hall and grabbed the handrail to pull himself up to a standing position and began walking and then started going down and before staff could get to R2 he fell to the ground. During an interview on 11/12/25 at 3:23 p.m., registered nurse (RN)-A stated after a resident has fallen, the nurse is supposed to initiate an immediate intervention to mitigate the risk of a resident falling again. RN-A further stated she was not aware that a resident's care plan needed to be revised to reflect the intervention and believes this would be something the director of nursing (DON) was responsible to complete. During an interview on 11/12/25 at 3:56 p.m., interim director of nursing (I-ADON) stated R2's care plan had not been revised to include any updated individualized fall prevention interventions nor R2's transfer changed to remove independent during transfers and had not had a wheelchair added to R2's care plan. I-ADON stated the DON does resident care plan revisions and not the nurses.	F0657		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245378	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 11/19/2025

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F0657 SS = D	Continued from page 26 R6's face sheet dated 11/19/25, identified diagnoses of hemiplegia (paralysis) affecting left side, diabetes mellitus (body does not make enough insulin), and heart failure (a condition where the heart does not pump enough blood to the body). R6's Annual Minium Data Set (MDS) dated 10/23/25, identified R6 was dependent for bed mobility/transfers, at risk for developing pressure ulcers, had no pressure ulcers, and was cognitively intact. R6's skin integrity focus care plan last revised on 4/29/25, identified R6 had a potential impairment to skin integrity related to bowel and bladder incontinence and impaired mobility. Goal to maintain or develop clean and intact skin. Interventions were as followed: may apply barrier cream after each incontinent episode; elevate heels off the bed; keep skin clean and dry, use lotion on dry skin, prefers to not be checked every two hours; pressure relieving/reducing cushion in wheelchair; standard pressure relieving/reducing mattress to protect skin while in bed. R6's nursing home rounding form dated 11/10/25, identified the nurse practitioner requested to check that R6's air mattress was working. During an observation and interview on 11/18/25 at 10:21 a.m., R6 was lying in bed on top of a specialty mattress in place. R6 stated she had this type of mattress on for some time due to a sore on her bottom and because she spends a lot of time in bed. NA-F stated R6 had been on an air bed for "some time" because she had sore on her bottom. During an interview on 11/18/25 at 10:57 a.m., director of nursing (DON) stated R6's care plan had not been revised to include the air mattress that was placed on her bed, and it should have been revised as soon as it was placed on her bed. Review of the facility's Care Plan, Comprehensive Person-Centered Policy undated, identified the interdisciplinary team reviews and updates the care plan: a. when there has been a significant change in the resident's condition. b. when the desired outcome is not met. c. when the resident has been readmitted to the facility from a hospital stay; and	F0657		

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F0657 SS = D	Continued from page 27 at least quarterly, in conjunction with the required quarterly MDS assessment	F0657		
F0658 SS = D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review the facility failed to ensure treatments were used per standards of practice and only applied with a corresponding physician order for 2 of 2 residents (R5, R7) reviewed for non-pressure related skin concerns. Findings include: Findings include R5's face sheet dated 11/19/25, identified diagnoses of neoplasm(cancer) of the ovary and thyroid gland, morbid obesity (excessive body fat), and abdominal hernia (where abdominal organs push through a weak spot in the abdominal wall). R5's impaired skin integrity focus care plan dated 10/31/25, identified R5 was at risk for impaired skin integrity related to morbid obesity and lack of mobility with goal of skin will remain intact. Interventions included as followed: encourage resident to frequently shift weight; encourage use of lifting devices while in bed and evaluate for pitting edema. R5's Admission Minimum Data Set (MDS) dated 11/4/25, identified R5 was received hospice services, was dependent with bed mobility, transfers, had no pressure, venous or arterial ulcers and was cognitively intact. R5's progress note dated 11/12/25 at 11:02 p.m., identified R5 had a fluid filled blister to her right lower extremity and is covered with a transparent dressing. R5's electronic health record (EHR) did not identify that the physician had been notified of R5's blister, nor an order obtained to apply a transparent dressing to the blister.	F0658	R5 and R7 have both since discharged from the facility. All current residents who have wounds, their orders and care plans were reviewed and updated as needed. Future residents who have or obtain wounds during the resident stay, the MD/NP will be notified and will have appropriate treatments initiated per facility policy and facility established formulary. Licensed nurses will be in-serviced on the Medication and Treatment order with emphasis on item #1 that instructs the nurse to only administer medications and treatments per MD order and item #3 that all drug and biologicals must be recorded in the resident chart. Director of Nursing is responsible for compliance. Audits on wound treatment orders being obtained prior to initiation will begin weekly x 2 weeks then monthly to ensure sustained compliance. Audit results will be reviewed by the Administrator, and the Administrator will take audit results to QAPI for review and recommendation. Compliance: 12/25/2025	12/25/2025

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F0658 SS = D	Continued from page 28 During an interview on 11/18/25 at 2:54 p.m., registered nurse (RN)-A stated on 11/12/25. she observed a fluid filled blister and discoloration on the back of R5's right leg and she had applied a clear Opsite (a transparent, waterproof adhesive film) dressing over the top of the blister, however, she did not notify the hospice agency nor the physician of the newly identified blister and did not obtain an order prior to applying the dressing to the new blister. RN-A stated she did not need to obtain an order before applying a dressing to the new blister and she would use "nursing judgement" to determine what type of dressing to apply. R7's face sheet dated 11/19/25, identified diagnoses of laceration to right lower leg, diabetes mellitus, and morbid obesity. R7's Admission MDS dated 10/26/25, identified R7 had no pressure, arterial, or venous ulcers and was cognitively intact. R7's wound management focus care plan dated 10/27/25, identified R7 had a wound right thigh just above knee. Goal of wound will show signs of improvement. Interventions as followed: administer antibiotics as ordered, monitor ulcer for signs of progression or declination, provider wound care per treatment order. R7's hospital after visit summary dated 10/20/25, identified R7 had sustained a laceration on her right lower thigh on 10/15/25 in her apartment and had received fifteen sutures to the area and to be removed in 12-15 days and keep wound clean and dry, watch for signs of infection and if noted signs of infection notify the doctor right away. R7's physician orders identified an order to keep wound clean and dry and watch for signs of infection and if noted signs of infection to notify the doctor right away. Start date 10/20/25. During an observation and interview on 11/19/25 at 9:12 a.m., R7's right leg, just above the knee, had a white foam dressing attached. R7's stated she had fallen before she was admitted and got a large cut on her right leg, and it had to be stitched up and staff have been covering it up. Licensed practical nurse (LPN)-B stated R7 had the sutures removed from her right leg a while ago, however, "it does not want to heal." LPN-B then removed an undated foam dressing from R7's wound and stated the dressing had a small amount of clear drainage on the bottom half of the dressing without any	F0658		

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F0658 SS = D	Continued from page 29 odor. R7 had a 8.5 cm of scabbed/scarred area and at the lateral end of the scar was a Y shaped open area that was approximately 1 cm in size. The Y shaped wound appeared macerated (softened skin due to prolonged exposure to moisture) and had two purple sutures in the bottom of the wound. LPN-B stated she had not noticed the sutures prior to today, however, “these two must have been missed”. LPN-B stated the sutures still in the wound could be the reason the wound is not healing. LPN-B then cleansed the wound with skin prep (a wipe that apply a protective film to the skin), applied bacitracin (a topical antibiotic) ointment, and a new foam dressing to R7’s right leg wound, however, identified that R7 did not have an order for this treatment but she had been applying if for some time to R7’s laceration. LPN-B then stated she will contact the physician to inform of the remaining sutures and obtain an order to cover the laceration. During an interview on 11/19/25 at 9:41 a.m., director of nursing (DON) stated R5 and R7’s orders that were applied are not part of the standing orders of the facility and it would be standard of practice for a nurse to contact the physician to obtain an order prior to administering any treatment and her expectation would be for licensed staff to ensure this is done prior to initiating a treatment. Review of the facility’s Medication and Treatment Orders policy dated 6/30/24, identified orders for medications and treatments will be consistent with principles of safe and effective order writing. Policy Interpretation and Implementation were as followed: 1. Medications shall be administered only upon the written order of a person duly licensed and authorized to prescribe such medications in this state. 2. Only authorized, licensed practitioners, or individuals authorized to take verbal orders from practitioners, shall be allowed to write orders in the medical record. 3. Drug and biological orders must be recorded on the Physician’s Order Sheet in the resident’s chart. Such orders are reviewed by the Pharmacist on a monthly basis. 4. All drug and biological orders shall be written, dated, and signed by the person lawfully authorized to give such an order.	F0658		

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F0658 SS = D	Continued from page 30 5. The signing of orders shall be by signature or a personal computer key. Signature stamps may not be used. 6. The staff and practitioner shall use only approved abbreviations and symbols when ordering and/or charting medications. 7. Verbal orders must be recorded immediately in the resident's chart by the person receiving the order and must include prescriber's last name, credentials, the date, and the time of the order. 8. Verbal orders must be signed by the prescriber at their next visit. 9. Orders for medications must include: a. Name and strength of the drug. b. Quantity, parameters, or specific duration of therapy. c. Dosage and frequency of administration. d. Route of administration; and e. Reason or problem for which given. 10. Only authorized personnel shall call in orders for prescribed medications to the pharmacy. Review of the facility's Skin Care Policy and Procedure undated, identified new or ineffective skin problems will be referred to the appropriate health professional and skin treatments will be performed per medical doctor order.	F0658		
F0684 SS = D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies	F0684	R5 and R7 have both since discharged from the facility. All current residents who have wounds will have a skin assessment completed and/or updated as needed. Future residents who have wounds develop will have a completed skin assessment, care plan initiated with interventions per facility policy.	12/25/2025

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F0684 SS = D	Continued from page 31 to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review the facility failed to comprehensively assess and monitor an open blister and discoloration of skin on 1 of 1 resident (R5) and in addition failed to comprehensively assess and monitor a laceration for 1 of 1 resident (R7) reviewed for non-pressure skin issues. Findings include: R5's face sheet dated 11/19/25, identified diagnoses of neoplasm(cancer) of the ovary and thyroid gland and morbid obesity (excessive body fat). R5's Admission Minimum Data Set (MDS) dated 11/4/25, identified R5 dependent with bed mobility and transfers, no pressure, venous or arterial ulcers, received hospice services, and was cognitively intact. R5's clinical admission assessment dated 10/29/25, identified R5's skin was warm, dry, and intact. R5 had an old intravenous site on her right antecubital space (the bend in arm) and the dorsum (top) of the right hand. No other skin issues noted on the clinical admission assessment. R5's hospice note dated 10/29/25, identified R5 was admitted to hospice and had no open areas on right lower calf area on admission. R5's impaired skin integrity focus care plan dated 10/31/25, identified R5 was at risk for impaired skin integrity related to morbid obesity and lack of mobility with goal of skin will remain intact. Interventions included as followed: encourage resident to frequently shift weight; encourage use of lifting devices while in bed and evaluate for pitting edema. Review of R5's electronic health record (EHR) between 10/30/25 through 11/15/25, did not include weekly skin check documentation. R5's progress note dated 11/12/25 at 11:02 p.m., identified R5 had a fluid filled blister to right lower extremity and is covered with a transparent dressing.	F0684	Continued from page 31 Licensed nurses will be in-serviced on the Skin Care Policy with emphasis on items 1, 5 and 6 that wounds are assessed upon admission and documented in the resident chart and skin is assessed weekly and treatments will be performed per physician order. Director of Nursing is responsible for compliance. Audits on weekly skin assessment completion and skin care plan interventions will begin weekly x 2 weeks then monthly to ensure sustained compliance. Audit results will be reviewed by the Administrator, and the Administrator will take audit results to QAPI for review and recommendation. Compliance: 12/25/2025	

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F0684 SS = D	Continued from page 32 R5's EHR did not identify a comprehensive assessment of the fluid filled blister identified on 11/12/25 that included but not limited to measurements, color, skin integrity surrounding blister, and pain. R5's hospice note dated 11/13/25, identified new wound and bruising noted on right inner calf with fluid filled blisters noted. Bruising measured 26 centimeter (cm) in length and 20 cm in width. Coordination made with facility nurses to question the new wounds and bruising and they are unsure of the origin as well. A corresponding image identified R5's right inner calf had a large purple area with a large irregular shaped fluid filled blister located in center of the calf closet to the ankle. Above the fluid filled blister, a second wound that appeared to be a small open area with the skin folded on the edges. The second wound appeared to be a blister that had opened. Both the blister and the open area were covered with a rectangular shaped transparent dressing over the top of the area. During an interview on 11/18/25 at 2:54 p.m., registered nurse (RN)-A stated on 11/12/25, she observed a large fluid filled blister and discoloration on the bottom of R5's right calf. RN-A did not measure the blister or the discoloration, nor complete a comprehensive assessment of the newly identified area and only applied an opsite (a waterproof, transparent, breathable film dressing) dressing over the top of the blister. RN-A stated that the director of nursing (DON) or assistant director of nursing (ADON) were the staff responsible for completion of comprehensive assessment of the wounds in the facility. During an interview on 11/18/25 at 1:57 p.m., interim director of nursing (I-ADON) stated in the morning of 11/13/25, he was informed of the blister and discoloration on R5's right leg, however, did not complete a comprehensive assessment to R5's right leg because the hospice nurse was going to look at it later on. I-ADON stated the DON was responsible for the weekly wound assessments, but unsure how or when they were completed. He was aware there was a clear opsite over the open blister but was unsure who put it on or when it was put on nor when it changed last. R7's face sheet dated 11/19/25, identified diagnosis of laceration (tear in the skin) to right lower leg. R7's Admission MDS dated 10/26/25, identified R7 had no pressure, arterial, or venous ulcers and was cognitively intact.	F0684		

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F0684 SS = D	Continued from page 33 R7's hospital after visit summary dated 10/20/25, identified R7 had sustained a laceration on her right lower thigh on 10/15/25 in her apartment and had received fifteen sutures to the area and to be removed in 12-15 days and keep wound clean and dry, watch for signs of infection and if noted signs of infection notify the doctor right away. Review of R7's record did not include a comprehensive skin assessment upon admission to the facility. R7's wound management focus care plan dated 10/27/25, identified R7 had a wound to right thigh just above knee. Goal of wound will show signs of improvement. Interventions as followed: administer antibiotics as ordered, monitor ulcer for signs of progression or declination, provider wound care per treatment order. R7's physician orders identified an order to keep wound clean and dry and watch for signs of infection and if noted signs of infection to notify the doctor right away. Start date 10/20/25. R7's Medication administration record (MAR) identified the aforementioned physician order. The MAR identified between 10/20/25 through 11/19/25 this task was completed by check marked boxes with no other information included. R7's nurse practitioner note dated 10/27/25, indicated R7 was due for suture removal to right thigh, incision with expanding warmth, malodor (unpleasant odor), and drainage. Incision appears as would dehisce if sutures removed and will delay suture removal as concern area not healed. R7's nurse practitioner note dated 10/30/25, indicated R7's wound had improved, and sutures removed on right knee and steri-strips (adhesive strips that hold lacerations by holding skin edges together) applied. R7's progress note dated 11/3/25 at 7:01 p.m., identified received response to communication left for provider regarding incision continuing to look red, slightly swollen and irritated. Nurse practitioner wrote "please mark around wound and update if concern of expanding." R7's progress note dated 11/3/25 at 9:51 p.m., identified R7's wound on right thigh cleaned and recovered. Drainage was brownish and odorous. R7's EHR reviewed 10/20/25 through 11/19/25 did not include completed weekly skin bath audits had been completed and not evident comprehensive assessments and	F0684		

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F0684 SS = D	Continued from page 34 routine monitoring had been completed for decline or improvement of the right leg wound. During an observation and interview on 11/19/25 at 9:12 a.m., R7's right leg, just above the knee, had a white foam dressing attached. R7's stated she had fallen before she was admitted and got a large cut on her right leg, and it had to be stitched up and staff have been covering it up. Licensed practical nurse (LPN)-B stated R7 had the sutures removed from her right leg a while ago, however, "it does not want to heal." LPN-B then removed an undated foam dressing from R7's wound and stated the dressing had a small amount of clear drainage on the bottom half of the dressing without any odor. R7 had a 8.5 cm of scabbed/scarred area with the lateral end of the scar was a Y shaped open area approximately 1 cm in size. The wound appeared macerated (softened skin due to prolonged exposure to moisture) and had what two purple sutures in the bottom of the wound. LPN-B stated she had not noticed the sutures prior to today, however, R7 had the sutures removed a while ago, "but these two must have been missed". LPN-B stated the sutures still in the wound could be the reason the wound is not healing. LPN-B further stated the weekly wound assessments are not getting completed and used to be done with a camera and an application in the EHR but has not been done to her knowledge. During an interview on 11/19/25 at 10:30a.m., DON stated R7 had not had a comprehensive assessment of her right leg laceration on admission, nor a weekly assessment completed to monitor the wound for healing. DON further stated R5 should have had a comprehensive assessment of the blister and discoloration of her leg and should have been done at the time the skin concern was identified. Review of the facility's Skin Care Policy and Procedure undated, identified to ensure that the skin care and wound management needs of all the residents are assessed and managed effectively to enhance the quality of life of all the residents residing in the facility the following: 1. The initial skin assessment is completed within 8 hours of admission. Any identified skin care issues are documented in the resident admission assessment. 2. A Braden Assessment will be completed to identify risk for skin breakdown category, 3. Residents with identified skin conditions or problems are referred to the appropriate health	F0684		

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F0684 SS = D	Continued from page 35 professional i.e., NP, Wound Consultant or MD. 4. Resident care plan will detail specific skin care management instructions that include but not limited to: · Skin care regimens (use of barrier/emollient creams); · Repositioning frequency · Aids (including pressure reducing mattresses, alternating surface mattress, wedges, cushions, and other equipment as required. · Moisture reduction · Relevant lifting/transferring procedures. 5. Resident skin will be assessed weekly and/or as resident allows. 6. Skin treatments will be performed per MD order. 7. New or ineffectively managed skin problems will be referred to the appropriate health professional. 8. Staff receive education on skin care and wound management upon hire and as needed in response to identified knowledge deficits or incidents. or incidents.	F0684		
F0686 SS = D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing.	F0686	R6 MD was notified on the pressure injury and new treatment orders were obtained. R6 care plan was reviewed and updated as needed. All current residents' skin was assessed, and their orders and care plans were reviewed and updated as needed. Future residents who develop wounds, the MD will be notified, new orders obtained, a skin assessment initiated and a skin care plan along with weekly wound assessments created until wound is healed per facility policy. Licensed nurses will be in-serviced on the Pressure Ulcer Skin Breakdown Clinical Protocol policy with emphasis on notifying the MD/NP of the wound and identifying type of wound, comprehensively assessing the wound and weekly wound monitoring until the wound is healed. Director of Nursing is responsible for compliance. Audits on weekly monitoring of the wound, identifying the type of wound and the appropriate wound order treatments will begin weekly x 2 weeks then monthly to	12/25/2025

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F0686 SS = D	Continued from page 36 This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review the facility failed to comprehensively assess and monitor a pressure wound, failed to timely notify the physician of new ulcer development, and failed to provide physician ordered treatments for 1 of 1 resident (R6) reviewed for skin integrity. Findings include: R6's face sheet dated 11/19/25, identified diagnoses of hemiplegia (paralysis) affecting left side, diabetes mellitus (body does not make enough insulin), and heart failure (a condition where the heart does not pump enough blood to the body). R6's skin integrity focus care plan last revised on 4/29/25, identified R6 had a potential impairment to skin integrity related to bowel and bladder incontinence and impaired mobility. Goal to maintain or develop clean and intact skin. Interventions were as followed: may apply barrier cream after each incontinent episode; elevate heels off the bed; keep skin clean and dry, use lotion on dry skin, prefers to not be checked every two hours; pressure relieving/reducing cushion in wheelchair; standard pressure relieving/reducing mattress to protect skin while in bed. R6's physician orders identified the following: -Calmoseptine external ointment apply to bilateral buttocks topically three times per day as skin protectant. Start date 9/3/25. R6's Braden Scale for Predicting Pressure Sore Risk dated 10/21/25, identified R6 was at risk for pressure ulcers due to having slightly limited sensory perception, skin being very moist, chairfast, and being very limited with mobility. R6's Annual Minimum Data Set (MDS) dated 10/23/25, identified R6 was dependent for bed mobility/transfers, at risk for developing pressure ulcers, had no pressure ulcers, and was cognitively intact. R6's weekly skin audit dated 10/16/25, identified "scattered open area to buttocks." The audit did not include any other information about the wound. In review of R6's record between 10/16/25 to 10/20/25	F0686	Continued from page 36 ensure sustained compliance. Audit results will be reviewed by the Administrator, and the Administrator will take audit results to QAPI for review and recommendation. Compliance: 12/25/2025	

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F0686 SS = D	Continued from page 37 there was no indication the wound was comprehensively assessed to include but not limited, location on the buttocks, measurements, pain, wound periphery, presence of drainage and/or odor. Further the record did not indicate would care treatments had been provided nor evident the physician was notified. R6's physician communication form dated 10/21/25, identified R6 had a two-centimeter (cm) x 2.4 cm scabbed area on left buttocks and requested an order for dressing as needed. R6's record did not indicate the type of wound and/or cause of wound. R6's progress note dated 10/21/25, identified received order communication from nurse practitioner to apply Mepilex to scabbed area on buttocks, change every 72 hours and as needed (PRN). R6's physician orders identified the following: -Mepilex as needed (PRN) to scabbed area on buttocks, change every 72 hours and PRN (start date 10/21/25). The October and November treatment administration record identified the order was transcribed to direct staff to change the dressing PRN and not that it was a scheduled every 72-hour change in addition to PRN. R6's weekly skin audit dated 10/23/25, identified open area to buttocks with progressive healing and superficial in appearance. R6's wound management focus care plan initiated eight days after wound identification on 10/24/25, did not specify what type of wound R6 had nor the location. The goal identified was wound will be free of signs of symptoms of infection. Interventions were as followed: provider wound care per treatment order; Mepilex (a type of foam dressing designed to cover and protect wounds while promoting healing) to open area on left buttocks and monitor for signs and symptoms of infection. R6's Weekly bath audit dated 10/30/25, 11/6/25, and 11/13/25, identified no skin issue present. R6's electronic health record medication administration record (MAR) for 10/21/25 through 11/18/25 indicated R6's wound on her buttocks had not had the physician ordered treatment applied. During an interview on 11/18/25 at 10:05 a.m., R6 stated she had a sore on the left side of her bottom	F0686		

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F0686 SS = D	Continued from page 38 that had “been there for a while” and hurts her at times. R6 stated said the aides are “putting some cream on my bottom” and she thinks it is getting better. During an observation and interview on 11/18/25 at 10:21 a.m., nursing assistant (NA)-F was assisting R6 with peri-cares and observed an open area on R6’s left buttocks at a bony prominence approximately 1 cm x 1 cm. R6’s wound had a pinkish/reddish center, no maceration. (softening of skin due to prolonged exposure to moisture), no drainage, and intact edges. NA-F stated R6’s wound on her left buttocks had been there for a while, however, was unsure of the exact date. Licensed practical nurse (LPN)-B then entered R6’s room and measured R6’s left buttocks wound at 0.4 cm x 0.8 cm and stated this wound appeared to her to be a pressure ulcer since it is at a bony prominence. LPN-B stated she knew R6 had an order for Mepilex dressing, but was unsure how long it had been applied to R6’s wound. LPN-B further stated she was unaware who is responsible for the weekly comprehensive assessment of pressure ulcers to stage them and make sure they are healing properly. LPN-B stated R6 had a cushion in her wheelchair and an air mattress on her bed, but unable to articulate any additional pressure ulcer prevention measure for R6. R6’s progress note dated 11/18/25, identified R6 had 0.4-centimeter (cm) x 0.8 cm stage 2 pressure ulcer on left buttocks. Received order for Mepilex dressing to area twice daily. During an interview on 11/18/25 at 10:57 a.m., director of nursing (DON) stated R6 had an order for Mepilex dressing to an open area on her left bottom identified on 10/21/25, however, was unaware that R6 had not had a dressing placed on the open area, nor that there was an open area on R6’s left buttocks that had been there for a while. DON started she is responsible to track and perform the comprehensive assessments of the pressure ulcers in the facility, however, had not “kept up with it.” R6 had not had a comprehensive assessment of the wound on her left buttocks on 10/21/25 to determine what type of wound it was or had a weekly comprehensive assessment to determine if the wound had been healing. A follow up interview at 3:00 p.m., DON stated she assessed R6’s left buttocks wound and would consider it a stage 2 pressure ulcer. Review of the facility’s Pressure Ulcer/Skin Breakdown-Clinical Protocol undated, identified the following: 1. The nursing staff and practitioner will assess and	F0686		

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F0686 SS = D	Continued from page 39 document an individual's significant risk factors for developing pressure ulcers; for example, immobility, recent weight loss, and a history of pressure ulcer(s). 2. In addition, the nurse shall describe and document/report the following: a. Full assessment of pressure sore including location, stage, length, width and depth, presence of exudates or necrotic tissue. b. Pain assessment. c. Resident's mobility status. d. Current treatments, including support surfaces; and e. All active diagnoses. 3. The staff and practitioner will examine the skin of newly admitted residents for evidence of existing pressure ulcers or other skin conditions. 4. The physician will assist the staff to identify the type (for example, arterial or stasis ulcer) and characteristics (presence of necrotic tissue, status of wound bed, etc.) of an ulcer. 5. The physician will help identify and define any complications related to pressure ulcers. Review of the facility's Skin Care Policy and Procedure undated, identified that the skin care and wound management needs of all residents are assessed and managed effectively to enhance the quality of life for all residents residing at this facility. The skin care and wound management needs and preferences of the residents will be assessed and management effectively. 1. The initial skin assessment is completed within 8 hours of admission. Any identified skin care issues are documented in the resident admission assessment. 2. A Braden Assessment will be completed to identify risk for skin breakdown category, 3. Residents with identified skin conditions or problems are referred to the appropriate health professional i.e., NP, Wound Consultant or MD. 4. Resident care plan will detail specific skin care management instructions that include but not limited	F0686		

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F0686 SS = D	Continued from page 40 to: · Skin care regimens (use of barrier/emollient creams); · Repositioning frequency · Aids (including pressure reducing mattresses, alternating surface mattress, wedges, cushions, and other equipment as required. · Moisture reduction · Relevant lifting/transferring procedures. 5. Resident skin will be assessed weekly and/or as resident allows. 6. Skin treatments will be performed per MD order. 7. New or ineffectively managed skin problems will be referred to the appropriate health professional. 8. Staff receive education on skin care and wound management upon hire and as needed in response to identified knowledge deficits or incidents	F0686		
F0689 SS = SQC-J	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to comprehensively assess falls for root cause, implement appropriate interventions and revise the care plan to prevent and/or reduce the risk for future falls for 2 of 3 residents (R2, R4) reviewed for accidents. This resulted in an immediate jeopardy (IJ) for 2 when he sustained a head laceration following a fall and an IJ for R4 when after repeated falls sustained shoulder dislocation that had not identified since the last imaging that did not show	F0689	R2 has since passed away. All current residents who are at high risk for falls, their care plans were reviewed and/or updated as needed. Future residents who experience a fall they will have a risk management incident completed to determine root cause of fall and their care plan will be updated with appropriate interventions per facility policy. Facility nurses and nurse aides were in-serviced on the Assessing causes of falls policy with emphasis on the entire policy with special focus on the steps in the procedure items, documentation and reporting. Lastly, the IDT team was in-serviced on the Falls and Falls Management with focus on the policy section entitled “Monitoring Subsequent Falls and Falls Risks which instructs the team to monitor and document the resident’s response to interventions to reduce falls along with item #3 that if a resident continues to fall, the staff will re-evaluate the plan and determine if appropriate to continue or change interventions. Director of Nursing is responsible for compliance. Audits on fall incident for root cause and care plan interventions initiated after fall will begin weekly x 2 weeks then monthly to ensure sustained compliance.	12/25/2025

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F0689 SS = SQC-J	Continued from page 41 dislocation on 7/30/25. The IJ began on 10/20/25 after R2 had a fall that resulted in head laceration, the facility failed to complete a comprehensive analysis and implement appropriate interventions which resulted in and/or could have mitigated the risk of subsequent falls. The administrator and director of nursing (DON) were notified of the IJ on 11/13/25 at 4:01p.m. The immediate jeopardy was removed on 11/17/25 at 4:45 p.m., but non-compliance remained at the lower scope and severity level D, which indicated no actual harm with the potential for more than minimal harm that is not immediate jeopardy. Findings include: R2's face sheet dated 11/14/25, identified diagnoses of Alzheimer's disease (a progressive neurological disorder and the most common cause of dementia), congestive heart failure (a chronic condition where the heart muscle cannot pump enough blood to meet the body's needs), diabetes mellitus (the body does not produce enough insulin), and chronic obstructive respiratory failure (when the airways that carry air to the lungs become narrow or damaged). R2's fall focus care plan dated 2/3/25, identified R2 was at risk for falls as evident by scoring tool, antidepressant use, and wandering behaviors. R2's care plan goal was to be free from falls. Interventions included: -educate on the importance of maintaining a safe environment, free from potential fall hazards. -evaluate fall risk on admission and as needed; review medication for drugs that increase the risk for falls. -Intervention added on 5/12/25 to assist R2 with ambulation and transfers, utilizing therapy recommendations. R2's fall risk assessment dated 11/5/25, identified R2 was at risk for falls due to having 1-2 falls in the past 3 months; disorientated; balance with standing and while walking; takes 3-4 high risk medications; had a change in medication (or medication class) or change in dosage in the past five days. No interventions under risk for falls were selected on the assessment. R2's Annual Minimum Data Set (MDS) dated 11/6/25, indicated R2 had severe cognitive impairment. R2 used a wheelchair and needed supervision/touching assistance	F0689	Continued from page 41 Audit results will be reviewed by the Administrator, and the Administrator will take audit results to QAPI for review and recommendation. Compliance: 12/25/2025	

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F0689 SS = SQC-J	Continued from page 42 for transfers, had one fall with no injury, one fall with minor injury since admission and had severe cognitive impairment. R2's progress note dated 10/20/25 at 3:18 a.m., identified R2 was found on the floor sitting between bed and his chair, bed table next to the wall with blood on the floor and a laceration on the back of the head 7-8 centimeters (cm) across and had to be taken to the hospital. R2's fall incident report dated 10/20/25 at 1:46 a.m., identified R2 was found on the floor in his room with a 7-8 cm laceration on the back of his head and an abrasion on the right inner arm. R2 thought he was answering the phone. There was no indication of a comprehensive analysis to identify causal factors was completed, no immediate interventions, and no indication R2's care plan was revised. R2's emergency department (ED) note dated 10/20/25, identified R2 was seen following a fall at the nursing home and sustained a 6.0 cm laceration on the top of his head and needed to have the scalp wound closed with 8 or 9 staples and bandage applied. R2's progress note dated 10/20/25 at 4:44 a.m., identified R2 returned from the ED and was to have sutures removed in 9-10 days. R2's fall incident report dated 11/4/25 at 8:45 a.m., identified R2 was found in his room kneeling and leaning on a chair in his room. There was no indication of a comprehensive analysis to identify causal factors was completed, no immediate interventions, and no indication R2's care plan was revised. R2's progress note dated 11/5/25 at 11:10 a.m., identified a long-term care evaluation completed for R2. R2 had two falls since last evaluation and had a safety concern with a high fall potential. R2's progress note dated 11/6/25 at 11:51 p.m., identified R2 was given a wheelchair related to him being unsteady on his feet. R2 was given an as needed Seroquel. R2's care plan had not been revised to identify an intervention that R2 required a wheelchair. R2's progress note dated 11/7/25 at 10:42 a.m., identified family had been asked about getting a different chair as current chair is not safe and difficult for resident to get to standing position.	F0689		

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F0689 SS = SQC-J	Continued from page 43 Family stated they had a chair they will bring in to replace the current chair. Offered to use a chair from the facility and family stated they will bring one in. R2's fall incident report dated 11/7/25 at 6:29 p.m., identified R2 was found lying on his face in his room at 5:50 p.m. There was no indication of a comprehensive analysis to identify causal factors was completed, no immediate interventions, and no indication R2's care plan was revised. R2's fall incident report dated 11/9/25 at 4:50 p.m., identified R2 was found sitting on the floor in his room next to his chair. R2 was trying to pick up specks on the floor and had been sitting in chair which is low to ground. R2's fall incident report dated 11/10/25 at 8:30 p.m., identified R2 was found sitting between chair and bedside table. There was no indication of a comprehensive analysis to identify causal factors was completed, no immediate intervention, and no indication R2's care plan was revised. R2's fall incident report dated 11/11/25 at 8:30 p.m., identified R2 was in hall and grabbed the handrail to pull himself up to a standing position and began walking and then started going down and before staff could get to R2 he fell to the ground. There was no indication of a comprehensive analysis to identify causal factors was completed, no immediate intervention, and no indication R2's care plan was revised. During an interview on 11/13/25 at 10:23 a.m., consulting pharmacist (C-Pharm) stated normally the facility would notify her of a resident having frequent falls to perform a medication review to see if medication could be a cause of the frequent falls, however, had not been notified of R2's frequent falls. C-Pharm further indicated since R2 was administered Seroquel, an antipsychotic medication, which could increase risk for falls because of the associated side effects of drowsiness, dizziness, and orthostatic hypotension (sudden drop of systolic blood pressure with position changes). Since 10/31/25, R2 had duplicative antipsychotic therapy because Haloperidol as needed (PRN) was added in addition to Seroquel which may have caused the increase in R2's falls since 11/7/25 due to that type of medication given more frequently. R2's progress note dated 11/12/25 at 10:56 p.m., identified R2 was seen wanting to stand up from	F0689		

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F0689 SS = SQC-J	Continued from page 44 wheelchair and was unsteady on his feet. R2 then began pulling on his pants like he wanted to use the bathroom. Staff provided 1:1 with R2 in his room and after calmed down was brought to lobby for proper supervision. R2's care plan and Kardex (abbreviated care plan) were not revised to include nor define "proper supervision". During an interview on 11/12/25 at 12:05 p.m., licensed practical nurse (LPN)-A stated R2 had fallen a few times since 11/7/25. however, had not been informed of any new fall prevention interventions for R2. LPN-A stated the nurses did not update the care plan nor determine a root cause of a fall and thought the DON was responsible for that but was not sure. During an interview on 11/12/25 at 10:51a.m., (Interim Assistant Director of Nursing (I-ADON) stated R2 had fallen a "bunch" of times this weekend, however, was not able to articulate what occurred during the falls. During a follow up interview at 3:56 p.m., I-ADON was unable to articulate fall prevention interventions for R2 and stated R2 needs "One to one at times, but we are not able to provide that service." R2's falls had been discussed at the morning meetings; however, a causal analysis had not been completed, and he had not been trained on the process, so he was unsure of the facility's process on completing the causal analysis following a fall. I-ADON indicated he had not made any revisions to R2's care plan and was unsure whom in the facility would be responsible for the updates. During an interview on 11/12/25 at 5:11 p.m., director of nursing (DON) stated R2 was a high fall risk and was very impulsive due to his diagnosis of Alzheimer's. DON stated R2's fall that occurred on 10/20/25 resulted in a large laceration on the back of his head that required him to be sent to the ED to have the area sutured. R2 had falls in the facility after 10/20/25, however, had not had a comprehensive causal analysis performed for any of his falls. R2's care plan was not revised to include individualized fall prevention interventions to mitigate the risk of future falls and limit the likelihood for serious injury. DON stated, "this should have been done." During an interview on 11/12/25 at 12:38 p.m., LPN-B stated following a resident's fall, the nurses needed to fill out the risk management (incident report) documenting what happened during the fall, If the nurse determined an appropriate fall intervention it would be verbally passed onto the next shift until the IDT reviewed the incident information. LPN-B stated the nurses do not update the care plan to include new fall	F0689		

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F0689 SS = SQC-J	Continued from page 45 prevention interventions and had not been instructed to do so. During an interview on 11/12/25 at 3:23 p.m., registered nurse (RN)-A stated she was working when R2 fell on 11/10/25. RN-A stated she had not completed a comprehensive causal analysis of R2's fall and believed the ADON and DON would have that completed. RN-A stated she told staff R2 needed to be kept in the lobby for close supervision and normally would include this in the progress notes so the next shifts would be aware, however, she had not documented the intervention in R2's progress notes. R2's fall incident report dated 11/13/25 at 6:30 a.m., identified R2 was sitting in his swivel recliner 30 seconds prior and then was found on the floor laying on his left side. R2 sustained an abrasion to left elbow. Nurse called the daughter and asked her to bring a new chair for R2 and remove the swivel recliner. During an interview on 11/13/25 at 8:08 a.m., licensed practical nurse (LPN)-B stated R2 had fallen from his swivel recliner in his room today. LPN-B had been asking for a while for the swivel recliner to be removed, however, it had not been removed. LPN-B explained the swivel recliner was the cause of most of R2's falls because the chair was low to the ground, and it moved when he attempted to stand up. LPN-B stated she would check if there was a stationary chair in the facility until family could bring a chair from home. During an interview on 11/13/25 at 8:22 a.m., I-ADON stated R2 had fallen out of his swivel recliner around 6:30 a.m. today. The hospice aide was in R2's room, the side left R2 sitting in his recliner when she left the room, "only 30-seconds" later she returned to find R2 on the floor. I-ADON stated R2 could be "very quick" when he would self-transfer; staff tried "their best" to keep an eye on R2 when he was awake, but there are times when staff needed to leave him alone do other things and in that time R2 could fall and get injured. During an observation on 11/13/25 at 9:42 a.m., R2 was seated in a wheelchair next to the nursing station, When R2's family entered the facility, R2 stood up from his wheelchair with the breaks unlocked (no anti-roll back devices on the wheels) and started to walk towards his family without staff's awareness or presence. R2 was unsteady on his feet so he grabbed ahold the top of the nursing station with his left hand while he walked. R2's family informed R2 they were going to bring him a new chair. R2's family stood next to him attempting to get him to sit back in his wheelchair. At 9:50 a.m.	F0689		

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F0689 SS = SQC-J	Continued from page 46 staff came and assisted R2 back to his room with family. During an interview on 11/13/25 at 10:00 a.m., family member (FM)-D stated they brought in a new chair because today he fell out of it again. FM-A stated the facility talked to them about getting a new chair at the last care conference, however, just have not had time to bring it until today. During an interview on 11/13/25 at 9:52 a.m., nursing assistant (NA)-A could not articulate what the fall prevention interventions were for R2 and stated she would need to check the care plan/Kardex in the electronic health record (EHR), upon looking at R2's Kardex/care plan she only identified call light should be within reach. NA-A further stated we would attempt to keep R2 seated in his wheelchair because he was unsteady on his feet and been complaining of feeling dizzy at times. Staff would attempt to distract him when he was agitated. NA-A also stated if the interventions were not in the care plan/Kardex, staff would be unsure of the falls preventions interventions that were in place. During an interview on 11/12/25 at 3:02 p.m., NA-B was unable to articulate fall prevention interventions for R2 and stated if we saw him get up from his chair, we would attempt to get him to sit back down or distract him. NA-B stated she would review a resident's care plan to see what the fall interventions were, but looked on R2's EHR and did not see any specific fall prevention interventions his care plan should be updated to make sure staff were aware of what they were supposed to do to keep R2 safe. During an interview on 11/13/25 at 1:41 p.m., medical director (MD) stated the likelihood of R2 getting serious injury from a fall is "pretty high" and any resident with a fall from any height has the likelihood to sustain serious injury following a fall from any height. R4's face sheet dated 11/14/25, identified diagnoses of unspecified dislocation of right shoulder joint, obesity, and schizophrenia. R4's Quarterly MDS dated 8/7/25, indicated R4 did not have cognitive impairment. R4 had no limitation in range of motion in her upper extremities and used a walker and wheelchair. R4 was independent in transfers, continent of bowel, and frequently incontinent of urine. The MDS identified R4 had no falls since prior assessment even though R4 had documented falls on	F0689		

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F0689 SS = SQC-J	Continued from page 47 8/2/25 and 8/7/25. R4's fall focus care plan revised on 5/21/25 identified R4 was high-risk for falls related to confusion, deconditioning, psychoactive medication drug use, and history of voices in her head telling her to fall to the floor. Goal was to not sustain serious injury. Interventions dated 11/20/24, identified as the following: -Be sure call light is within reach and encourage to use it for assistance as needed. The resident needs prompt response to all requests for assistance. -encourage the resident to participate in activities that promote exercise, physical activity for strengthening an improve mobility such as walking with staff. -Review information on past falls and attempt to determine cause of falls. Record possible root cause. Alter remove any potential causes if possible. Educate resident/family/caregivers/IDT as to causes. -the resident needs activities that minimize the potential for falls, while providing diversion and distraction, group activities, puzzles, word searches, reading materials, and coloring activities. -the resident uses grab bars on her bed to assist with repositioning and the need to feel safe. Resident has a low bed and fall mat. R4's fall incident report dated 8/2/25 at 9:30 a.m., identified R4 was getting dried off from the shower with staff assistance, then slammed her walker into the wall of the tub room and put herself on the floor and indicated this was a behavior. R4 broke her walker and had no injury. R4 was placed in a wheelchair until walker could be fixed. There was no indication of a comprehensive analysis to identify potential modifiable and non-modifiable risk factors other than R4's "behavior." Although a behavior was identified as a causal factor there was no indication of immediate intervention that addressed R4's behavior of putting herself on the floor nor evident R2's care plan was revised. R4's fall incident report dated 8/6/25 at 10:30 a.m., identified R4 was heard "hollering" in her room and was observed lying safely on her bed. Staff reassured	F0689		

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F0689 SS = SQC-J	Continued from page 48 resident and left the room when R4 began to holler again. About one minute later was found on the floor next to her bed and over the bed table. R4 was assisted off the floor and then taken to the lobby area where she could be observed more closely/frequently. There was no indication of a comprehensive analysis to identify causal factors was completed and no indication R2's care plan was revised. R4/s fall incident report dated 8/25/25 at 11:00 a.m., identified a witnessed fall was observed in the lounge. R4 put herself on the floor and was witnessed by staff. There was no indication of a comprehensive analysis to identify causal factors was completed and no indication an immediate intervention was implemented nor evident R2's care plan was revised. During an interview on 11/13/25 at 1:32 p.m., DON reviewed R4's fall record and stated she did not interview staff to determine all potential causal factors of R4's fall on 8/2/25 and 8/25/25. R4's fall incident report dated 9/4/25 at 8:45 a.m., identified R4 was walking with her walker from common area to her room, when she started to veer towards the wall, she then let go of the walker and held onto the handrail and lowered self to the floor to a sitting position. There was no indication of a comprehensive analysis and although the report identified an intervention for physical therapy to evaluate and treat, there was no indication of an immediate intervention that would prevent/mitigate the risk for falls until the therapy evaluation and treatment if applicable. R4's physical therapy (PT) evaluation note dated 9/9/25, identified R4 had pain in right shoulder. History of falls in past year, however, exact number unknown; patient was injured from fall with the current injury. R4 had a fear of falling and right upper extremity had impaired range of motion. Reason for therapy was to facilitate motor control, minimize falls and enhance rehab potential. Although R4 had reported right shoulder pain there was no indication she was evaluated by a physician. R4's fall incident report dated 10/1/25 at 1:00 p.m., identified R4 was found on the floor next to her bed with two pillows under her head. R4 stated "I put the pillows down and laid on the floor and should not have done that." R4 had an incontinent stool at the time of the fall. There was no indication of a comprehensive analysis to identify causal factors was completed, no immediate intervention, and no indication R2's care	F0689		

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F0689 SS = SQC-J	Continued from page 49 plan was revised. R4's fall incident report dated 10/28/25 at 4:00 p.m., identified R4 was found sitting down on the floor. R4's bed was in the lowest position and R4 stated she slid down the bed. There was no indication of a comprehensive analysis to identify causal factors was completed, no indication of immediate intervention, and no indication R4's care plan was revised. R4's fall incident report dated 11/6/25 at 10:00 a.m., identified R4 was found on the floor face down, with the table tipped over and pants and underwear down. R4 was having pain all over and was sent to the emergency department for evaluation. R4's progress note dated 11/6/25 at 12:18 p.m., identified nurse had eyes on R4 at 9:45 a.m. during medication pass, R4 was sitting in the chair and had pants down around ankles and this nurse assisted R4 to get pants back up. R4 was compliant and redirected. Then at 10:00 a.m., R4 was found on the floor with face to the floor. R4 was having pain all over and was sent to the ED. R4's emergency department (ED) orthopedic consult note dated 11/6/25, identified reason for the consult was right shoulder dislocation. R4 fell earlier in the day and sustained an injury to her right shoulder and hip. R4 had had a right shoulder dislocation that failed closed reduction back in April and subsequently underwent open reduction. Findings on CT scan suggest that this dislocation is not acute and is chronic in nature. Patient's daughter does note that R4 has had several falls after the initial shoulder reduction in April of 2025. It is likely that shoulder dislocated with one of these falls [while a resident at the facility], but R4 was never formally evaluated. R4 had significant limitation to range of motion of the shoulder for several months now. "I do not believe an attempted closed reduction would not be successful at this point as her shoulder has likely been dislocated for some time now." R4's progress note dated 11/6/25 at 5:05 p.m., R4 returned from ED and had an order that R4 may wear sling for comfort and was to follow up with orthopedics if continued shoulder pain, to discuss surgical correction. Upon return from the ED there was no indication of a comprehensive analysis to identify causal factors was completed, no indication of immediate intervention, and no indication R4's care plan was revised.	F0689		

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F0689 SS = SQC-J	Continued from page 50 R4's fall risk assessment dated 11/7/25, identified R4 was high-risk for falls due to three of more falls in past 3 months, ambulatory/incontinent, three or more predisposing diagnoses, and takes 3-4 medications. R4's nurse practitioner nursing home visit note dated 11/10/25, identified R4 was seen following an ED visit on 11/6/25 after a fall. Right shoulder CT showed anterior glenohumeral dislocation (when the ball of the upper arm bone is forced out of the shoulder's cup shaped socket) with the humeral head abutting the coracoid process. Was recommended to see orthopedics for a follow up, however, declined to be seen. R4 had underwent reduction right shoulder under anesthesia 4/8/25. R4 had been following orthopedics and last x-rays done 7/30/25 showed no acute fracture or dislocation of the right shoulder (indicating the dislocation happened after 7/30/25). During an interview on 11/13/25 at 12:03 p.m., nurse practitioner (NP) stated R4 was seen for an ED follow up from 11/6/25. R4 has a right shoulder dislocation and orthopedics offered her a follow up and R4 declined. R4 had had surgery to replace a right shoulder dislocation in April 2025, which could make R4's shoulder weaken and could have easily dislocated again. During an observation and interview on 11/13/25 at 9:30 a.m., R4 had her right arm in a sling and stated the last time she fell she was trying to take herself to the bathroom, lost her balance and fell on her shoulder. R4 stated her shoulder began to hurt "really bad" and had to be sent to the ED to have it checked out. "And it sounded like it was dislocated again which may have been from one of my falls I had, but she was not sure." During an interview on 11/13/25 at 9:52 a.m., nursing assistant (NA)-A stated R4 sometimes would try to take herself to the bathroom and fall. NA-A was unaware of any fall prevention interventions that were currently in place for R4. NA-A then opened the electronic health record (EHR) and found R4's care plan and stated her fall care plan just said call light in reach and gait belt, however, was not able to find any further care plan interventions. During an interview on 11/13/25 at 1:24 p.m., director of nursing (DON) stated she was not aware of what the facility's fall prevention program consisted of nor what the facility's policies were. DON further stated she had not performed a causal analysis of any of R4's falls and was unaware she was supposed to be	F0689		

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F0689 SS = SQC-J	Continued from page 51 documenting in the resident's record and updating the care plan. DON stated she had not had any formal training on how to perform a root cause analysis and was trying to "read up" on how that was completed. During an interview on 11/17/25 at 11:35 a.m., DON stated the IDT team determined R2's falls had been caused by the swivel chair moved when R2 attempted to get up from the chair; the chair has been removed from R2's room and R2 had been placed on one-to-one supervision. R4 had a fall prevention intervention added to her care plan to offer toileting if R4 was observed pulling her pants down, however, had been placed under the incorrect focus in R4's care plan and would be moved under the appropriate focus. During an observation on 11/17/25 at 10:43 a.m., R4 was seated in her wheelchair in the lobby when R4 stood up and began pulling her pants and brief down. NA-E then walked up to R4 and assisted R4 to pull her pants back up, however, did not offer R4 to toilet (according to the care plan), instead rolled R4 to the DON's office. During an interview on 11/17/25 at 11:07 a.m., NA-E stated he was unaware of R2 and R4's fall prevention interventions and had not had anything passed on in report. NA-E then went to the EHR, but was unable to locate fall prevention focus care plan along with the fall interventions for R2 and R4. During an interview on 11/17/25 at 10:55 a.m., NA-C stated she was unaware of fall prevention interventions for R2 and R4 and stated she would need to check the care plan/Kardex, however, was unable to find the fall interventions for R2 or R4 in the care plan/Kardex. During an interview on 11/17/25 at 12:18 p.m., LPN-C stated if a resident had a fall she would then add a new intervention to the care plan to prevent future falls. LPN-C stated she would add an appropriate intervention based on the likely reason for the fall, however, was unsure how to make sure the intervention was added to the Kardex. The immediate jeopardy that began on 10/20/25, was removed on 11/17/25 at 4:45 p.m., when it was verified, the facility implemented the following: -The facility reviewed their fall policies, and no revisions were warranted. -R2 and R4's falls were reviewed by the interdisciplinary team (IDT) and the incident reports	F0689		

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F0689 SS = SQC-J	Continued from page 52 were updated indicating a causal analysis and care plans updated. -Fall risk assessment scoring report was run and identified residents who are high risk for falls who experienced a fall since 11/1/25 had their care plans reviewed and/or updated based on a root cause analysis of the falls. - The facility in-serviced nurses and nurse aides on the assessing causes of falls policy with emphasis on the entire policy with special focus on the steps in the procedure items, documentation, and reporting. -Interdisciplinary team (IDT) was in serviced on comprehensive care plan with emphasis on direction to develop care plan interventions after a thorough review of data and sequencing events and that assessments of residents are ongoing, and care plans need to be revised as the resident's condition changes. -IDT was in-serviced on falls and falls management with focus on the policy section entitled "Monitoring subsequent falls and fall risk which instructs the team to monitor and document the resident's response to interventions to reduce falls Review of the facility's Falls and Fall Risk, Managing policy undated, identified Based on previous evaluations and current data, the staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling. Included the following: Resident-Centered Approaches to Managing Falls and Fall Risk 1. The staff, with the input of the attending physician, will implement a resident-centered fall prevention plan to reduce the specific risk factor(s) of falls for each resident at risk or with a history of falls. 2. If a systematic evaluation of a resident's fall risk identifies several possible interventions, the staff may choose to prioritize interventions (i.e., to try one or a few at a time, rather than many at once). 3. Examples of initial approaches might include exercise and balance training, a rearrangement of room furniture, improving footwear, changing the lighting, etc.	F0689		

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F0689 SS = SQC-J	Continued from page 53 4. In conjunction with the consultant pharmacist and nursing staff, the attending physician will identify and adjust medications that may be associated with an increased risk of falling, or indicate why those medications could not be tapered or stopped, even for a trial period. 5. If falling recurs despite initial interventions, staff will implement additional or different interventions, or indicate why the current approach remains relevant. 6. If underlying causes cannot be readily identified or corrected, staff will try various interventions, based on assessment of the nature or category of falling, until falling is reduced or stopped, or until the reason for the continuation of the falling is identified as unavoidable. 7. In conjunction with the attending physician, staff will identify and implement relevant interventions (e.g., hip padding or treatment of osteoporosis, as applicable) to try to minimize serious consequences of falling. Monitoring Subsequent Falls and Fall Risk 1. The staff will monitor and document each resident's response to interventions intended to reduce falling or the risks of falling. 2. If interventions have been successful in preventing falling, staff will continue the interventions or reconsider whether these measures are still needed if a problem that required the intervention (e.g., dizziness or weakness) has resolved. 3. If the resident continues to fall, staff will re-evaluate the situation and whether it is appropriate to continue or change current interventions. As needed, the attending physician will help the staff reconsider possible causes that may not previously have been identified. 4. The staff and/or physician will document the basis for conclusions that specific irreversible risk factors exist that continue to present a risk for falling or injury due to falls. Review of the facility's Assessing Falls and Their Causes procedure dated 3/1/22, identified the purposes of the procedure are to provide guidelines for assessing a resident after a fall and to assist staff	F0689		

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F0689 SS = SQC-J	Continued from page 54 in identifying causes of the fall. Steps in the Procedure included: After a Fall: 1. If a resident has just fallen or is found on the floor without a witness to the event, nursing staff will record vital signs including neurological assessment and evaluate for possible injuries to the head, neck, spine, and extremities. 2. If there is evidence of a significant injury such as a fracture or bleeding, nursing staff will provide appropriate first aid. Once an assessment rules out significant injury, nursing staff will help the resident to a comfortable sitting or lying position and the staff will lift the resident via mechanical lift and will document relevant details. 3. Nursing staff will notify the resident's Attending Physician and family. When a fall results in a significant injury or condition change, nursing staff will notify the practitioner immediately by phone. 4. Nursing staff will observe for delayed complications of a fall for approximately forty-eight (48) hours after an observed or suspected fall and will document findings in the medical record. 5. Documentation will include any observed signs or symptoms of pain, swelling, bruising, deformity, and/or decreased mobility; and any changes in level of responsiveness/consciousness and overall function. It will note the presence or absence of significant findings. A new fall and pain assessment should be completed. 6. An incident report must be completed for resident falls. The incident report form should be completed by the assigned staff nurse at the time via risk management incident portal. Defining Details of Falls: 1. After an observed or probable fall, the staff will clarify the details of the fall, such as when the fall occurred and what the individual was trying to do at the time the fall occurred. Identifying Causes of a Fall or Fall Risk:	F0689		

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F0689 SS = SQC-J	Continued from page 55 1. Within 24 hours of a fall, the nursing staff will begin to try to identify possible or likely causes of the incident. They will refer to resident-specific evidence including medical history, known functional impairments, etc. 2. Staff will evaluate chains of events or circumstances preceding a recent fall, including: a. Time of day of the fall. b. Time of the last meal. c. What the resident was doing. d. Whether the resident was standing, walking, reaching, or transferring from one position to another. e. Whether the resident was among other persons or alone. f. Whether the resident was trying to get to the toilet. g. Whether any environmental risk factors were involved (e.g., slippery floor, poor lighting, furniture or objects in the way); and/or h. Whether there is a pattern of falls for this resident. 3. The staff will continue to collect and evaluate information until they either identify the cause of falling or determine that the cause cannot be found. 4. The Unit Manager or Director of Nursing Services should consult with the Attending Physician or Medical Director to confirm specific causes from among multiple possibilities. 5. As indicated, the Attending Physician will examine the resident or may initiate testing to try to identify causes. If the cause is unknown but no additional evaluation is done, the physician or nursing staff should note why (e.g., workup already done, finding a cause would not change the approach, etc.). 6. When possible, the Attending Physician or nursing staff will document the basis for identifying specific factors as the cause.	F0689		
F0842 SS = D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5),483.70(h)(1)-(5)	F0842	R1 physician notes were uploaded into the resident record. All current resident records were reviewed for physician visits and order summaries and were obtained	12/25/2025

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F0842 SS = D	Continued from page 56 §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(h) Medical records. §483.70(h)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(h)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(h)(3) The facility must safeguard medical	F0842	Continued from page 56 and/or updated as needed. Future resident physician visits and order summaries will be obtained and uploaded into the resident record per facility policy. The Health Information Coordinator and Director of Nursing was in-serviced on the Scanning Procedure and Care Connect Procedures that give instructions on how documents are uploaded into the system and on the Physician Visit Policy that the physician will review the resident's total program of care, including medications and treatments, at each visit and sign off on new orders as well as be available to initiate new orders. A progress note should be completed after each physician visits and uploaded into the resident chart. Director of Nursing is responsible for compliance. Audits on physician visit progress notes being uploaded into the resident chart and physician visit tracking will begin weekly x 2 weeks then monthly to ensure sustained compliance. Audit results will be reviewed by the Administrator, and the Administrator will take audit results to QAPI for review and recommendation. Compliance: 12/25/2025	

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F0842 SS = D	Continued from page 57 record information against loss, destruction, or unauthorized use. §483.70(h)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(h)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is NOT MET as evidenced by: Based on interviews and document review the facility failed to maintain a complete, accurate and readily accessible medical record was maintained for 2 of 3 residents (R1, R4) who were noted to have missing information in their record. Findings include: R1's face sheet dated 11/13/25, identified diagnoses of atherosclerotic heart disease (plaque buildup in the arteries), morbid obesity (excess fat), depression (a mood disorder characterized by persistent sadness), and anxiety (a mental and physical state characterized by feelings of dread or worry). R1's Minimum Data Set (MDS) dated 10/22/25, was independent with transfers and was cognitively intact.	F0842		

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F0842 SS = D	Continued from page 58 During an interview on 11/14/25 at 2:04 p.m., health information manager (HIM) stated R1 had been seen for routine nursing home visits on 8/1/25 and 10/7/25, however, R1's physician visit dictated notes had not been placed in R1's electronic health record (EHR), due to the notes being located in the outside medical systems. HIM stated she does not have access to the outside medical system to obtain the notes, however, will have the director of nursing (DON) obtain the records. Review of R1's electronic health record (EHR) on 11/19/25, did not include the 8/1/25, nor the 10/7/25 physician visit notes were in R1's facility EHR. An email received on 11/19/25 at 8:23 a.m., from the director of nursing (DON) included a copies of R1's nursing home physician visit notes from 8/1/25 and 10/7/25. R1's physician notes dated 8/1/25, identified R1 had been seen on routine nursing home rounds. R1's nurse practitioner nursing home visit note dated 10/7/25, indicated R1 was seen for nursing home rounds. R4's face sheet dated 11/14/25, identified diagnoses of unspecified dislocation (an injury where the bone becomes dislodged from their normal place) of right shoulder joint, obesity, and schizophrenia (a chronic brain disorder that affects how a person thinks, feels and acts). During an interview on 11/14/25 at 2:04 p.m., HIM stated R4 had been seen for a physician recertification visit on 9/26/25. Review of R4's EHR on 11/14/25, identified R4's 9/26/25 recertification visit note had been uploaded however not until 11/14/25. During an interview on 11/14/25 at 2:04 p.m., HIM stated R4 had a routine nursing home visit on 9/26/25, however, the note had not been removed from the outside medical system EHR to be placed into R4's chart until 11/14/25. HIM stated she was responsible for the uploading visit notes, that were received via fax. The other notes from outside medical visits needed to be accessed prior to uploading them into the facility's EHR system which she did not have access to. HIM needed to have the director of nursing (DON) obtain the note for R1 and R4. HIM was unaware of the facility's process to ensure that the notes were placed timely in the resident's EHR.	F0842		

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F0842 SS = D	Continued from page 59 During an interview on 11/19/25 at 4:10 p.m., vice president of clinical services (VP-CS) stated the facility has a system in the electronic health record that allows staff to enter the outside electronic health record and extract dictated notes and had shown the HIM a while ago on how to perform this task but had to demonstrate this task again today. The staff would need to find the notes and download the notes and then place the note in the facility's EHR under the "miscellaneous" tab. During an interview on 11/19/25 at 2:20 p.m., director of nursing (DON) stated she was unaware that R1 and R4's notes had not been placed in the facility's EHR in a timely manner. DON further stated R1 and R4's notes located in the outside medical record system belong to the outside medical system and are not a part of the facility's EHR, and her expectation would be that all resident's visit notes be placed in the EHR as soon and they are available and by not having R1 and R4's notes in the facility EHR could lead to something being missed and in the event of an emergency the resident's medical record would not be complete. Requested the facility's policy on maintaining an accurate and complete medical record, however, did not receive.	F0842		
F0849 SS = D	Hospice Services CFR(s): 483.70(n)(1)-(4) §483.70(n) Hospice services. §483.70(n)(1) A long-term care (LTC) facility may do either of the following: (i) Arrange for the provision of hospice services through an agreement with one or more Medicare-certified hospices. (ii) Not arrange for the provision of hospice services at the facility through an agreement with a Medicare-certified hospice and assist the resident in transferring to a facility that will arrange for the provision of hospice services when a resident requests a transfer. §483.70(n)(2) If hospice care is furnished in an LTC facility through an agreement as specified in paragraph (o)(1)(i) of this section with a hospice, the LTC facility must meet the following requirements:	F0849	R2 and R5 have since passed away. All current residents who are on hospice services, their care plans and hospice care conference coordination will be reviewed and/or updated as needed. Future residents will have their hospice coordination performed by the social service designee per facility policy. The Social Service Designee and Director of Nursing will be in-serviced on the Hospice Policy with emphasis item #2 that the ADON will be designated clinical individual to coordinate care and social service designee will be responsible for coordinating hospice facility staff participation in hospice resident care conference. Director of Nursing is responsible for compliance. Audits on hospice care plans, visit schedule and facility hospice care conference will begin weekly x 3 weeks then monthly to ensure sustained compliance. Audit results will be reviewed by the Administrator and taken to QAPI for review and recommendation. Compliance: 12/25/2025	12/25/2025

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F0849 SS = D	Continued from page 60 (i) Ensure that the hospice services meet professional standards and principles that apply to individuals providing services in the facility, and to the timeliness of the services. (ii) Have a written agreement with the hospice that is signed by an authorized representative of the hospice and an authorized representative of the LTC facility before hospice care is furnished to any resident. The written agreement must set out at least the following: (A) The services the hospice will provide. (B) The hospice's responsibilities for determining the appropriate hospice plan of care as specified in §418.112 (d) of this chapter. (C) The services the LTC facility will continue to provide based on each resident's plan of care. (D) A communication process, including how the communication will be documented between the LTC facility and the hospice provider, to ensure that the needs of the resident are addressed and met 24 hours per day. (E) A provision that the LTC facility immediately notifies the hospice about the following: (1) A significant change in the resident's physical, mental, social, or emotional status. (2) Clinical complications that suggest a need to alter the plan of care. (3) A need to transfer the resident from the facility for any condition. (4) The resident's death. (F) A provision stating that the hospice assumes responsibility for determining the appropriate course of hospice care, including the determination to change the level of services provided. (G) An agreement that it is the LTC facility's responsibility to furnish 24-hour room and board care, meet the resident's personal care and nursing needs in coordination with the hospice representative, and ensure that the level of care provided is appropriately based on the individual resident's needs. (H) A delineation of the hospice's responsibilities,	F0849		

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F0849 SS = D	Continued from page 61 including but not limited to, providing medical direction and management of the patient; nursing; counseling (including spiritual, dietary, and bereavement); social work; providing medical supplies, durable medical equipment, and drugs necessary for the palliation of pain and symptoms associated with the terminal illness and related conditions; and all other hospice services that are necessary for the care of the resident's terminal illness and related conditions. (I) A provision that when the LTC facility personnel are responsible for the administration of prescribed therapies, including those therapies determined appropriate by the hospice and delineated in the hospice plan of care, the LTC facility personnel may administer the therapies where permitted by State law and as specified by the LTC facility. (J) A provision stating that the LTC facility must report all alleged violations involving mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of patient property by hospice personnel, to the hospice administrator immediately when the LTC facility becomes aware of the alleged violation. (K) A delineation of the responsibilities of the hospice and the LTC facility to provide bereavement services to LTC facility staff. §483.70(n)(3) Each LTC facility arranging for the provision of hospice care under a written agreement must designate a member of the facility's interdisciplinary team who is responsible for working with hospice representatives to coordinate care to the resident provided by the LTC facility staff and hospice staff. The interdisciplinary team member must have a clinical background, function within their State scope of practice act, and have the ability to assess the resident or have access to someone that has the skills and capabilities to assess the resident. The designated interdisciplinary team member is responsible for the following: (i) Collaborating with hospice representatives and coordinating LTC facility staff participation in the hospice care planning process for those residents receiving these services. (ii) Communicating with hospice representatives and other healthcare providers participating in the	F0849		

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F0849 SS = D	Continued from page 62 provision of care for the terminal illness, related conditions, and other conditions, to ensure quality of care for the patient and family. (iii) Ensuring that the LTC facility communicates with the hospice medical director, the patient's attending physician, and other practitioners participating in the provision of care to the patient as needed to coordinate the hospice care with the medical care provided by other physicians. (iv) Obtaining the following information from the hospice: (A) The most recent hospice plan of care specific to each patient. (B) Hospice election form. (C) Physician certification and recertification of the terminal illness specific to each patient. (D) Names and contact information for hospice personnel involved in hospice care of each patient. (E) Instructions on how to access the hospice's 24-hour on-call system. (F) Hospice medication information specific to each patient. (G) Hospice physician and attending physician (if any) orders specific to each patient. (v) Ensuring that the LTC facility staff provides orientation in the policies and procedures of the facility, including patient rights, appropriate forms, and record keeping requirements, to hospice staff furnishing care to LTC residents. §483.70(n)(4) Each LTC facility providing hospice care under a written agreement must ensure that each resident's written plan of care includes both the most recent hospice plan of care and a description of the services furnished by the LTC facility to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, as required at §483.24. This REQUIREMENT is NOT MET as evidenced by: Based on interview, and document review the facility failed to ensure there was a communication process	F0849		

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F0849 SS = D	Continued from page 63 between the long-term care (LTC) facility and the hospice provider to ensure the needs of the resident are addressed and met 24 hours per day. In addition, the facility failed to ensure a designated interdisciplinary team member (IDT) was responsible for the coordinating with hospice representative and LTC staff in the hospice care planning process for 2 of 2 residents (R2, R5) reviewed for hospice services. Findings include: Findings include: R2's face sheet dated 11/14/25, identified diagnoses of Alzheimer's disease(a progressive neurological disorder and the most common cause of dementia), congestive heart failure (a chronic condition where the heart muscle cannot pump enough blood to meet the body's needs), diabetes mellitus (the body does not produce enough insulin), and chronic obstructive respiratory failure (when the airways that carry air to the lungs become narrow or damaged). R2's Annual Minimum Data Set (MDS) dated 11/6/25, identified R2 received hospice care, needed supervision/touching assistance for transfers, and had severe cognitive impairment. Review of R2's care plan on 11/12/25, did not identify a hospice focus care plan had been initiated. During an interview on 11/13/25 at 8:06 a.m., licensed practical nurse (LPN)-B stated all resident's that are under hospice care have a binder at the nurse's station that has things such as hospice visit schedules, orders, and hospice care plans. LPN-B stated sometimes the hospice information is kept under the miscellaneous tab in the residents EHR, however, was unable to locate R2's hospice plan of care in the binder at the nursing station nor the electronic health record (HER). During an interview on 11/12/25 at 2:11 p.m., hospice registered nurse (HRN)-G stated she is unaware of one specific staff member that hospice will coordinate care with the facility and will just communicate with the staff nurse when they perform a visit. The hospice plan of care is normally kept in the binder at the nursing station at the facility, however, was unaware that R2's hospice plan of care was not in the binder. R2 had been admitted to hospice on 10/31/25 and a hospice plan of care had been faxed to the facility the same day, however, was unsure if it was verified if it had been received. HRN -G stated she will be faxing another copy of the hospice plan of care to the facility to ensure	F0849		

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F0849 SS = D	Continued from page 64 it is added to R2's hospice binder. R5's face sheet dated 11/19/25, identified diagnoses of neoplasm(cancer) of the ovary and thyroid gland and morbid obesity (excessive body fat). R5's Admission Minimum Data Set (MDS) dated 11/4/25, identified R5 dependent with bed mobility and transfers, no pressure, venous or arterial ulcers, received hospice services, and was cognitively intact. R5's hospice plan of care dated 10/29/25, identified R5 had problem of skin integrity and to prevent skin breakdown R5 was to be turned and repositioned every two hours and as needed to promote skin integrity and prevent breakdown. R5's skin integrity focus care plan dated 10/31/25, identified R5 was at risk for impaired skin integrity related to morbid obesity and lack of mobility. Goal of skin to remain intact. Interventions were as followed: Encourage Resident to frequently shift weight; encourage the use of lifting devices while in bed; Evaluate for pitting edema; evaluate skin integrity; Keep skin clean and well lubricated. R5's facility care plan had not been updated to coordinate with the 10/29/25 hospice plan of care to turn and reposition R5 every two hours. R5's physical mobility focus care plan dated 10/31/25, identified R5 has impaired physical mobility. Goal of will be able to perform activity within physical limits. Interventions were as followed: assist resident in performing movements/tasks; ensure call light is available to Resident; ensure resident is in proper position for tasks. R5's clinical admission assessment dated 10/29/25, identified R5's skin was warm, dry, and intact. R5 had an old intravenous site on her right antecubital space (the bend in arm) and the dorsum (top) of the right hand. No other skin issues noted on the clinical admission assessment. R5's progress note dated 11/12/25 at 11:02 p.m., identified R5 had a fluid filled blister to right lower extremity and is covered with a transparent dressing. R5's progress note did not identify the hospice agency had been notified of the blister found on R5's leg. During an interview on 11/18/25 at 2:54 p.m., registered nurse (RN)-A stated on 11/12/25, she observed a large fluid filled blister with discoloration on the bottom of R5's right calf and had	F0849		

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F0849 SS = D	Continued from page 65 applied a clear transparent dressing over the blister. RN-A further stated she did not contact the hospice agency inform of the new area of concern nor to inform of the dressing that had been placed on R5's right leg. During an interview on 11/18/25 at 12:24 p.m., hospice registered nurse (HRN)-C stated R5's hospice's plan of care and the facility's plan of care are supposed to almost mirror each other and that R5' s plan of care identified R5 was supposed to be turned and repositioned every 2 hours, however, was unsure if staff at the facility were turning and repositioning R5 as per her plan of care. During an interview on 11/19/25, director of nursing (DON) stated that the facility needs to coordinate with hospice with any change in condition of a resident to ensure hospice is aware of a change in status to ensure there is accurate coordination. Don further stated, R5's hospice plan of care that reflected to turning and repositioning R5 every two hours to prevent skin breakdown should have been added to the facility care plan to make sure the care is coordinated with hospice. Review of the facility's Hospice Program Policy undated, identified the facility had not identified a member of the IDT as a designated staff in the policy to coordinate care provided to the resident by our facility staff and the hospice staff. The policy included the following: In general, it is the responsibility of the facility to meet the resident's personal care and nursing needs in coordination with the hospice representative and ensure that the level of care provided is appropriately based on the individual resident's needs. These responsibilities include the following: a. Twenty-four-hour room and board care. b. Administering prescribed therapies, including those therapies determined appropriate by the hospice and delineated in the hospice plan of care. c. Notifying the hospice about the following: (1) A significant change in the resident's physical, mental, social, or emotional status. (2) Clinical complications that suggest a need to alter the plan of care. (3) A need to transfer the resident from the facility	F0849		

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F0849 SS = D	Continued from page 66 for any condition. (4) The resident's death. d. Communicating with the hospice provider (and documenting such communication) to ensure that the needs of the resident are addressed and met 24 hours per day; and e. Reporting any alleged violations involving mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of resident property by hospice personnel, to the hospice administrator immediately upon awareness of the alleged violation. 1. The resident may choose to specify his or her attending physician, or another physician/practitioner, as the hospice attending physician. 2. Our facility has designated _____ (Name) _____ (Title) to coordinate care provided to the resident by our facility staff and the hospice staff. (Note: this individual is a member of the IDT with clinical and assessment skills who is operating within the state scope of practice act). He or she is responsible for the following: f. Collaborating with hospice representatives and coordinating facility staff participation in the hospice care planning process for residents receiving these services; g. Communicating with hospice representatives and other healthcare providers participating in the provision of care for the terminal illness, related conditions, and other conditions, to ensure quality of care for the resident and family. h. Ensuring that the LTC facility communicates with the hospice medical director, the resident's attending physician, and other practitioners participating in the provision of care to the resident as needed to coordinate the hospice care with the medical care provided by other physicians. i. Obtaining the following information from the hospice: (1) The most recent hospice plan of care specific to each resident. (2) Hospice election form.	F0849		

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F0849 SS = D	Continued from page 67 (3) Physician certification and recertification of the terminal illness specific to each resident. (4) Names and contact information for hospice personnel involved in hospice care of each resident. (5) Instructions on how to access the hospice's 24-hour on-call system. (6) Hospice medication information specific to each resident; and (7) Hospice physician and attending physician (if any) orders specific to each resident. j. Ensuring that our facility staff provides orientation on the policies and procedures of the facility, including resident rights, appropriate forms, and record keeping requirements, to hospice staff furnishing care to the residents. 3. Coordinated care plans for residents receiving hospice services will include the most recent hospice plan of care as well as the care and services provided by our facility (including the responsible provider and discipline assigned to specific tasks) in order to maintain the resident's highest practicable physical, mental and psychosocial well-being	F0849		
F0867 SS = F	QAPI/QAA Improvement Activities CFR(s): 483.75(c)(1)-(4)d)(1)(2)(e)(1)-(3)(g)(2)(ii)(iii) §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following: §483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement. §483.75(c)(2) Facility maintenance of effective systems	F0867	The facility next QAPI meeting will tentatively be held December 18, 2025, and an addendum for the October and November QAPI data for falls and psychotropic use will be reviewed to determine root cause for falls and review of psychotropic use to identify duplicate therapy, non-pharmalogical interventions and review of GDR data for October and November. The IDT team and facility staff will be in-serviced on the QAPI Plan Policy that provides a means to identify and resolve potential negative outcomes related to resident care. The Facility Administrator is responsible for compliance. Audits on identified areas of concern (falls and psychotropic use) and action plan from the monthly QAPI report for each will begin weekly x 1 week then monthly to ensure sustained compliance. Audit results will be reviewed by the Administrator, and the Administrator will take audit results to QAPI for review and recommendation.	12/25/2025

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F0867 SS = F	Continued from page 68 to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.71 and including how such information will be used to develop and monitor performance indicators. §483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation. §483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events. §483.75(d) Program systematic analysis and systemic action. §483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained. §483.75(d)(2) The facility will develop and implement policies addressing: (i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems; (ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and (iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained. §483.75(e) Program activities. §483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on	F0867	Continued from page 68 Compliance: 12/25/2025	

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F0867 SS = F	Continued from page 69 high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care. §483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility. §483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.71. Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section. §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review the facility failed to ensure the Quality Assurance and Performance Improvement (QAPI) committee identified, investigated, analyzed, and responded to increase in resident falls and as needed (PRN) psychotropics being administered as	F0867		

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F0867 SS = F	Continued from page 70 a chemical restraint by developing and implementing action plans for process improvement. This had the potential to affect all 34 residents that resident in the facility. Findings include: SEE F689: Based on observation, interview, and document review, the facility failed to comprehensively assess falls for root cause, implement appropriate interventions and revise the care plan to prevent and/or reduce the risk for future falls for 2 of 3 residents (R2, R4) reviewed for accidents. This resulted in an immediate jeopardy (IJ) for 2 when he sustained a head laceration following a fall and an IJ for R4 when after repeated falls sustained shoulder dislocation that had not identified since the last imaging that did not show dislocation on 7/30/25. SEE F605: Based on observation, interview, and document review the facility failed ensure residents were free from chemical restraints by not identifying duplicative antipsychotic therapy without appropriate indications, failed to identify target behaviors, failed to develop individualized non-pharmacological interventions, and failed to attempt and/or offer non-pharmacological interventions prior to the administration of as needed (PRN) doses of antipsychotic medications for 1 of 1 resident (R2) who had verbal and physical behaviors towards staff reviewed for falls. Review of the facility ‘s QAA/QAPI minutes identified the following: 6/27/25 QAA/QAPI minutes also identified that the facility had been cited at F605 (right to be free from chemical restraints) during a May 2025 survey. The facility developed an action plan to begin audits on resident target behaviors, non-pharmacological interventions attempted will begin twice per week for two weeks, then weekly for two weeks, then monthly to ensure compliance. 7/25/25 QAA/QAPI minutes dated 7/25/2, identified two F605 audits completed during the month of 6/25 and no issues noted. 8/29/25 QAA/QAPI minutes dated 8/29/2, identified one F605 audit completed for month of 7/25 and no issues noted. 9/26/25 QAA/QAPI minutes, identified the following:	F0867		

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F0867 SS = F	Continued from page 71 - the facility had eight falls involving 5 residents during 8/25. Actions taken for falls were resident-specific fixes (removing gripper strips, adding anti-roll back device, antibiotics, hospice care, and behavioral counseling) and did not have evidence of a systemic/root cause analysis across all falls. Actions appear reactive and individualized rather than addressing broader facility-wide risks. -Audits for psychotropic medication audit for F605 covered 5 residents with as needed (PRN) psychotropic orders. QAA/QAPI minutes did not identify how many residents lacked documentation of non-pharmacological interventions prior to administration. Results of audits were not documented, only a note that staff were re-educated without rationale provided why re-education was necessary. 10/31/25 QAA/QAPI minutes identified the following: -the facility had four falls in 9/25. Actions taken for falls were resident-specific fixes (care planning purposeful movement, re-orientation, floor mats, wider bed). No evidence of evaluating patterns, trends, or systemic interventions. Re-orientation is noted as only effective short-term, but no alternative strategies were explored. -Audits for psychotropic medication audit for F605 Audit referenced 8/25 again, not September. Stated six residents had PRN psychotropic orders. QAA/QAPI minutes had audit results missing and did not identify rationale for re-education not documented and no evidence that an audit was completed for September. Review of the facility's October 2025 incident report listing identified that fifteen falls occurred and was an increase from four falls for the month of September 2025. 10/8/25 F605 audit for 9/25 identified 5 residents charts reviewed and identified the following: -One resident received PRN psychotropic seventeen times and did not have consistent documented of a non-pharmacological intervention attempted prior to administration. -One resident received PRN psychotropic three times and did not have any non-pharmacological interventions documented.	F0867		

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F0867 SS = F	Continued from page 72 -Comment on audit identified that this was discussed with the director of nursing about interventions not being documented and target behaviors listed on all psychotropic medications. F605 audit completed on 11/5/25 for October 2025 identified 5 residents' charts were reviewed and identified the following: -four residents used a PRN psychotropic medication, however, did not have any documentation of non-pharmacological intervention documented attempted prior to administering medication. During an interview on 11/18/25 at 2:45 p.m., administrator stated that the QAA/QAPI committee meets monthly where the previous month's data is discussed and analyzed. Administrator stated the facility had a sharp increase in falls from the month of October 2025 from the previous month of September 2025, however, the facility had not identified the increase in falls as a concern and therefore had not brought this concern to the quality committee to discuss and create and appropriate action plan to assist the facility to determine possible causes of the increase in resident falls. Administrator stated this concern should be brought to the quality committee as soon as possible to develop a plan to correct this concern and not wait until the next month to address the problem. Administrator stated with regards to the chemical restraints the facility had been cited May 2025 for concern for psychotropics being used as chemical restraints and not having a documented non-pharmacological intervention prior to administration. The QAA/QAPI committee determined an action plan to begin doing audits of residents with prescribed as needed (PRN) psychotropics to ensure documentation was being completed by licensed staff of a non-pharmacological intervention prior to administering the PRN psychotropic. The audits which began June 2025 and had not identified a concern for the months of 6/25. 7/25, however, the 8/25, 9/25 and 10/25 audits identified PRN psychotropics were being administered without a documented non-pharmacological intervention attempted prior being administered. Administrator stated the QAPI committee had not discussed the identified concern for non-compliance and had not made any amendment to the facility's action plan and should have done this when the audits completed during 8/25, 9/25, and 10/25 identified non-compliance and if the QAPI committee had done this it may have prevented this non-compliance for	F0867		

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F0867 SS = F	Continued from page 73 re-occurring for an extended period. Review of the facility's Quality Assurance and Performance Improvement (QAPI) Plan policy identified the facility shall develop, implement, and maintain and ongoing, facility-wide QAPI plan designed to monitor and evaluate the quality and safety of resident care, pursue methods to improve care quality, and resolve identified problems. The objectives of the QAPI Plan are to: 1. Provide a means to identify and resolve present and potential negative outcomes related to resident care and services. 2. Reinforce and build upon effective systems and processes related to the delivery of quality care and services. 3. Provide structure and processes to correct identified quality and/or safety deficiencies. 4. Establish and implement plans to correct deficiencies, and to monitor the effects of these action plans on resident outcome. 5. Help departments, consultants, and ancillary services that provide direct or indirect care to residents to communicate effectively, and to delineate lines of authority, responsibility, and accountability. 6. Provide a means to centralize and coordinate comprehensive QAPI activities in order to meet the needs of the residents and the facility; and 7. Establish systems and processes to maintain documentation relative to the QAPI Program, as a basis for demonstrating that there is an effective ongoing program.	F0867		

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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 11/7/25,11/12/25,11/13/25,11/14/25,11/17/25,11/18/25, and 11/19/25 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	20000		12/25/2025

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

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20000	Continued from page 1 completed. The following complaints were reviewed. H53787182C (2661210) and H53787703C (2668560) with a licensing order issued at 830,1535, 255, 555, 570, 900, and 625. 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		
20255	Quality Assessment and Assurance Committee CFR(s): MN Rule 4658.0070 A nursing home must maintain a quality assessment and assurance committee consisting of the administrator, the director of nursing services, the medical director or other physician designated by the medical director, and at least three other members of the nursing home's staff, representing disciplines directly involved in	20255	Corrected	12/25/2025

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20255	Continued from page 2 resident care. The quality assessment and assurance committee must identify issues with respect to which quality assurance activities are necessary and develop and implement appropriate plans of action to correct identified quality deficiencies. The committee must address, at a minimum, incident and accident reporting, infection control, and medications and pharmacy services. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on interview and document review the facility failed to ensure the Quality Assurance and Performance Improvement (QAPI) committee identified, investigated, analyzed, and responded to increase in resident falls and as needed (PRN) psychotropics being administered as a chemical restraint by developing and implementing action plans for process improvement. This had the potential to affect all 34 residents that resident in the facility. Findings include: F867 SEE F689: Based on observation, interview, and document review, the facility failed to comprehensively assess falls for root cause, implement appropriate interventions and revise the care plan to prevent and/or reduce the risk for future falls for 2 of 3 residents (R2, R4) reviewed for accidents. This resulted in an immediate jeopardy (IJ) for 2 when he sustained a head laceration following a fall and an IJ for R4 when after repeated falls sustained shoulder dislocation that had not identified since the last imaging that did not show dislocation on 7/30/25. SEE F605: Based on observation, interview, and document review the facility failed ensure residents were free from chemical restraints by not identifying duplicative antipsychotic therapy without appropriate indications, failed to identify target behaviors, failed to develop individualized non-pharmacological interventions, and failed to attempt and/or offer non-pharmacological interventions prior to the administration of as needed (PRN) doses of antipsychotic medications for 1 of 1 resident (R2) who had verbal and physical behaviors towards staff reviewed for falls. Review of the facility ‘s QAA/QAPI minutes identified the following: 6/27/25 QAA/QAPI minutes also identified that the facility had been cited at F605 (right to be free from	20255		

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20255	Continued from page 3 chemical restraints) during a May 2025 survey. The facility developed an action plan to begin audits on resident target behaviors, non-pharmacological interventions attempted will begin twice per week for two weeks, then weekly for two weeks, then monthly to ensure compliance. 7/25/25 QAA/QAPI minutes dated 7/25/2, identified two F605 audits completed during the month of 6/25 and no issues noted. 8/29/25 QAA/QAPI minutes dated 8/29/2, identified one F605 audit completed for month of 7/25 and no issues noted. 9/26/25 QAA/QAPI minutes, identified the following: - the facility had eight falls involving 5 residents during 8/25. Actions taken for falls were resident-specific fixes (removing gripper strips, adding anti-roll back device, antibiotics, hospice care, and behavioral counseling) and did not have evidence of a systemic/root cause analysis across all falls. Actions appear reactive and individualized rather than addressing broader facility-wide risks. -Audits for psychotropic medication audit for F605 covered 5 residents with as needed (PRN) psychotropic orders. QAA/QAPI minutes did not identify how many residents lacked documentation of non-pharmacological interventions prior to administration. Results of audits were not documented, only a note that staff were re-educated without rationale provided why re-education was necessary. 10/31/25 QAA/QAPI minutes identified the following: -the facility had four falls in 9/25. Actions taken for falls were resident-specific fixes (care planning purposeful movement, re-orientation, floor mats, wider bed). No evidence of evaluating patterns, trends, or systemic interventions. Re-orientation is noted as only effective short-term, but no alternative strategies were explored. -Audits for psychotropic medication audit for F605 Audit referenced 8/25 again, not September. Stated six residents had PRN psychotropic orders. QAA/QAPI minutes had audit results missing and did not identify rationale for re-education not documented and no evidence that an audit was completed for September.	20255		

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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
20255	Continued from page 4 Review of the facility's October 2025 incident report listing identified that fifteen falls occurred and was an increase from four falls for the month of September 2025. 10/8/25 F605 audit for 9/25 identified 5 residents charts reviewed and identified the following: -One resident received PRN psychotropic seventeen times and did not have consistent documented of a non-pharmacological intervention attempted prior to administration. -One resident received PRN psychotropic three times and did not have any non-pharmacological interventions documented. -Comment on audit identified that this was discussed with the director of nursing about interventions not being documented and target behaviors listed on all psychotropic medications. F605 audit completed on 11/5/25 for October 2025 identified 5 residents' charts were reviewed and identified the following: -four residents used a PRN psychotropic medication, however, did not have any documentation of non-pharmacological intervention documented attempted prior to administering medication. During an interview on 11/18/25 at 2:45 p.m., administrator stated that the QAA/QAPI committee meets monthly where the previous month's data is discussed and analyzed. Administrator stated the facility had a sharp increase in falls from the month of October 2025 from the previous month of September 2025, however, the facility had not identified the increase in falls as a concern and therefore had not brought this concern to the quality committee to discuss and create and appropriate action plan to assist the facility to determine possible causes of the increase in resident falls. Administrator stated this concern should be brought to the quality committee as soon as possible to develop a plan to correct this concern and not wait until the next month to address the problem. Administrator stated with regards to the chemical restraints the facility had been cited May 2025 for concern for psychotropics being used as chemical restraints and not having a documented non-pharmacological intervention prior to administration. The QAA/QAPI committee determined an action plan to begin doing audits of residents with	20255		

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20255	Continued from page 5 prescribed as needed (PRN) psychotropics to ensure documentation was being completed by licensed staff of a non-pharmacological intervention prior to administering the PRN psychotropic. The audits which began June 2025 and had not identified a concern for the months of 6/25. 7/25, however, the 8/25, 9/25 and 10/25 audits identified PRN psychotropics were being administered without a documented non-pharmacological intervention attempted prior being administered. Administrator stated the QAPI committee had not discussed the identified concern for non-compliance and had not made any amendment to the facility's action plan and should have done this when the audits completed during 8/25, 9/25, and 10/25 identified non-compliance and if the QAPI committee had done this it may have prevented this non-compliance for re-occurring for an extended period. Review of the facility's Quality Assurance and Performance Improvement (QAPI) Plan policy identified the facility shall develop, implement, and maintain and ongoing, facility-wide QAPI plan designed to monitor and evaluate the quality and safety of resident care, pursue methods to improve care quality, and resolve identified problems. The objectives of the QAPI Plan are to: 1. Provide a means to identify and resolve present and potential negative outcomes related to resident care and services. 2. Reinforce and build upon effective systems and processes related to the delivery of quality care and services. 3. Provide structure and processes to correct identified quality and/or safety deficiencies. 4. Establish and implement plans to correct deficiencies, and to monitor the effects of these action plans on resident outcome. 5. Help departments, consultants, and ancillary services that provide direct or indirect care to residents to communicate effectively, and to delineate lines of authority, responsibility, and accountability. 6. Provide a means to centralize and coordinate comprehensive QAPI activities in order to meet the needs of the residents and the facility; and 7. Establish systems and processes to maintain documentation relative to the QAPI Program, as a basis	20255		

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20255	Continued from page 6 for demonstrating that there is an effective ongoing program. SUGGESTED METHOD OF CORRECTION: The QAPI committee should review and/or revise QAPI policies and procedures to develop, implement, and maintain an effective, comprehensive, data-driven QAPI program that focuses on indicators of the outcomes for care and quality of life. Data brought forth should have meaningful review of each area noted. QAPI should identify benchmarks and goals, and review data to identify trends, create action plans to achieve their goals, and to monitor facility progress. QAPI should then report those efforts to the Governing Body to monitor for compliance. The administrator will be responsible for implementation. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	20255		
20555	Comprehensive Plan of Care; Development CFR(s): MN Rule 4658.0405 Subp. 1 Subpart 1. Development. A nursing home must develop a comprehensive plan of care for each resident within seven days after the completion of the comprehensive resident assessment as defined in part 4658.0400. The comprehensive plan of care must be developed by an interdisciplinary team that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, with the participation of the resident, the resident's legal guardian or chosen representative. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on interview and document review the facility failed to develop a comprehensive person-centered behavior care plan with individualized interventions for behavior management for 1 of 1resident (R2) with Alzheimer’s Disease. Findings include: R2’s face sheet dated 11/14/25, identified diagnoses of Alzheimer’s disease(a progressive neurological disorder and the most common cause of dementia), congestive heart failure (a chronic condition where the heart muscle cannot pump enough blood to meet the body’s needs), diabetes mellitus (the body does not	20555	Corrected	12/25/2025

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20555	Continued from page 7 produce enough insulin), and chronic obstructive respiratory failure (when the airways that carry air to the lungs become narrow or damaged). R2's Significant Change Minimum Data Set (MDS) dated 11/6/25, identified R2 needed supervision/touching assistance for transfers, had severe cognitive impairment, had physical behavior symptoms towards others 1-3 days, verbal behavior symptoms directed towards others 4-6 days, but less than daily, and other behavioral symptoms not directed towards others (e.g., physical symptoms such as hitting or scratching self, pacing, rummaging, sexual acts, disrobing in public, or verbal symptoms like screaming, disruptive sounds) occurred 4-6 days, but less than daily, and was taking an anti-psychotic. R2's psychotropic medication management focus care plan dated 2/3/25, identified goal will be free from medication side effects. Interventions were as followed: -Consult pharmacist to review medications-target behaviors: hallucinations, delusions, agitation, excessive worrying, pacing (anti-psychotic), insomnia, sad/depressed mood, sexual behaviors (anti-depressant). -Non-pharmacological interventions-reassure and redirect resident, engage resident in a meaningful activity, conversation, or television show of his interest, offer snack, offer restroom, one to one. R2's behavior focus care plan dated 3/18/25, identified R2 had a behavior problem due to vascular dementia with severe anxiety. Goal to have fewer episodes of socially inappropriate socially inappropriate behaviors weekly. Interventions added 3/18/25 were as followed: -observe behavior episodes and attempt to determine underlying cause, consider location, time of day, persons involved, and situations. - provide a program of activities that is of interest and accommodates resident status or call family to come for a visit if available and other interventions fail. R2's behavior management focus care plan dated 8/12/25, identified goal to remain safe. Interventions were as followed: -ensure the safety of resident and others -evaluate elopement risk	20555		

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20555	Continued from page 8 -monitor for cognitive factors that may contribute to new behavior. -monitor for environmental factors that may contribute to new behavior. -monitor for signs and symptoms of infection. -reorient resident to person, place, time, and situation. -utilize diversion techniques as needed. R2's outpatient geriatric psychiatry follow-up note dated 10/16/25, identified R2 was seen due to a requested appointment due to worsening behaviors at the skilled nursing facility. Encourage ongoing utilization of non-pharmacological interventions, such as environmental modifications, distractions, music, and relaxation activities to manage behaviors as well. R2's record did not identify a comprehensive assessment of R2's behaviors and individualized behavior interventions that are effective for R2. R2's progress note dated 11/2/25, identified R2 was agitated and would not/unable to follow directions, was sitting at the nurse's desk. R2 was given a sandwich and taken to his room and urinated on the floor in his room. R2's progress note dated 11/3/25, identified R2 was yelling and wandering into other resident's rooms, undressing in the hallways, swinging at staff and urinated on the wall in his room. Interventions attempted of redirection and family sitting with resident which was only effective for few minutes. R2's psychosocial quarterly progress note dated 11/4/25, identified R2 had dementia with behaviors and follow psychiatry. R2 does have behavioral issues including wandering, verbal and physical aggression and is resistive with taking medications and cares. R2's preferences evaluation progress note dated 11/5/25, identified R2 prefers country music, and it very important to him to be around animals such as pets, and favorite activities included watching television, visiting, looking at tractor and truck books and to go outside when the weather is nice. R2's care plan did not identify R2's preferences. R2's progress note dated 11/5/25, identified R2 was going in and out of resident rooms and when attempted redirection, R2 becomes aggressive towards staff and	20555		

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20555	Continued from page 9 grabbed the nurse and attempted to “shove” staff. R2’s progress note dated 11/9/25, identified R2 was yelling out at staff and other residents. R2’s progress note dated 11/11/25, identified R2 was restless and was given as needed medication to help with restlessness. R2’s progress note dated 11/12/25, identified R2 attempted to stand up from the wheelchair and as staff attempted to redirect R2 he became loud and agitated and urinated on the floor. During an interview on 11/7/25 at 3:38 p.m., nursing assistant (NA)-D) stated R2’s behaviors had been getting “worse” over the past few weeks, however, was unable to articulate specific care plan non-pharmacological interventions for R2, that staff should be using to decrease R2’s behaviors. NA-D stated that without having specific behavior interventions in his care plan would make it “very difficult” for unfamiliar staff to care for R2 and could make R2’s behaviors “worse”. During an interview on 11/7/25 at 4:00 p.m., NA-E stated R2 had some “good days and “bad days” due to his dementia, however, NA-E was unable to articulate what type of non-pharmacological interventions staff were supposed to use to help decrease R2’s symptoms. NA-E was unable to identify any interventions on R2’s care plan that would be effective in reducing his behaviors. During an interview on 11/7/25 at 4:13 p.m., director of nursing (DON) stated R2’s care plan had not been created to include person-centered interventions to decrease his behaviors to give direction of staff to assist R2 with each identified and/or newly identified behaviors. DON stated she will be meeting with the team to add person-centered interventions on R2’s care plan to reduce some of R2’s behaviors. R2’s behavior focus care plan had added Interventions added on 11/7/25, that included that R2’s triggers include pain, having to use the bathroom, hallucinations, thinking he is working/you are an employee. R2 owned a backhoe company and farmed/worked with livestock. R2’s behavior is deescalated by the following: 1) ensure that you have R2’s attention by calmly but firmly saying his name-saying it multiple times may be required.	20555		

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20555	Continued from page 10 2) ensure you have eye contact 3) ask R2 is he needs to use the restroom 4) ask if R2 is hungry 5) offer R2 something to drink 6)ask R2 questions rather that giving commands 7) alert nurse to assess if as needed medications may be needed 8) talk mechanics, horses, farming with patient/ask questions about this topic. During an interview on 11/19/25 at 1:53 p.m., social services designee (SSD) stated that the facility does not analyze R2's behaviors to determine person centered behavior reduction interventions and ensure those interventions are placed in a resident's care plan. SSD stated since R2's care plan had included individualized behavior interventions on 11/7/25, she had already noticed a decrease in R2's behaviors. Review of the facility's Care Plan, Comprehensive Person-Centered Policy undated, indicated a comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. Policy Interpretation and Implementation were as followed: 1. The interdisciplinary team (IDT), in conjunction with the resident and his/her family or legal representative, develops and implements a comprehensive, person-centered care plan for each resident. 2. The comprehensive, person-centered care plan is developed within seven (7) days of the completion of the required MDS assessment (Admission, Annual or Significant Change in Status), and no more than 21 days after admission. 3. The care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment. 4. If the participation of the resident and his/her resident representative in developing the resident's care plan is determined to not be practicable, an explanation is documented in the resident's medical record. The explanation should include what steps were taken to include the resident or representative in the process.	20555		

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20555	Continued from page 11 5. The comprehensive, person-centered care plan: 1. includes measurable objectives and timeframes. 2. describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, including: 1. services that would otherwise be provided for the above but are not provided due to the resident exercising his or her rights, including the right to refuse treatment. 2. any specialized services to be provided because of PASARR recommendations; and 3. which professional services are responsible for each element of care. 3. includes the resident's stated goals upon admission and desired outcomes. 4. builds on the resident's strengths; and 5. reflects currently recognized standards of practice for problem areas and conditions. 6. Services provided for or arranged by the facility and outlined in the comprehensive care plan are: 1. provided by qualified persons. 2. culturally competent; and 3. trauma informed. 7. Care plan interventions are chosen only after data gathering, proper sequencing of events, careful consideration of the relationship between the resident's problem areas and their causes, and relevant clinical decision making. 8. When possible, interventions address the underlying source(s) of the problem area(s), not just symptoms or triggers. 9. Assessments of residents are ongoing, and care plans are revised as information about the residents and the residents' conditions change. 10. The interdisciplinary team reviews and updates the	20555		

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20555	Continued from page 12 care plan: 1. when there has been a significant change in the resident's condition. 2. when the desired outcome is not met. 3. when the resident has been readmitted to the facility from a hospital stay; and 4. at least quarterly, in conjunction with the required quarterly MDS assessment. 11. The resident has the right to refuse to participate in the development of his/her care plan and medical and nursing treatments. Such refusals are documented in the resident's clinical record in accordance with established policies. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee should review and revise policies and procedures related to creating a comprehensive care plan within 7 days after a comprehensive assessment to ensure cares meet the specific needs of each individual resident. The director of nursing or designee should develop a system to educate staff and develop a monitoring system and perform measurable audits to ensure individual care plans are created and implemented. The results of those audits should be taken to the QAPI committee to determine compliance or the need for further monitoring. The administrator should be responsible to ensure oversight occurs. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	20555		
20570	Comprehensive Plan of Care; Revision CFR(s): MN Rule 4658.0405 Subp. 4 Subp. 4. Revision. A comprehensive plan of care must be reviewed and revised by an interdisciplinary team that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, with the participation of the resident, the resident's legal guardian or chosen representative at least quarterly and within seven days of the revision of the comprehensive resident assessment required by part 4658.0400, subpart 3, item B. This LICENSURE REQUIREMENT is NOT MET as evidenced by:	20570	Corrected	12/25/2025

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20570	Continued from page 13 Based on observation, interview, and document review the facility failed to revise the care plan for 2 of 3 residents (R2, R6) who were reviewed for falls and impaired skin integrity. Findings include: F657 R2's face sheet dated 11/14/25, identified diagnoses of Alzheimer's disease(a progressive neurological disorder and the most common cause of dementia), congestive heart failure (a chronic condition where the heart muscle cannot pump enough blood to meet the body's needs), diabetes mellitus (the body does not produce enough insulin), and chronic obstructive respiratory failure (when the airways that carry air to the lungs become narrow or damaged). R2's Annual Minimum Data Set (MDS) dated 11/6/25, identified R2 used a wheelchair and needed supervision/touching assistance for transfers and ambulation, had one fall with no injury, one fall with minor injury since admission and had severe cognitive impairment. R2's functional performance focus care plan dated 2/3/25, identified R2's care plan goal of to progress towards personal discharge goal during stay. Interventions were as followed: - Transfer - Independent / no set-up or physical help - Toilet use - Limited assist / two-person physical assist - Walk in corridor - Supervision / no set-up or physical help - Locomotion on Unit - Supervision / no set-up or physical - Locomotion off Unit - Supervision / no set-up or physical R2's fall focus care plan dated 2/3/25, identified R2 was at risk for falls as evident by scoring tool, antidepressant use, and wandering behaviors. R2's care plan goal was to be free from falls. Interventions included: -educate on the importance of maintaining a safe	20570		

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20570	Continued from page 14 environment, free from potential fall hazards. -evaluate fall risk on admission and as needed; review medication for drugs that increase the risk for falls. -Intervention added on 5/12/25 to assist R2 with ambulation and transfers, utilizing therapy recommendations. During an observation on 11/12/25 at 10:25 a.m., R2 was seated in a wheelchair, propelling himself with his feet around the lobby. R2's care plan had not been revised to reflect R2 used a wheelchair. During an interview on 11/12/25 at 10:33 a.m., nursing assistant (NA)-A stated R2's care plan indicated R2 was independent with transfers, however, R2 had not been independent for "a while" due to being "unsteady" on his feet and had multiple falls. NA-A further stated R2 had been wheelchair while out of his room, however, R2's care plan had not been updated to reflect this change. In review of R2's care plan in conjunction with R2's fall record there was no indication R2's fall care plan goals were appropriate, and interventions were evaluated for effectiveness that would prevent or mitigate the risk for recurrent falls and/or the care plan was revised with new interventions based on R2's safety needs to prevent falls and falls with major injury. R2's fall incident report dated 10/20/25 at 1:46 a.m., identified R2 was found on the floor in his room with a 7-8 cm laceration on the back of his head and an abrasion on the right inner arm. R2 thought he was answering the phone. R2's fall incident report dated 11/4/25 at 8:45 a.m., identified R2 was found in his room kneeling and leaning on a chair in his room. R2's fall incident report dated 11/7/25 at 6:29 p.m., identified R2 was found lying on his face in his room at 5:50 p.m. R2's fall incident report dated 11/9/25 at 4:50 p.m., identified R2 was found sitting on the floor in his room next to his chair. R2 was trying to pick up specks on the floor and had been sitting in chair which is low to ground. R2's fall incident report dated 11/10/25 at 8:30 p.m.,	20570		

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20570	Continued from page 15 identified R2 was found sitting between chair and bedside table. R2's fall incident report dated 11/11/25 at 8:30 p.m., identified R2 was in hall and grabbed the handrail to pull himself up to a standing position and began walking and then started going down and before staff could get to R2 he fell to the ground. During an interview on 11/12/25 at 3:23 p.m., registered nurse (RN)-A stated after a resident has fallen, the nurse is supposed to initiate an immediate intervention to mitigate the risk of a resident falling again. RN-A further stated she was not aware that a resident's care plan needed to be revised to reflect the intervention and believes this would be something the director of nursing (DON) was responsible to complete. During an interview on 11/12/25 at 3:56 p.m., interim director of nursing (I-ADON) stated R2's care plan had not been revised to include any updated individualized fall prevention interventions nor R2's transfer changed to remove independent during transfers and had not had a wheelchair added to R2's care plan. I-ADON stated the DON does resident care plan revisions and not the nurses. R6's face sheet dated 11/19/25, identified diagnoses of hemiplegia (paralysis) affecting left side, diabetes mellitus (body does not make enough insulin), and heart failure (a condition where the heart does not pump enough blood to the body). R6's Annual Minium Data Set (MDS) dated 10/23/25, identified R6 was dependent for bed mobility/transfers, at risk for developing pressure ulcers, had no pressure ulcers, and was cognitively intact. R6's skin integrity focus care plan last revised on 4/29/25, identified R6 had a potential impairment to skin integrity related to bowel and bladder incontinence and impaired mobility. Goal to maintain or develop clean and intact skin. Interventions were as followed: may apply barrier cream after each incontinent episode; elevate heels off the bed; keep skin clean and dry, use lotion on dry skin, prefers to not be checked every two hours; pressure relieving/reducing cushion in wheelchair; standard pressure relieving/reducing mattress to protect skin while in bed. R6's nursing home rounding form dated 11/10/25, identified the nurse practitioner requested to check	20570		

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20570	Continued from page 16 that R6's air mattress was working. During an observation and interview on 11/18/25 at 10:21 a.m., R6 was lying in bed on top of a specialty mattress in place. R6 stated she had this type of mattress on for some time due to a sore on her bottom and because she spends a lot of time in bed. NA-F stated R6 had been on an air bed for "some time" because she had sore on her bottom. During an interview on 11/18/25 at 10:57 a.m., director of nursing (DON) stated R6's care plan had not been revised to include the air mattress that was placed on her bed, and it should have been revised as soon as it was placed on her bed. Review of the facility's Care Plan, Comprehensive Person-Centered Policy undated, identified the interdisciplinary team reviews and updates the care plan: a. when there has been a significant change in the resident's condition. b. when the desired outcome is not met. c. when the resident has been readmitted to the facility from a hospital stay; and at least quarterly, in conjunction with the required quarterly MDS assessment SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and revise policies and procedures related to revision of the care plan as needed to meet the needs of each individual resident. The director of nursing or designee could develop a system to educate staff and develop a monitoring system to ensure individual care plans are revised as necessary. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	20570		
20625	Clinical Record Contents; In General CFR(s): MN Rule 4658.0450 Subp. 1 A-P Subpart 1. In general. Each resident's clinical record, including nursing notes, must include: A. the condition of the resident at the time of admission;	20625	Corrected	12/25/2025

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20625	Continued from page 17 B. temperature, pulse, respiration, and blood pressure, according to part 4658.0520, subpart 2, item I; C. the resident's height and weight, according to part 4658.0520, subpart 2, item J; D. the resident's general condition, actions, and attitudes; E. observations, assessments, and interventions provided by all disciplines responsible for care of the resident, with the exception of confidential communications with religious personnel; F. significant observations on, for example, behavior, orientation, adjustment to the nursing home, judgment, or moods; G. date, time, quantity of dosage, and method of administration of all medications, and the signature of the nurse or authorized persons who administered the medication; H. a report of a tuberculin test within the three months prior to admission, as described in part 4658.0810; I. reports of laboratory examinations; J. dates and times of all treatments and dressings; K. dates and times of visits by all licensed health care practitioners; L. visits to clinics or hospitals; M. any orders or instructions relative to the comprehensive plan of care; N. any change in the resident's sleeping habits or appetite; O. pertinent factors regarding changes in the resident's general conditions; and	20625		

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20625	Continued from page 18 P. results of the initial comprehensive resident assessment and all subsequent comprehensive assessments as described in part 4658.0400. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on interviews and document review the facility failed to maintain a complete, accurate and readily accessible medical record was maintained for 2 of 3 residents (R1, R4) who were noted to have missing information in their record. Findings include: F842 R1's face sheet dated 11/13/25, identified diagnoses of atherosclerotic heart disease (plaque buildup in the arteries), morbid obesity (excess fat), depression (a mood disorder characterized by persistent sadness), and anxiety (a mental and physical state characterized by feelings of dread or worry). R1's Minimum Data Set (MDS) dated 10/22/25, was independent with transfers and was cognitively intact. During an interview on 11/14/25 at 2:04 p.m., health information manager (HIM) stated R1 had been seen for routine nursing home visits on 8/1/25 and 10/7/25, however, R1's physician visit dictated notes had not been placed in R1's electronic health record (EHR), due to the notes being located in the outside medical systems. HIM stated she does not have access to the outside medical system to obtain the notes, however, will have the director of nursing (DON) obtain the records. Review of R1's electronic health record (EHR) on 11/19/25, did not include the 8/1/25, nor the 10/7/25 physician visit notes were in R1's facility EHR. An email received on 11/19/25 at 8:23 a.m., from the director of nursing (DON) included a copies of R1's nursing home physician visit notes from 8/1/25 and 10/7/25. R1's physician notes dated 8/1/25, identified R1 had been seen on routine nursing home rounds. R1's nurse practitioner nursing home visit note dated 10/7/25, indicated R1 was seen for nursing home rounds.	20625		

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20625	Continued from page 19 R4's face sheet dated 11/14/25, identified diagnoses of unspecified dislocation (an injury where the bone becomes dislodged from their normal place) of right shoulder joint, obesity, and schizophrenia (a chronic brain disorder that affects how a person thinks, feels and acts). During an interview on 11/14/25 at 2:04 p.m., HIM stated R4 had been seen for a physician recertification visit on 9/26/25. Review of R4's EHR on 11/14/25, identified R4's 9/26/25 recertification visit note had been uploaded however not until 11/14/25. During an interview on 11/14/25 at 2:04 p.m., HIM stated R4 had a routine nursing home visit on 9/26/25, however, the note had not been removed from the outside medical system EHR to be placed into R4's chart until 11/14/25. HIM stated she was responsible for the uploading visit notes, that were received via fax. The other notes from outside medical visits needed to be accessed prior to uploading them into the facility's EHR system which she did not have access to. HIM needed to have the director of nursing (DON) obtain the note for R1 and R4. HIM was unaware of the facility's process to ensure that the notes were placed timely in the resident's EHR. During an interview on 11/19/25 at 4:10 p.m., vice president of clinical services (VP-CS) stated the facility has a system in the electronic health record that allows staff to enter the outside electronic health record and extract dictated notes and had shown the HIM a while ago on how to perform this task but had to demonstrate this task again today. The staff would need to find the notes and download the notes and then place the note in the facility's EHR under the "miscellaneous" tab. During an interview on 11/19/25 at 2:20 p.m., director of nursing (DON) stated she was unaware that R1 and R4's notes had not been placed in the facility's EHR in a timely manner. DON further stated R1 and R4's notes located in the outside medical record system belong to the outside medical system and are not a part of the facility's EHR, and her expectation would be that all resident's visit notes be placed in the EHR as soon and they are available and by not having R1 and R4's notes in the facility EHR could lead to something being missed and in the event of an emergency the resident's medical record would not be complete. Requested the facility's policy on maintaining an	20625		

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20625	Continued from page 20 accurate and complete medical record, however, did not receive. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee should review and revise policies and procedures related to verifying and transcribing orders in the electronic medical record and/or develop a monitoring system to ensure resident records are true and accurate. The director of nursing or designee should educate staff and perform measurable audits. The results of those audits should be taken to QAPI to determine compliance or the need for further monitoring. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	20625		
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 the resident prefers to remain in bed. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to comprehensively assess falls for root cause, implement appropriate interventions and revise the care plan to prevent and/or reduce the risk for future falls for 2 of 3 residents (R2, R4) reviewed for accidents. This resulted in an immediate jeopardy (IJ) for 2 when he sustained a head laceration following a fall and an IJ for R4 when after repeated falls sustained shoulder dislocation that had not identified since the last imaging that did not show dislocation on 7/30/25. Findings include: F689 R2's face sheet dated 11/14/25, identified diagnoses of Alzheimer's disease (a progressive neurological disorder and the most common cause of dementia), congestive heart failure (a chronic condition where the	20830	Corrected	12/25/2025

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20830	Continued from page 21 heart muscle cannot pump enough blood to meet the body's needs), diabetes mellitus (the body does not produce enough insulin), and chronic obstructive respiratory failure (when the airways that carry air to the lungs become narrow or damaged). R2's fall focus care plan dated 2/3/25, identified R2 was at risk for falls as evident by scoring tool, antidepressant use, and wandering behaviors. R2's care plan goal was to be free from falls. Interventions included: -educate on the importance of maintaining a safe environment, free from potential fall hazards. -evaluate fall risk on admission and as needed; review medication for drugs that increase the risk for falls. -Intervention added on 5/12/25 to assist R2 with ambulation and transfers, utilizing therapy recommendations. R2's fall risk assessment dated 11/5/25, identified R2 was at risk for falls due to having 1-2 falls in the past 3 months; disorientated; balance with standing and while walking; takes 3-4 high risk medications; had a change in medication (or medication class) or change in dosage in the past five days. No interventions under risk for falls were selected on the assessment. R2's Annual Minimum Data Set (MDS) dated 11/6/25, indicated R2 had severe cognitive impairment. R2 used a wheelchair and needed supervision/touching assistance for transfers, had one fall with no injury, one fall with minor injury since admission and had severe cognitive impairment. R2's progress note dated 10/20/25 at 3:18 a.m., identified R2 was found on the floor sitting between bed and his chair, bed table next to the wall with blood on the floor and a laceration on the back of the head 7-8 centimeters (cm) across and had to be taken to the hospital. R2's fall incident report dated 10/20/25 at 1:46 a.m., identified R2 was found on the floor in his room with a 7-8 cm laceration on the back of his head and an abrasion on the right inner arm. R2 thought he was answering the phone. There was no indication of a comprehensive analysis to identify causal factors was completed, no immediate interventions, and no indication R2's care plan was revised.	20830		

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20830	Continued from page 22 R2's emergency department (ED) note dated 10/20/25, identified R2 was seen following a fall at the nursing home and sustained a 6.0 cm laceration on the top of his head and needed to have the scalp wound closed with 8 or 9 staples and bandage applied. R2's progress note dated 10/20/25 at 4:44 a.m., identified R2 returned from the ED and was to have sutures removed in 9-10 days. R2's fall incident report dated 11/4/25 at 8:45 a.m., identified R2 was found in his room kneeling and leaning on a chair in his room. There was no indication of a comprehensive analysis to identify causal factors was completed, no immediate interventions, and no indication R2's care plan was revised. R2's progress note dated 11/5/25 at 11:10 a.m., identified a long-term care evaluation completed for R2. R2 had two falls since last evaluation and had a safety concern with a high fall potential. R2's progress note dated 11/6/25 at 11:51 p.m., identified R2 was given a wheelchair related to him being unsteady on his feet. R2 was given an as needed Seroquel. R2's care plan had not been revised to identify an intervention that R2 required a wheelchair. R2's progress note dated 11/7/25 at 10:42 a.m., identified family had been asked about getting a different chair as current chair is not safe and difficult for resident to get to standing position. Family stated they had a chair they will bring in to replace the current chair. Offered to use a chair from the facility and family stated they will bring one in. R2's fall incident report dated 11/7/25 at 6:29 p.m., identified R2 was found lying on his face in his room at 5:50 p.m. There was no indication of a comprehensive analysis to identify causal factors was completed, no immediate interventions, and no indication R2's care plan was revised. R2's fall incident report dated 11/9/25 at 4:50 p.m., identified R2 was found sitting on the floor in his room next to his chair. R2 was trying to pick up specks on the floor and had been sitting in chair which is low to ground. R2's fall incident report dated 11/10/25 at 8:30 p.m., identified R2 was found sitting between chair and bedside table. There was no indication of a comprehensive analysis to identify causal factors was	20830		

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20830	Continued from page 23 completed, no immediate intervention, and no indication R2's care plan was revised. R2's fall incident report dated 11/11/25 at 8:30 p.m., identified R2 was in hall and grabbed the handrail to pull himself up to a standing position and began walking and then started going down and before staff could get to R2 he fell to the ground. There was no indication of a comprehensive analysis to identify causal factors was completed, no immediate intervention, and no indication R2's care plan was revised. During an interview on 11/13/25 at 10:23 a.m., consulting pharmacist (C-Pharm) stated normally the facility would notify her of a resident having frequent falls to perform a medication review to see if medication could be a cause of the frequent falls, however, had not been notified of R2's frequent falls. C-Pharm further indicated since R2 was administered Seroquel, an antipsychotic medication, which could increase risk for falls because of the associated side effects of drowsiness, dizziness, and orthostatic hypotension (sudden drop of systolic blood pressure with position changes). Since 10/31/25, R2 had duplicative antipsychotic therapy because Haloperidol as needed (PRN) was added in addition to Seroquel which may have caused the increase in R2's falls since 11/7/25 due to that type of medication given more frequently. R2's progress note dated 11/12/25 at 10:56 p.m., identified R2 was seen wanting to stand up from wheelchair and was unsteady on his feet. R2 then began pulling on his pants like he wanted to use the bathroom. Staff provided 1:1 with R2 in his room and after calmed down was brought to lobby for proper supervision. R2's care plan and Kardex (abbreviated care plan) were not revised to include nor define "proper supervision". During an interview on 11/12/25 at 12:05 p.m., licensed practical nurse (LPN)-A stated R2 had fallen a few times since 11/7/25. however, had not been informed of any new fall prevention interventions for R2. LPN-A stated the nurses did not update the care plan nor determine a root cause of a fall and thought the DON was responsible for that but was not sure. During an interview on 11/12/25 at 10:51a.m., (Interim Assistant Director of Nursing (I-ADON) stated R2 had fallen a "bunch" of times this weekend, however, was not able to articulate what occurred during the falls. During a follow up interview at 3:56 p.m., I-ADON was	20830		

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20830	Continued from page 24 unable to articulate fall prevention interventions for R2 and stated R2 needs “One to one at times, but we are not able to provide that service.” R2’s falls had been discussed at the morning meetings; however, a causal analysis had not been completed, and he had not been trained on the process, so he was unsure of the facility’s process on completing the causal analysis following a fall. I-ADON indicated he had not made any revisions to R2’s care plan and was unsure whom in the facility would be responsible for the updates. During an interview on 11/12/25 at 5:11 p.m., director of nursing (DON) stated R2 was a high fall risk and was very impulsive due to his diagnosis of Alzheimer’s. DON stated R2’s fall that occurred on 10/20/25 resulted in a large laceration on the back of his head that required him to be sent to the ED to have the area sutured. R2 had falls in the facility after 10/20/25, however, had not had a comprehensive causal analysis performed for any of his falls. R2’s care plan was not revised to include individualized fall prevention interventions to mitigate the risk of future falls and limit the likelihood for serious injury. DON stated, “this should have been done.” During an interview on 11/12/25 at 12:38 p.m., LPN-B stated following a resident’s fall, the nurses needed to fill out the risk management (incident report) documenting what happened during the fall, If the nurse determined an appropriate fall intervention it would be verbally passed onto the next shift until the IDT reviewed the incident information. LPN-B stated the nurses do not update the care plan to include new fall prevention interventions and had not been instructed to do so. During an interview on 11/12/25 at 3:23 p.m., registered nurse (RN)-A stated she was working when R2 fell on 11/10/25. RN-A stated she had not completed a comprehensive causal analysis of R2’s fall and believed the ADON and DON would have that completed. RN-A stated she told staff R2 needed to be kept in the lobby for close supervision and normally would include this in the progress notes so the next shifts would be aware, however, she had not documented the intervention in R2’s progress notes. R2’s fall incident report dated 11/13/25 at 6:30 a.m., identified R2 was sitting in his swivel recliner 30 seconds prior and then was found on the floor laying on his left side. R2 sustained an abrasion to left elbow. Nurse called the daughter and asked her to bring a new chair for R2 and remove the swivel recliner.	20830		

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20830	Continued from page 25 During an interview on 11/13/25 at 8:08 a.m., licensed practical nurse (LPN)-B stated R2 had fallen from his swivel recliner in his room today. LPN-B had been asking for a while for the swivel recliner to be removed, however, it had not been removed. LPN-B explained the swivel recliner was the cause of most of R2's falls because the chair was low to the ground, and it moved when he attempted to stand up. LPN-B stated she would check if there was a stationary chair in the facility until family could bring a chair from home. During an interview on 11/13/25 at 8:22 a.m., I-ADON stated R2 had fallen out of his swivel recliner around 6:30 a.m. today. The hospice aide was in R2's room, the side left R2 sitting in his recliner when she left the room, "only 30-seconds" later she returned to find R2 on the floor. I-ADON stated R2 could be "very quick" when he would self-transfer; staff tried "their best" to keep an eye on R2 when he was awake, but there are times when staff needed to leave him alone do other things and in that time R2 could fall and get injured. During an observation on 11/13/25 at 9:42 a.m., R2 was seated in a wheelchair next to the nursing station, When R2's family entered the facility, R2 stood up from his wheelchair with the breaks unlocked (no anti-roll back devices on the wheels) and started to walk towards his family without staff's awareness or presence. R2 was unsteady on his feet so he grabbed ahold the top of the nursing station with his left hand while he walked. R2's family informed R2 they were going to bring him a new chair. R2's family stood next to him attempting to get him to sit back in his wheelchair. At 9:50 a.m. staff came and assisted R2 back to his room with family. During an interview on 11/13/25 at 10:00 a.m., family member (FM)-D stated they brought in a new chair because today he fell out of it again. FM-A stated the facility talked to them about getting a new chair at the last care conference, however, just have not had time to bring it until today. During an interview on 11/13/25 at 9:52 a.m., nursing assistant (NA)-A could not articulate what the fall prevention interventions were for R2 and stated she would need to check the care plan/Kardex in the electronic health record (EHR), upon looking at R2's Kardex/care plan she only identified call light should be within reach. NA-A further stated we would attempt to keep R2 seated in his wheelchair because he was unsteady on his feet and been complaining of feeling dizzy at times. Staff would attempt to distract him when he was agitated. NA-A also stated if the	20830		

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20830	Continued from page 26 interventions were not in the care plan/Kardex, staff would be unsure of the falls preventions interventions that were in place. During an interview on 11/12/25 at 3:02 p.m., NA-B was unable to articulate fall prevention interventions for R2 and stated if we saw him get up from his chair, we would attempt to get him to sit back down or distract him. NA-B stated she would review a resident's care plan to see what the fall interventions were, but looked on R2's EHR and did not see any specific fall prevention interventions his care plan should be updated to make sure staff were aware of what they were supposed to do to keep R2 safe. During an interview on 11/13/25 at 1:41 p.m., medical director (MD) stated the likelihood of R2 getting serious injury from a fall is "pretty high" and any resident with a fall from any height has the likelihood to sustain serious injury following a fall from any height. R4's face sheet dated 11/14/25, identified diagnoses of unspecified dislocation of right shoulder joint, obesity, and schizophrenia. R4's Quarterly MDS dated 8/7/25, indicated R4 did not have cognitive impairment. R4 had no limitation in range of motion in her upper extremities and used a walker and wheelchair. R4 was independent in transfers, continent of bowel, and frequently incontinent of urine. The MDS identified R4 had no falls since prior assessment even though R4 had documented falls on 8/2/25 and 8/7/25. R4's fall focus care plan revised on 5/21/25 identified R4 was high-risk for falls related to confusion, deconditioning, psychoactive medication drug use, and history of voices in her head telling her to fall to the floor. Goal was to not sustain serious injury. Interventions dated 11/20/24, identified as the following: -Be sure call light is within reach and encourage to use it for assistance as needed. The resident needs prompt response to all requests for assistance. -encourage the resident to participate in activities that promote exercise, physical activity for strengthening an improve mobility such as walking with staff. -Review information on past falls and attempt to determine cause of falls. Record possible root cause.	20830		

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20830	Continued from page 27 Alter remove any potential causes if possible. Educate resident/family/caregivers/IDT as to causes. -the resident needs activities that minimize the potential for falls, while providing diversion and distraction, group activities, puzzles, word searches, reading materials, and coloring activities. -the resident uses grab bars on her bed to assist with repositioning and the need to feel safe. Resident has a low bed and fall mat. R4's fall incident report dated 8/2/25 at 9:30 a.m., identified R4 was getting dried off from the shower with staff assistance, then slammed her walker into the wall of the tub room and put herself on the floor and indicated this was a behavior. R4 broke her walker and had no injury. R4 was placed in a wheelchair until walker could be fixed. There was no indication of a comprehensive analysis to identify potential modifiable and non-modifiable risk factors other than R4's "behavior." Although a behavior was identified as a causal factor there was no indication of immediate intervention that addressed R4's behavior of putting herself on the floor nor evident R2's care plan was revised. R4's fall incident report dated 8/6/25 at 10:30 a.m., identified R4 was heard "hollering" in her room and was observed lying safely on her bed. Staff reassured resident and left the room when R4 began to holler again. About one minute later was found on the floor next to her bed and over the bed table. R4 was assisted off the floor and then taken to the lobby area where she could be observed more closely/frequently. There was no indication of a comprehensive analysis to identify causal factors was completed and no indication R2's care plan was revised. R4/s fall incident report dated 8/25/25 at 11:00 a.m., identified a witnessed fall was observed in the lounge. R4 put herself on the floor and was witnessed by staff. There was no indication of a comprehensive analysis to identify causal factors was completed and no indication an immediate intervention was implemented nor evident R2's care plan was revised. During an interview on 11/13/25 at 1:32 p.m., DON reviewed R4's fall record and stated she did not interview staff to determine all potential causal factors of R4's fall on 8/2/25 and 8/25/25. R4's fall incident report dated 9/4/25 at 8:45 a.m., identified R4 was walking with her walker from common	20830		

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20830	Continued from page 28 area to her room, when she started to veer towards the wall, she then let go of the walker and held onto the handrail and lowered self to the floor to a sitting position. There was no indication of a comprehensive analysis and although the report identified an intervention for physical therapy to evaluate and treat, there was no indication of an immediate intervention that would prevent/mitigate the risk for falls until the therapy evaluation and treatment if applicable. R4's physical therapy (PT) evaluation note dated 9/9/25, identified R4 had pain in right shoulder. History of falls in past year, however, exact number unknown; patient was injured from fall with the current injury. R4 had a fear of falling and right upper extremity had impaired range of motion. Reason for therapy was to facilitate motor control, minimize falls and enhance rehab potential. Although R4 had reported right shoulder pain there was no indication she was evaluated by a physician. R4's fall incident report dated 10/1/25 at 1:00 p.m., identified R4 was found on the floor next to her bed with two pillows under her head. R4 stated "I put the pillows down and laid on the floor and should not have done that." R4 had an incontinent stool at the time of the fall. There was no indication of a comprehensive analysis to identify causal factors was completed, no immediate intervention, and no indication R2's care plan was revised. R4's fall incident report dated 10/28/25 at 4:00 p.m., identified R4 was found sitting down on the floor. R4's bed was in the lowest position and R4 stated she slid down the bed. There was no indication of a comprehensive analysis to identify causal factors was completed, no indication of immediate intervention, and no indication R4's care plan was revised. R4's fall incident report dated 11/6/25 at 10:00 a.m., identified R4 was found on the floor face down, with the table tipped over and pants and underwear down. R4 was having pain all over and was sent to the emergency department for evaluation. R4's progress note dated 11/6/25 at 12:18 p.m., identified nurse had eyes on R4 at 9:45 a.m. during medication pass, R4 was sitting in the chair and had pants down around ankles and this nurse assisted R4 to get pants back up. R4 was compliant and redirected. Then at 10:00 a.m., R4 was found on the floor with face to the floor. R4 was having pain all over and was sent to the ED.	20830		

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20830	Continued from page 29 R4's emergency department (ED) orthopedic consult note dated 11/6/25, identified reason for the consult was right shoulder dislocation. R4 fell earlier in the day and sustained an injury to her right shoulder and hip. R4 had had a right shoulder dislocation that failed closed reduction back in April and subsequently underwent open reduction. Findings on CT scan suggest that this dislocation is not acute and is chronic in nature. Patient's daughter does note that R4 has had several falls after the initial shoulder reduction in April of 2025. It is likely that shoulder dislocated with one of these falls [while a resident at the facility], but R4 was never formally evaluated. R4 had significant limitation to range of motion of the shoulder for several months now. "I do not believe an attempted closed reduction would not be successful at this point as her shoulder has likely been dislocated for some time now." R4's progress note dated 11/6/25 at 5:05 p.m., R4 returned from ED and had an order that R4 may wear sling for comfort and was to follow up with orthopedics if continued shoulder pain, to discuss surgical correction. Upon return from the ED there was no indication of a comprehensive analysis to identify causal factors was completed, no indication of immediate intervention, and no indication R4's care plan was revised. R4's fall risk assessment dated 11/7/25, identified R4 was high-risk for falls due to three of more falls in past 3 months, ambulatory/incontinent, three or more predisposing diagnoses, and takes 3-4 medications. R4's nurse practitioner nursing home visit note dated 11/10/25, identified R4 was seen following an ED visit on 11/6/25 after a fall. Right shoulder CT showed anterior glenohumeral dislocation (when the ball of the upper arm bone is forced out of the shoulder's cup shaped socket) with the humeral head abutting the coracoid process. Was recommended to see orthopedics for a follow up, however, declined to be seen. R4 had underwent reduction right shoulder under anesthesia 4/8/25. R4 had been following orthopedics and last x-rays done 7/30/25 showed no acute fracture or dislocation of the right shoulder (indicating the dislocation happened after 7/30/25). During an interview on 11/13/25 at 12:03 p.m., nurse practitioner (NP) stated R4 was seen for an ED follow up from 11/6/25. R4 has a right shoulder dislocation and orthopedics offered her a follow up and R4 declined. R4 had had surgery to replace a right	20830		

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20830	Continued from page 30 shoulder dislocation in April 2025, which could make R4's shoulder weaken and could have easily dislocated again. During an observation and interview on 11/13/25 at 9:30 a.m., R4 had her right arm in a sling and stated the last time she fell she was trying to take herself to the bathroom, lost her balance and fell on her shoulder. R4 stated her shoulder began to hurt "really bad" and had to be sent to the ED to have it checked out. "And it sounded like it was dislocated again which may have been from one of my falls I had, but she was not sure." During an interview on 11/13/25 at 9:52 a.m., nursing assistant (NA)-A stated R4 sometimes would try to take herself to the bathroom and fall. NA-A was unaware of any fall prevention interventions that were currently in place for R4. NA-A then opened the electronic health record (EHR) and found R4's care plan and stated her fall care plan just said call light in reach and gait belt, however, was not able to find any further care plan interventions. During an interview on 11/13/25 at 1:24 p.m., director of nursing (DON) stated she was not aware of what the facility's fall prevention program consisted of nor what the facility's policies were. DON further stated she had not performed a causal analysis of any of R4's falls and was unaware she was supposed to be documenting in the resident's record and updating the care plan. DON stated she had not had any formal training on how to perform a root cause analysis and was trying to "read up" on how that was completed. During an interview on 11/17/25 at 11:35 a.m., DON stated the IDT team determined R2's falls had been caused by the swivel chair moved when R2 attempted to get up from the chair; the chair has been removed from R2's room and R2 had been placed on one-to-one supervision. R4 had a fall prevention intervention added to her care plan to offer toileting if R4 was observed pulling her pants down, however, had been placed under the incorrect focus in R4's care plan and would be moved under the appropriate focus. During an observation on 11/17/25 at 10:43 a.m., R4 was seated in her wheelchair in the lobby when R4 stood up and began pulling her pants and brief down. NA-E then walked up to R4 and assisted R4 to pull her pants back up, however, did not offer R4 to toilet (according to the care plan), instead rolled R4 to the DON's office. During an interview on 11/17/25 at 11:07 a.m., NA-E	20830		

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20830	Continued from page 31 stated he was unaware of R2 and R4's fall prevention interventions and had not had anything passed on in report. NA-E then went to the EHR, but was unable to locate fall prevention focus care plan along with the fall interventions for R2 and R4. During an interview on 11/17/25 at 10:55 a.m., NA-C stated she was unaware of fall prevention interventions for R2 and R4 and stated she would need to check the care plan/Kardex, however, was unable to find the fall interventions for R2 or R4 in the care plan/Kardex. During an interview on 11/17/25 at 12:18 p.m., LPN-C stated if a resident had a fall she would then add a new intervention to the care plan to prevent future falls. LPN-C stated she would add an appropriate intervention based on the likely reason for the fall, however, was unsure how to make sure the intervention was added to the Kardex. The immediate jeopardy that began on 10/20/25, was removed on 11/17/25 at 4:45 p.m., when it was verified, the facility implemented the following: -The facility reviewed their fall policies, and no revisions were warranted. -R2 and R4's falls were reviewed by the interdisciplinary team (IDT) and the incident reports were updated indicating a causal analysis and care plans updated. -Fall risk assessment scoring report was run and identified residents who are high risk for falls who experienced a fall since 11/1/25 had their care plans reviewed and/or updated based on a root cause analysis of the falls. - The facility in-serviced nurses and nurse aides on the assessing causes of falls policy with emphasis on the entire policy with special focus on the steps in the procedure items, documentation, and reporting. -Interdisciplinary team (IDT) was in serviced on comprehensive care plan with emphasis on direction to develop care plan interventions after a thorough review of data and sequencing events and that assessments of residents are ongoing, and care plans need to be revised as the resident's condition changes. -IDT was in-serviced on falls and falls management with focus on the policy section entitled "Monitoring subsequent falls and fall risk which instructs the team to monitor and document the resident's response to	20830		

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20830	Continued from page 32 interventions to reduce falls Review of the facility's Falls and Fall Risk, Managing policy undated, identified Based on previous evaluations and current data, the staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling. Included the following: Resident-Centered Approaches to Managing Falls and Fall Risk 1. The staff, with the input of the attending physician, will implement a resident-centered fall prevention plan to reduce the specific risk factor(s) of falls for each resident at risk or with a history of falls. 2. If a systematic evaluation of a resident's fall risk identifies several possible interventions, the staff may choose to prioritize interventions (i.e., to try one or a few at a time, rather than many at once). 3. Examples of initial approaches might include exercise and balance training, a rearrangement of room furniture, improving footwear, changing the lighting, etc. 4. In conjunction with the consultant pharmacist and nursing staff, the attending physician will identify and adjust medications that may be associated with an increased risk of falling, or indicate why those medications could not be tapered or stopped, even for a trial period. 5. If falling recurs despite initial interventions, staff will implement additional or different interventions, or indicate why the current approach remains relevant. 6. If underlying causes cannot be readily identified or corrected, staff will try various interventions, based on assessment of the nature or category of falling, until falling is reduced or stopped, or until the reason for the continuation of the falling is identified as unavoidable. 7. In conjunction with the attending physician, staff will identify and implement relevant interventions (e.g., hip padding or treatment of osteoporosis, as applicable) to try to minimize serious consequences of falling.	20830		

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20830	Continued from page 33 Monitoring Subsequent Falls and Fall Risk 1. The staff will monitor and document each resident's response to interventions intended to reduce falling or the risks of falling. 2. If interventions have been successful in preventing falling, staff will continue the interventions or reconsider whether these measures are still needed if a problem that required the intervention (e.g., dizziness or weakness) has resolved. 3. If the resident continues to fall, staff will re-evaluate the situation and whether it is appropriate to continue or change current interventions. As needed, the attending physician will help the staff reconsider possible causes that may not previously have been identified. 4. The staff and/or physician will document the basis for conclusions that specific irreversible risk factors exist that continue to present a risk for falling or injury due to falls. Review of the facility's Assessing Falls and Their Causes procedure dated 3/1/22, identified the purposes of the procedure are to provide guidelines for assessing a resident after a fall and to assist staff in identifying causes of the fall. Steps in the Procedure included: After a Fall: 1. If a resident has just fallen or is found on the floor without a witness to the event, nursing staff will record vital signs including neurological assessment and evaluate for possible injuries to the head, neck, spine, and extremities. 2. If there is evidence of a significant injury such as a fracture or bleeding, nursing staff will provide appropriate first aid. Once an assessment rules out significant injury, nursing staff will help the resident to a comfortable sitting or lying position and the staff will lift the resident via mechanical lift and will document relevant details. 3. Nursing staff will notify the resident's Attending Physician and family. When a fall results in a significant injury or condition change, nursing staff will notify the practitioner immediately by phone.	20830		

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20830	Continued from page 34 4. Nursing staff will observe for delayed complications of a fall for approximately forty-eight (48) hours after an observed or suspected fall and will document findings in the medical record. 5. Documentation will include any observed signs or symptoms of pain, swelling, bruising, deformity, and/or decreased mobility; and any changes in level of responsiveness/consciousness and overall function. It will note the presence or absence of significant findings. A new fall and pain assessment should be completed. 6. An incident report must be completed for resident falls. The incident report form should be completed by the assigned staff nurse at the time via risk management incident portal. Defining Details of Falls: 1. After an observed or probable fall, the staff will clarify the details of the fall, such as when the fall occurred and what the individual was trying to do at the time the fall occurred. Identifying Causes of a Fall or Fall Risk: 1. Within 24 hours of a fall, the nursing staff will begin to try to identify possible or likely causes of the incident. They will refer to resident-specific evidence including medical history, known functional impairments, etc. 2. Staff will evaluate chains of events or circumstances preceding a recent fall, including: a. Time of day of the fall. b. Time of the last meal. c. What the resident was doing. d. Whether the resident was standing, walking, reaching, or transferring from one position to another. e. Whether the resident was among other persons or alone. f. Whether the resident was trying to get to the toilet. g. Whether any environmental risk factors were involved	20830		

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20830	Continued from page 35 (e.g., slippery floor, poor lighting, furniture or objects in the way); and/or h. Whether there is a pattern of falls for this resident. 3. The staff will continue to collect and evaluate information until they either identify the cause of falling or determine that the cause cannot be found. 4. The Unit Manager or Director of Nursing Services should consult with the Attending Physician or Medical Director to confirm specific causes from among multiple possibilities. 5. As indicated, the Attending Physician will examine the resident or may initiate testing to try to identify causes. If the cause is unknown but no additional evaluation is done, the physician or nursing staff should note why (e.g., workup already done, finding a cause would not change the approach, etc.). 6. When possible, the Attending Physician or nursing staff will document the basis for identifying specific factors as the cause. SUGGESTED METHOD OF CORRECTION: The Director of Nursing (DON) or designee should review policies and procedures, train staff, and implement measures to ensure appropriate supervision and analysis of falls occurs for fall prevention. The DON or designee should educate staff and conduct measurable audits of fall to ensure analysis of the root cause is completed, and ensure identified interventions are in place to prevent falls. The DON or designee should ensure the results of those audits are taken to QAPI to determine compliance or the need for ongoing monitoring. TIMEFRAME FOR CORRECTION: Twenty-One (21) days.	20830		
20900	Rehab - Pressure Ulcers CFR(s): MN Rule 4658.0525 Subp. 3 Subp. 3. Pressure sores. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: A. a resident who enters the nursing home without pressure sores does not develop pressure sores unless	20900	Corrected	12/25/2025

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20900	Continued from page 36 the individual's clinical condition demonstrates, and a physician authenticates, that they were unavoidable; and B. a resident who has pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review the facility failed to comprehensively assess and monitor a pressure wound, failed to timely notify the physician of new ulcer development, and failed to provide physician ordered treatments for 1 of 1 resident (R6) reviewed for skin integrity. Findings include: F686 R6's face sheet dated 11/19/25, identified diagnoses of hemiplegia (paralysis) affecting left side, diabetes mellitus (body does not make enough insulin), and heart failure (a condition where the heart does not pump enough blood to the body). R6's skin integrity focus care plan last revised on 4/29/25, identified R6 had a potential impairment to skin integrity related to bowel and bladder incontinence and impaired mobility. Goal to maintain or develop clean and intact skin. Interventions were as followed: may apply barrier cream after each incontinent episode; elevate heels off the bed; keep skin clean and dry, use lotion on dry skin, prefers to not be checked every two hours; pressure relieving/reducing cushion in wheelchair; standard pressure relieving/reducing mattress to protect skin while in bed. R6's physician orders identified the following: -Calmoseptine external ointment apply to bilateral buttocks topically three times per day as skin protectant. Start date 9/3/25. R6's Braden Scale for Predicting Pressure Sore Risk dated 10/21/25, identified R6 was at risk for pressure ulcers due to having slightly limited sensory perception, skin being very moist, chairfast, and being very limited with mobility.	20900		

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20900	Continued from page 37 R6's Annual Minimum Data Set (MDS) dated 10/23/25, identified R6 was dependent for bed mobility/transfers, at risk for developing pressure ulcers, had no pressure ulcers, and was cognitively intact. R6's weekly skin audit dated 10/16/25, identified "scattered open area to buttocks." The audit did not include any other information about the wound. In review of R6's record between 10/16/25 to 10/20/25 there was no indication the wound was comprehensively assessed to include but not limited, location on the buttocks, measurements, pain, wound periphery, presence of drainage and/or odor. Further the record did not indicate would care treatments had been provided nor evident the physician was notified. R6's physician communication form dated 10/21/25, identified R6 had a two-centimeter (cm) x 2.4 cm scabbed area on left buttocks and requested an order for dressing as needed. R6's record did not indicate the type of wound and/or cause of wound. R6's progress note dated 10/21/25, identified received order communication from nurse practitioner to apply Mepilex to scabbed area on buttocks, change every 72 hours and as needed (PRN). R6's physician orders identified the following: -Mepilex as needed (PRN) to scabbed area on buttocks, change every 72 hours and PRN (start date 10/21/25). The October and November treatment administration record identified the order was transcribed to direct staff to change the dressing PRN and not that it was a scheduled every 72-hour change in addition to PRN. R6's weekly skin audit dated 10/23/25, identified open area to buttocks with progressive healing and superficial in appearance. R6's wound management focus care plan initiated eight days after wound identification on 10/24/25, did not specify what type of wound R6 had nor the location. The goal identified was wound will be free of signs of symptoms of infection. Interventions were as followed: provider wound care per treatment order; Mepilex (a type of foam dressing designed to cover and protect wounds while promoting healing) to open area on left buttocks and monitor for signs and symptoms of	20900		

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20900	Continued from page 38 infection. R6's Weekly bath audit dated 10/30/25, 11/6/25, and 11/13/25, identified no skin issue present. R6's electronic health record medication administration record (MAR) for 10/21/25 through 11/18/25 indicated R6's wound on her buttocks had not had the physician ordered treatment applied. During an interview on 11/18/25 at 10:05 a.m., R6 stated she had a sore on the left side of her bottom that had "been there for a while" and hurts her at times. R6 stated said the aides are "putting some cream on my bottom" and she thinks it is getting better. During an observation and interview on 11/18/25 at 10:21 a.m., nursing assistant (NA)-F was assisting R6 with peri-cares and observed an open area on R6's left buttocks at a bony prominence approximately 1 cm x 1 cm. R6's wound had a pinkish/reddish center, no maceration. (softening of skin due to prolonged exposure to moisture), no drainage, and intact edges. NA-F stated R6's wound on her left buttocks had been there for a while, however, was unsure of the exact date. Licensed practical nurse (LPN)-B then entered R6's room and measured R6's left buttocks wound at 0.4 cm x 0.8 cm and stated this wound appeared to her to be a pressure ulcer since it is at a bony prominence. LPN-B stated she knew R6 had an order for Mepilex dressing, but was unsure how long it had been applied to R6's wound. LPN-B further stated she was unaware who is responsible for the weekly comprehensive assessment of pressure ulcers to stage them and make sure they are healing properly. LPN-B stated R6 had a cushion in her wheelchair and an air mattress on her bed, but unable to articulate any additional pressure ulcer prevention measure for R6. R6's progress note dated 11/18/25, identified R6 had 0.4-centimeter (cm) x 0.8 cm stage 2 pressure ulcer on left buttocks. Received order for Mepilex dressing to area twice daily. During an interview on 11/18/25 at 10:57 a.m., director of nursing (DON) stated R6 had an order for Mepilex dressing to an open area on her left bottom identified on 10/21/25, however, was unaware that R6 had not had a dressing placed on the open area, nor that there was an open area on R6's left buttocks that had been there for a while. DON started she is responsible to track and perform the comprehensive assessments of the pressure ulcers in the facility, however, had not "kept up with it." R6 had not had a comprehensive assessment of the	20900		

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20900	Continued from page 39 wound on her left buttocks on 10/21/25 to determine what type of wound it was or had a weekly comprehensive assessment to determine if the wound had been healing. A follow up interview at 3:00 p.m., DON stated she assessed R6's left buttocks wound and would consider it a stage 2 pressure ulcer. Review of the facility's Pressure Ulcer/Skin Breakdown-Clinical Protocol undated, identified the following: 1. The nursing staff and practitioner will assess and document an individual's significant risk factors for developing pressure ulcers; for example, immobility, recent weight loss, and a history of pressure ulcer(s). 2. In addition, the nurse shall describe and document/report the following: a. Full assessment of pressure sore including location, stage, length, width and depth, presence of exudates or necrotic tissue. b. Pain assessment. c. Resident's mobility status. d. Current treatments, including support surfaces; and e. All active diagnoses. 3. The staff and practitioner will examine the skin of newly admitted residents for evidence of existing pressure ulcers or other skin conditions. 4. The physician will assist the staff to identify the type (for example, arterial or stasis ulcer) and characteristics (presence of necrotic tissue, status of wound bed, etc.) of an ulcer. 5. The physician will help identify and define any complications related to pressure ulcers. Review of the facility's Skin Care Policy and Procedure undated, identified that the skin care and wound management needs of all residents are assessed and managed effectively to enhance the quality of life for all residents residing at this facility. The skin care and wound management needs and preferences of the residents will be assessed and management effectively. 1. The initial skin assessment is completed within 8	20900		

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20900	Continued from page 40 hours of admission. Any identified skin care issues are documented in the resident admission assessment. 2. A Braden Assessment will be completed to identify risk for skin breakdown category, 3. Residents with identified skin conditions or problems are referred to the appropriate health professional i.e., NP, Wound Consultant or MD. 4. Resident care plan will detail specific skin care management instructions that include but not limited to: · Skin care regimens (use of barrier/emollient creams); · Repositioning frequency · Aids (including pressure reducing mattresses, alternating surface mattress, wedges, cushions, and other equipment as required. · Moisture reduction · Relevant lifting/transferring procedures. 5. Resident skin will be assessed weekly and/or as resident allows. 6. Skin treatments will be performed per MD order. 7. New or ineffectively managed skin problems will be referred to the appropriate health professional. 8. Staff receive education on skin care and wound management upon hire and as needed in response to identified knowledge deficits or incidents SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, should review all residents at risk for pressure ulcers to assure they are receiving the necessary treatment/services to prevent pressure ulcers from developing and to promote healing of pressure ulcers. The director of nursing or designee should conduct measurable audits for a specific amount of time of the delivery of care to residents affected and those who have the potential to be affected to ensure appropriate care and services are implemented and reduce the risk for pressure ulcer development. The DON or designee should bring all audit information to the Quality Assurance Performance Improvement (QAPI) committee to determine compliance or the need for further monitoring.	20900		

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20900	Continued from page 41 TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	20900		
21535	Unnecessary Drug Usage; General CFR(s): MN Rule4658.1315 Subp.1 ABCD Subpart 1. General. A resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used: A. in excessive dose, including duplicate drug therapy; B. for excessive duration; C. without adequate indications for its use; or D. in the presence of adverse consequences which indicate the dose should be reduced or discontinued. In addition to the drug regimen review required in part 4658.1310, the nursing home must comply with provisions in the Interpretive Guidelines for Code of Federal Regulations, title 42, section 483.25 (1) found in Appendix P of the State Operations Manual, Guidance to Surveyors for Long-Term Care Facilities, published by the Department of Health and Human Services, Health Care Financing Administration, April 1992. This standard is incorporated by reference. It is available through the Minitex interlibrary loan system and the State Law Library. It is not subject to frequent change. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review the facility failed ensure residents were free from chemical restraints by not identifying duplicative antipsychotic therapy without appropriate indications, failed to identify target behaviors, failed to develop individualized non-pharmacological interventions, and failed to attempt and/or offer non-pharmacological interventions prior to the administration of as needed (PRN) doses of antipsychotic medications for 1 of 1 resident (R2) who had verbal and physical behaviors towards staff reviewed for falls. Findings include: F605 Antipsychotic medications are a class of drugs used to	21535	Corrected	12/25/2025

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21535	Continued from page 42 treat psychosis—conditions where a person has difficulty distinguishing reality, often involving delusions, hallucinations, paranoia, or disorganized thinking According to the Food and Drug Administration (FDA) the package insert for Seroquel (quetiapine) carries boxed warnings for increased mortality in elderly patients with dementia-related psychosis and suicidal thoughts/behaviors in children, adolescents, and young adults. Seroquel (quetiapine) has a rapid onset for sedation (within hours), but its therapeutic effects on mood, psychosis, or depression typically take days to weeks to become noticeable, with full benefit often requiring several weeks. Its half-life is about 6–7 hours (immediate-release and extended-release), meaning it takes roughly 30–35 hours for full elimination from the body. According to the FDA Haldol (Haloperidol Lactate) the package insert for Haldol has a boxed warning for increased mortality in elderly patients with dementia-related psychosis. Its half-life is about 14–37 hours orally. The onset of action varies: oral onset is 2–6 hours. Falls risk in elderly due to sedation and blood pressure changes. R2's face sheet dated 11/14/25, identified R2 had diagnoses of Alzheimer's disease (a progressive brain disorder that slowly destroys memory and thinking skills) and vascular dementia severe with anxiety (an advanced stage of cognitive decline caused by blood vessel damage in the brain). R2's Annual Minimum Data Set (MDS) dated 11/6/25, indicated R2 had severe cognitive impairment and required supervision/touching assistance for transfers. During the assessment period R2 had physical behavior symptoms towards others 1-3 days, verbal behavior symptoms directed towards others 4-6 days, other behavioral symptoms not directed towards others (e.g., physical symptoms such as hitting or scratching self, pacing, rummaging, sexual acts, disrobing in public, or verbal symptoms like screaming, disruptive sounds) occurred 4-6 days , and was taking an anti-psychotic (a class of psychiatric medications used to manage symptoms of psychosis, such as hallucinations, delusions, and paranoia). R2's psychotropic medication management focus care plan dated 2/3/25, identified goal will be free from medication side effects. Interventions were as followed:	21535		

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21535	Continued from page 43 -Consult pharmacist to review medications-target behaviors: hallucinations, delusions, agitation, excessive worrying, pacing (anti-psychotic), insomnia, sad/depressed mood, sexual behaviors (anti-depressant). -Non-pharmacological interventions that were identified were not individualized and/or person centered. Interventions included reassure and redirect resident, engage resident in a meaningful activity, conversation, or television show of his interest, offer snack, offer restroom, one to one. R2's behavior focus care plan dated 3/18/25, identified R2 had vascular dementia with severe anxiety. Goal to have fewer episodes of socially inappropriate behaviors weekly. Interventions were as followed: -observe behavior episodes and attempt to determine underlying cause, consider location, time of day, persons involved, and situations. -provide a program of activities that is of interest and accommodates resident status or call family to come for a visit if available and other interventions fail. R2's geriatric psychiatry follow-up note dated 10/16/25, indicated the facility requested an earlier appointment for increasing behaviors. Facility and family could not identify any stressors or environmental changes that could impact R2's behaviors. Reviewed dementia and its inevitable progression to moderate to severe dementia, which may require escalation of medication to manage symptoms. Suggested initiating discussions with palliative care if R2 required medication increase. R2's record was reviewed from 6/24/25 through 11/13/25 and identified R2 had a been first prescribed scheduled Seroquel on 6/24/25; a PRN (as needed) dose was added on 7/19/25. Further review from 10/30/25 through 11/13/25 revealed R2 continued on scheduled Seroquel in addition to PRN doses available and then Haldol (Haloperidol Lactate) was prescribed for PRN doses (in addition to Seroquel) when R2 was admitted to hospice which was duplicative antipsychotic therapy. During review of the R2's medication administration records (MAR), in conjunction with progress notes, and Behavior Monitoring and Intervention Reports (BMIR) there was no indication target behaviors were identified for the determination of which medication (Seroquel versus Haldol) should be used, nor evident non-pharmacological interventions were developed, offered or attempted prior to the administration of an as needed antipsychotic medication. Of mention R2's record also	21535		

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21535	Continued from page 44 identified R2 had 5 falls (11/4/25, 11/7/25, 11/9/25, 11/10/25, and 11/11/25) when both medications were used on the same days. The records from 10/30/25 through 11/13/25 identified the following: R2's progress note dated 10/30/25, identified nurse practitioner attempted to remove staples to back of head, however, R2 was "not having it." R2's nurse practitioner progress noted dated 10/30/25, identified R2 was seen for an acute visit for staple removal to the back of the head from a recent fall. Only able to remove one staple today and recommend contact psychiatrist today to request consideration of a PRN medication to help with aggravation and restlessness today. R2's progress note dated 11/1/25, identified R2 was admitted to hospice services on 10/31/25 and received an order for Haldol 2 mg/ml-administer 2.5 mg prior to staple removal and then ok to use every 4 hours PRN if other medications are not managing agitation. Change PRN Seroquel to 25 mg three times per day for unmanaged agitation. During an interview on 11/13/25 at 10:23 a.m., consulting pharmacist (C-Pharm) stated having a Haloperidol and Seroquel order would be considered duplicate therapy since they both are in the same drug class (anti-psychotics). This had the potential to cause increase in falls, drowsiness, orthostatic hypotension, and dizziness. C-Pharm was not aware R2 had received this duplicate drug and if she had known she would have asked for the Haloperidol to be discontinued. R2's BMIR on 11/1/25 included behaviors of agitation, restlessness, insomnia, experiencing something not there and refusing cares at 6:21 a.m. and 7:59 p.m., however, was given a PRN Seroquel at 10:32 p.m. which was 2 hours and 33 minutes after the documented behavior. R2's progress note dated 11/2/25 at 10:43 a.m., identified R2 was in a good mood and had staples removed from back of head. R2's BMIR on 11/2/25 did not identify R2 demonstrated any behaviors, however, R2's MAR identified Haldol was given 2:00 p.m. R2's BMIR on 11/3/25 did not identify R2 demonstrated any behaviors, however, R2's MAR identified Seroquel was given 12:01a.m. R2's progress note dated 11/5/25 at 3:18 p.m.,	21535		

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21535	Continued from page 45 identified a new order from hospice to start Haloperidol (Haldol) 2 mg/ml: 0.5 ml every 4 hours if needed for agitation or hallucinations. R2's MAR identified Haldol was given at 9:31 a.m., 1:37 p.m. and 8:37 p.m. R2's progress note dated 11/5/25 at 9:36 p.m., identified R2 was in and out of resident rooms. Is redirected and becomes aggressive towards staff. R2 grabbed this nurse arm and proceeded to shove nurse, even with Haldol on board and remains resistive with cares. R2 BMIR on 12/5/25 included behaviors of grabbing others, pushing others, cursing at others, express frustration with others, screaming at others, agitated, anxious/restless, neglecting self-care, and refusing care at 10:07 p.m. R2's MAR then identified R2 was administered Seroquel at 11:27 p.m. R2's MAR on 11/6/25 identified Haldol was given at 3:28 a.m.,11:03 a.m. and 2:34 p.m., however, R2's BMIR did not identify a behavior of being agitated, anxious/restless, experiencing something not there, refusing care until 10:23 p.m. Progress note dated 11/6/25 at 10:51 p.m., identified R2 became very loud throughout the shift, especially when staff try to assist R2. R2 was given a PRN Seroquel. R2's BMIR on 11/7/25 did not identify R2 demonstrated any behaviors, however, R2's MAR identified Haldol was given at 12:16 p.m. and Seroquel was given 3:54 p.m. R2's BMIR on 11/9/25 included behaviors of cursing and screaming, neglecting self-care and agitation observed at 3:30 a.m. R2's MAR on 11/9/25 identified Haldol was administered at 10:04 a.m., approximately 5 ½ hours after the behaviors at 3:30 a.m. R2's BMIR also included behaviors of cursing and screaming, neglecting self-care and agitation observed at 1:59 p.m., and 9:44 p.m., however, PRN Seroquel was administered at 10:26 p.m., which was approximately 45 minutes after the last the behavior. R2's BMIR on 11/10/25 did not identify R2 demonstrated any behaviors, however, R2 was administered Haldol at 1:25 a.m.,10:07 a.m., and 11:42 p.m. and Seroquel was given at 4:50 a.m. During an interview on 11/18/25 at 11:22 a.m., registered nurse (RN)-B stated she administered R2 a PRN dose of Haldol on 11/10/25 at 11:42 p.m. R2 had been attempting to self-transfer while seated in his wheelchair. RN-B stated she instructed staff to attempt to take R2 to the bathroom. R2 used the toilet, however, R2 refused to stand up from the toilet and	21535		

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21535	Continued from page 46 began striking out at staff. RN-B stated staff then attempted to use a stand-aid (a medical device that helps individuals with limited mobility to stand up and move positions) to get R2 to agree to get off the toilet, but R2 began hitting, pinching, and yelling at staff. RN-B stated she then gave R2 a dose of Haldol to “get him to settle down and “get him to cooperate” as he was hitting the staff and not agreeing to get off the toilet. RN-B stated she had not tried any other non-pharmacological interventions or assessed if R2 was in pain and offered pain medication first instead of trying an antipsychotic first. During a interview on 11/14/25 at 10:44 a.m., C-Pharm stated Haldol could be used as a chemical restraint if used in the “wrong way”. Haldol can cause side effects such as lethargy and sedation in which could cause a resident to have an increase in falls. R2’s PRN antipsychotic administrations records were reviewed with C-Pharm. C-Pharm stated prior to any PRN psychotropic being administered, a non-pharmacological interventions would have to be attempted and this would need to be documented in the resident’s medical record. Administering a medication to have a resident to “cooperate” would be considered use of a chemical restraint and should not been used in that way. R2’s BMIR on 11/11/25 did not identify R2 demonstrated any behaviors, however, R2’s MAR identified Haldol was given at 11:05 a.m. and Seroquel was given 11:33 p.m. R2’s progress notes dated 11/11/25 at 2:06 p.m., identified R2 was up and restless and was given as needed and scheduled medication to help with restlessness. During an interview on 11/12/25 at 2:11p.m., hospice registered nurse (HRN)-G stated when she performed a routine visit for R2 on 11/12/25, she discovered that R2 had both Haldol and Seroquel PRN orders. HRN-G further stated that this was a “red flag” because of the duplicate drugs, and she had contacted the physician to see if the Haldol PRN could be discontinued. HRN-G stated Haldol PRN is normally part of the hospice standing orders and was unsure what was the rationale it was added in addition to the Seroquel PRN. R2’s hospice progress note dated 11/12/25 at 3:12p.m., identified R2 had four falls since last week and staff had been using PRN Haldol and PRN Seroquel in addition to the scheduled Seroquel and was there a reason a reason both anti-psychotics prescribed. Both medications indicated use for anxiety, agitation (Haldol also notes delirium and Seroquel indicates	21535		

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21535	Continued from page 47 hallucinations). R2's hospice progress noted dated 11/13/25 at 8:45 a.m., indicated the Haldol order was to be given prior to suture removal and nursing staff stated when R2 received the Haldol, R2 responded very well and took the remainder of his medications that R2 had previously been refusing. Physician ordered to remove Haldol off R2's medication list. During a interview on 11/14/25 at 10:44 a.m., C-Pharm stated Haldol could be used as a chemical restraint if used in the "wrong way". Haldol can cause side effects such as lethargy and sedation in which could cause a resident to have an increase in falls. R2's PRN antipsychotic administrations records were reviewed with C-Pharm. C-Pharm stated prior to any PRN psychotropic being administered, a non-pharmacological interventions would have to be attempted and this would need to be documented in the resident's medical record. Administering a medication to have a resident to "cooperate" would be considered use of a chemical restraint and should not been used in that way. During an interview on 11/12/25 at 12:34 p.m., nursing assistant (NA)-F stated when R2 got agitated with NA's, "we would just get the nurse to give him some Haldol to mellow him out, so he does not yell so much." During an interview on 11/19/25 at 3:32 pm., RN-G stated a residents have the right to be treated with dignity and respect, including to be free from chemical restraints. H-RN stated if her family member had been administered a PRN anti-psychotic like Haldol to get her "to cooperate or "settle her down" without trying some sort of non-pharmacological intervention prior she would be "appalled" that that happened her family member. During an interview on 11/12/25 at 10:16 a.m., licensed practical nurse (LPN)-A stated Haloperidol was ordered for R2 as a "pain medication" and Seroquel was ordered as an "anti-anxiety" medication. If R2 is having pain, we can give him the Haloperidol. LPN-A then obtained a drug reference book and identified that Haloperidol and Seroquel were both an anti-psychotic medication and that would be considered a duplicate therapy. LPN-A stated if she noted a duplicate therapy in a resident's chart, she would not contact the provider, because this would be up to the discretion of the physician to make that determination if they needed it. LPN-A did not identify a concern that R2 had this duplicate therapy of Haloperidol and Seroquel. LPN-A was unable to articulate what the possible side effects of these	21535		

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21535	Continued from page 48 medications were and had to reference the drug reference book to identify drowsiness, dizziness, and increase in falls as some of the listed side effects. LPN-A stated that she was unaware if a non-pharmacological intervention needed to be tried before administering an as needed antipsychotic. R2's as needed Seroquel and Haloperidol was ordered for agitation, so if R2 was agitated we would administer this to him to "settle down". During an interview on 11/12/25 at 11:47 a.m., interim assistant director of nursing (I-ADON) stated R2 had an order for Haldol and Seroquel PRN to be given for agitation, he was unaware of the drug class (a group of medications that share similar chemical structures and act through the same mechanism) that Haldol and Seroquel were in, nor the side effects of either of the medications. I-ADON then proceeded to "Google" Haldol and Seroquel and then stated they were both considered anti-psychotic medications and that the Haldol and Seroquel had been ordered by the hospice agency and he would not have gotten clarification to see if hospice wanted a duplicate therapy, because "the doctor must have wanted it for R2." I-ADON was not aware if a non- pharmacological intervention needed to be attempted prior to administering a PRN antipsychotic or where that would be documented. I-ADON stated both Seroquel and Haloperidol could cause sedation, lethargy (a state of unusual drowsiness), and dizziness when administered and if it was used in the incorrect way it could be considered a chemical restraint. During an interview on 11/19/25 at 3:18 p.m., medical director (MD) stated R2's Haloperidol was only initially ordered as a one-time dose to give prior to the provider removing the sutures on the back of the head. The as needed every 4-hour dose was only supposed to be given as a last resort if no other medication were effective and was unaware that R2 had received multiple doses of this medication and had now discontinued the as needed Haloperidol to "clean up" his record. During an interview on 11/12/25 at 5:11 p.m., director of nursing (DON) stated R2 had been followed by psychiatry and had an order for Seroquel scheduled and PRN for agitation and hallucinations, however R2 was admitted to hospice on 10/31/25 when a PRN order for Haldol was also added to R2's orders. DON stated Haldol and Seroquel PRN would be a duplication of therapy since both medications are in the same drug class and should have not had both orders at the same time. DON stated the facility should have called and got clarification from the physician that ordered the PRN	21535		

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21535	Continued from page 49 Haldol to see if this was supposed to be in R2's orders. DON further stated staff are supposed to document and attempt a non-pharmacological intervention prior to administering any PRN psychotropic medications. DON reviewed R2's progress notes from 11/1/25 to 11/12/25 and did not identify any documentation of a non-pharmacological intervention prior to administration of the PRN Haldol or Seroquel. During an interview on 11/18/25 at 2:45 p.m., administrator stated all PRN psychotropics should have a documented non-pharmacological intervention prior to the medication to being administered and should never be given out of convenience. Review of the facility's Anti-psychotic Medication Use policy undated, identified residents will not receive medications that are not clinically indicated to treat a specific condition. Policy Interpretation and Implementation were as follow: 1. A psychotropic medication is any mediation that affects brain activity associated with mental processes and behavior. 2. Drugs in the following categories are considered psychotropic medications and are subject to prescribing, monitoring, and review requirements specific to psychotropic medications: a. Anti-psychotics. b. Anti-depressants. c. Anti-anxiety medications; and d. Hypnotics. 3. Residents, families, and/or the representative are involved in the medication management process. Psychotropic medication management includes: a. indications for use. b. dose (including duplicate therapy); c. duration. d. adequate monitoring for efficacy and adverse consequences; and e. preventing, identifying, and responding to adverse consequences.	21535		

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21535	Continued from page 50 4. Residents who have not used psychotropic medications are not prescribed or given these medications unless the medication is determined to be necessary to treat a specific condition that is diagnosed and documented in the medical record. 5. Use of psychotropic medications (other than antipsychotics) are not increased when efforts to decrease antipsychotic medications are being implemented. 6. Medications not classified as anti-psychotic, anti-depressant, anti-anxiety, and hypnotic medication are not prescribed or administered as a substitution for another psychotropic medication unless there is a documented clinical indication consistent with clinical standard of practice. 7. Categories of medications which affect brain activity such as antihistamines, anti-cholinergic medications, and central nervous system medications that are prescribed as a substitute for or an adjunct to a psychotropic medication are monitored and managed as psychotropic medications. 8. Consideration of the use of any psychotropic medication is based on comprehensive review of the resident. This includes evaluation of the resident's signs and symptoms in order to identify underlying causes. 9. Use of psychotropic medications may be considered appropriate in specific circumstances. These include: a. acute or emergency situations. b. enduring conditions; and/or c. new admissions where the resident is already on a psychotropic medication. 10. Non-pharmacological approaches are used (unless contraindicated) to minimize the need for medications, permit the lowest possible dose, and allow for discontinuation of medications when possible. 11. Residents on psychotropic medications receive gradual dose reductions (coupled with non-pharmacological interventions), unless clinically contraindicated, in an effort to discontinue these medications. 12. Psychotropic medications are not prescribed or	21535		

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21535	Continued from page 51 given on a PRN basis unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record. a. PRN orders for psychotropic medications are limited to 14 days. (1) For psychotropic medications that are NOT antipsychotics: If the prescriber or attending physician believes it is appropriate to extend the PRN order beyond 14 days, he or she will document the rationale for extending the use and include the duration for the PRN order. (2) For psychotropic medications that ARE antipsychotics: PRN orders cannot be renewed unless the attending physician or prescriber evaluates the resident and documents the appropriateness of the medication. 13. If psychotropic medications are identified as possibly causing or contributing to adverse consequences, the prescriber will determine whether the medication(s) should be continued and document the rationale for this decision. Review of the facility's Anti-Psychotic Medication Use Policy undated, identified antipsychotic medications may be considered for residents with dementia but only after medical, physical, functional, psychological, emotional psychiatric, social and environmental causes of behavioral symptoms have been identified and addressed. Antipsychotic medications will be prescribed at the lowest possible dosage for the shortest period and are subject to gradual dose reduction and re-review. Antipsychotic medications will not be used if the only symptoms are one or more of the following: a. Wandering. b. Poor self-care. c. Restlessness. d. Impaired memory. e. Mild anxiety. f. Insomnia. g. Inattention or indifference to surroundings.	21535		

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21535	Continued from page 52 h. Sadness or crying alone that is not related to depression or other psychiatric disorders. i. Fidgeting. j. Nervousness; or k. Uncooperativeness. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee and the consulting pharmacist should develop and/or revise policies to monitor medications for adequate indications for use to treat a specific condition(s) as diagnosed/use of non-pharmacological interventions attempted/documented prior to administration are documented in the clinical record to ensure each resident's entire drug medication regimen is managed and monitored to promote or maintain the resident's highest practicable mental, physical, and psychosocial well-being and be consistent with manufacturer's recommendations and/or clinical practice guidelines, clinical standards of practice, medication references, clinical studies or evidence-based review articles that are published in medical and/or pharmacy journals. The director of nursing (DON) or designee and the consulting pharmacist should educate physicians and staff on the importance of ensuring medication ordered is appropriate for each resident's use. Audits should be developed to monitor medications for adequate indications for use and appropriate timeframes for a specific and measurable amount of time. The DON and/or designee should take those findings/education to the Quality Assurance Performance Improvement (QAPI) committee to determine compliance or the need for further monitoring. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21535		