Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Submitted

May 19, 2026

Administrator
The Waterview Shores LLC
402 - 13TH AVENUE
TWO HARBORS, MN 55616

RE: CCN: 048540300
Cycle Start Date: May 4, 2026

Dear Administrator:

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

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 May 1, 2026, the situation of immediate jeopardy to potential health and safety cited at F760 - Residents are Free of Significant Med Errors 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 June 3, 2026.

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 June 3, 2026, (42 CFR 488.417 (b)). They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective June 3, 2026, (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.

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, The Waterview Shores LLC}is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective May 4, 2026. 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 Operations Supervisor RR
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 byNovember 4, 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,

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697

Email: sarah.lane@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

May 19, 2026

Administrator
The Waterview Shores LLC
402 - 13TH AVENUE
TWO HARBORS, MN 55616

Re: State Nursing Home Licensing Orders
Event ID: 23017E-H1

Dear Administrator:

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

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

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

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

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

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

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

Lisa Krebs, Regional Operations Supervisor RR
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,

Sarah Lane

Sarah Lane, Compliance Analyst

Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697

Email: sarah.lane@state.mn.us

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June 12, 2026

Administrator
The Waterview Shores LLC
402 - 13TH AVENUE
TWO HARBORS, MN 55616

RE: CCN: 245471
Cycle Start Date: May 4, 2026

Dear Administrator:

On May 19, 2026, we notified you a remedy was imposed. On May 28, 2026, the Minnesota Departments of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of May 1, 2026.

As authorized by CMS the remedy of:

• Discretionary denial of payment for new Medicare and Medicaid admissions effective June 3, 2026 did not go into effect. (42 CFR 488.417 (b))

In our letter of May 19, 2026, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from May 4, 2026. This does not apply to or affect any previously imposed NATCEP loss.

The CMS Location may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

Sarah Lane

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health

P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697

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June 12, 2026

Administrator
The Waterview Shores LLC
402 - 13TH AVENUE
TWO HARBORS, MN 55616

Re: Reinspection Results
Event ID: 23017E-H2

Dear Administrator:

On May 28, 2026 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on May 4, 2026. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697

Email: sarah.lane@state.mn.us

An equal opportunity employer.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245471	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/04/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Waterview Shores LLC	**402 - 13TH AVENUE , TWO HARBORS, Minnesota, 55616**

(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 4/29/26 through 5/1/26 and 5/4/26, 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 F760 began on 4/3/26, when R1's provider order was incorrectly transcribed into R1's electronic medical record (EMR). The administrator, and director of nursing (DON) were notified of the IJ on 4/30/2026 at 4:45 p.m. The IJ was removed on 5/1/26. The above findings constituted Substandard Quality of Care and an extended survey was conducted on 5/1/26 and 5/4/26. The following complaints were reviewed: H54711618C (2992542) and H54711782C (2668408) with deficiencies cited at F755 and F760. 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		05/19/2026

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245471	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/04/2026

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F0760 SS = SQC-J	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is NOT MET as evidenced by: Based on interview and record review, the facility failed to ensure that residents were free from a significant medication error for 1 of 3 residents (R1) reviewed for medication errors. The facility's failure to ensure accurate transcriptions and available medication resulted in Immediate Jeopardy for R1 who was administered 39 incorrect and insufficient doses of lactulose (a medication that reduces ammonia levels in the blood) resulting in new onset of seizures, severe hyperammonemia and hospitalization. The IJ began on 4/3/26 when R1 did not receive six doses of scheduled lactulose because the medication was not available. The facility failed to ensure the lactulose order was accurately transcribed into R1's medical record resulting in 39 insufficient doses which subsequently resulted in R1's hospitalization. The administrator and director of nursing (DON) were notified of the IJ on 4/30/2026 at 4:45 p.m. The immediacy was removed on 5/1/26 but noncompliance remained at the lower scope and severity level of D - isolated, no actual harm with potential for more than minimal harm that is not immediate jeopardy. Findings include: R1's diagnoses list dated 4/29/26 included traumatic subdural hemorrhage (blood collection on the brain), disorder of urea cycle metabolism (liver dysfunction which leads to build-up of ammonia in the blood), hepatic encephalopathy (decline in mental function caused by severe liver disease), unspecified convulsions (added 4/24/26), and alcoholic cirrhosis of liver with ascites. R1's admission Minimum Data Set (MDS) dated 4/9/26 indicated no cognitive impairment. R1's hospital discharge orders dated 4/3/26 instructed l2actulose oral solution 30 grams (g)/45milliliters (mL). Give 45mL four times daily for unspecified cirrhosis of the liver. Hold if greater than three stools per day.	F0760	F760 Residents are Free of Significant Med Errors Immediate Corrective Action: R1 was hospitalized from 4/14 to 4/24/26. R1 returned to the facility 4/24/26. R1's medications reviewed to ensure they were all available to be administered. Corrective Action as it applies to others: All Lactulose or liquid medications were reviewed to ensure orders were transcribed correctly. All current resident medications reviewed to ensure medications are available and administered per order. If unavailable, ensure procedure is followed to address. Date of Compliance: 5/1/26 Recurrence will be prevented by: All policies and procedures related to transcription of physician orders, medication administration, the rights of medication administration, reporting discrepancies and medication not available to administer were reviewed and remain current. DON provided education on transcription of physician orders, medication administration, including the rights of medication administration, reporting discrepancies and the process to address unavailable medications with all licensed nurses, TMAs and Health Information staff. Audits will be completed for all liquid medications, including Lactulose, to ensure appropriate follow up measures are in place weekly for four weeks, then monthly for 3 months. Audits will be completed on missed medications 5 times weekly for 4 weeks, then weekly for 3 months. Corrections will be monitored by:	05/01/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245471	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/04/2026

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F0760 SS = SQC-J	Continued from page 2 R1's transcribed electronic medical record (EMR) physician order for lactulose dated 4/3/26 was inconsistent with the hospital discharge order; instead of 30g/45ml the order directed to give R1 lactulose oral solution 10g/15mL; give 15mL four times daily for unspecified cirrhosis of the liver. Hold if greater than three stools per day. R1's medication administration record (MAR) for April 2026 identified R1 did not receive two doses of lactulose on 4/3/26 and four doses on 4/4/26 as indicated by a "9" which instructed see nurse note. R1 received 39 doses of 10g/15mL from 4/5/26 to 4/14/26. R1's nursing note dated 4/3/26 at 6:28 p.m., indicated lactulose was not on hand but would be delivered on the first or second run. R1's nursing note dated 4/14/26 at 11:42 p.m. indicated at approximately 9:50 p.m., R1 began experiencing seizure-like activity. R1 was ultimately sent to the hospital. R1's hospital discharge summary dated 4/24/26 indicated R1 had been admitted due to hepatic encephalopathy, severe hyperammonemia (dangerously elevated ammonia levels in the blood that can cause confusion, altered mental status, and seizures) and new onset seizures. R1's nursing home provider note dated 4/27/26 indicated R1 had been hospitalized from 4/15/26 through 4/24/26 for encephalopathy and new onset seizure. It was discovered R1 was not taking lactulose correctly. Severe hyperammonemia was treated and resolved at time of discharge from the hospital. During an interview on 4/30/26 at 11:52 a.m., registered nurse (RN)-A stated she entered R1's admission orders into the EMR on 4/3/26. The concentration of 30g per 45mL of lactulose was not a drop-down option to be entered into the EMR, so she reached out to the pharmacy. RN-A thought the pharmacist told her 10g per 15mL was an equivalent dose to 30g per 45mL. RN-A sent an email to director of nursing (DON) asking to clarify the order with the provider. During an interview on 4/29/26 at 12:40 p.m., trained medication assistant (TMA)-A stated she noticed R1's lactulose order in the MAR did not match the order on the bottle. TMA-A stated the order on the bottle was to administer 45mL while the physician order was administer 15mL. She asked the	F0760	Continued from page 2 DON or Designee	05/01/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245471	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/04/2026

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F0760 SS = SQC-J	Continued from page 3 nurse licensed practical nurse LPN-A; LPN-A directed TMA-A to administer the amount directed on the physician order which was 15 ml. During an interview on 4/30/26 at 10:24 a.m., LPN-A stated she noticed R1's lactulose order in the MAR did not match the order on the bottle. In that situation, LPN-A stated the information in the MAR was usually the correct order and administered 15mL of lactulose. If the MAR didn't match the medication container, the nurse was to call the pharmacy so a different label could be placed on the container, but sometimes an order would change and the medication supply on hand would be used without changing the label. LPN-A did not contact the pharmacy nor did she alert DON. During an interview on 4/30/26 at 1:27 p.m., the DON stated on 4/3/26, she received an email from RN-A requesting clarification of R1's lactulose order. A request for clarification was sent to R1's discharging provider, the same order was received, and no additional clarification was requested. DON was not aware the dosage amount on the medication bottle did not match what was in the MAR. Following R1's admission to the hospital on 4/14/26, R1's guardian requested information about R1's lactulose order. DON discovered R1 had been receiving 10g of lactulose four times a day instead of the ordered 30g of lactulose four times a day. DON contacted the pharmacy and R1's current provider to clarify the order. R1's lactulose order was changed in the MAR to reflect the correct order and staff who administered the incorrect dose received education on what to do if the MAR and medication container did not match. DON stated when staff discovered the order in the MAR and the order on the lactulose bottle did not match, the lactulose should not have been administered, and a nurse should have contacted the DON and/or the pharmacy for clarification of the correct dose. DON confirmed she had not been notified that the order in the MAR did not match the order on the lactulose bottle. During an interview on 4/29/26 at 1:49 p.m., pharmacist (Pharm D) stated lactulose was used for hepatic encephalopathy. Administering a lower dose than prescribed could lead to a build-up of ammonia in the body which could result in confusion, disorientation, and possibly seizures due to increased stress on the body. Pharm D confirmed R1's provider order printed on the bottle of lactulose sent to the facility on 4/3/26 was lactulose10g/15mL, Give 45mL by mouth four times daily. PharmD further stated administering 10 grams of lactulose instead of 30 grams over several days	F0760		05/01/2026

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F0760 SS = SQC-J	Continued from page 4 would be considered a significant medication error due to build up of ammonia in the body which could result in confusion, disorientation, and possibly seizures due to increased stress on the body. During an interview on 4/30/26 at 12:52 p.m., the medical director (MD) stated if there were any concerns about a provider order, the provider should be contacted right away for clarification. MD stated this was a significant medication error because administering a lower than prescribed dose of lactulose could lead to a build-up of ammonia and other toxins in the body which could lead to seizures and hospitalization. The Medication Administration policy last reviewed 4/24/26 instructed prior to medication administration right resident, right drug, right route and right time were to be applied for each medication being administered. Prior to administration of any medication, the medication and dosage schedule on the resident's MAR are compared with the medication label. If the label and MAR are different and the container has not already been flagged, indicating a change in directions or if there is any other reason to question the dosage or directions, the physician's orders are checked for the correct dosage schedule. If a medication with a current, active order cannot be located in the medication cart/drawer, other areas of the medication cart, medication room are searched. If the medication cannot be located after further investigation, the pharmacy is contacted or medication removed from the emergency kit. The IJ that began on 4/3/26 was removed on 5/1/26 when the following was verified by interview or document review: -Facility audited all lactulose and liquid medications for transcription accuracy. -All current resident medications reviewed to ensure medications are available and administered per order. -Policies and procedures related to transcription of physician orders, medication administration, reporting discrepancies, and medication not available to administer were reviewed. -All nurses, TMA's and health information were educated prior to the start of their shift on transcription of physician orders, medication administration including rights of medication administration, reporting discrepancies, and the	F0760		05/01/2026

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F0760 SS = SQC-J	Continued from page 5 process to address unavailable medications	F0760		05/01/2026
F0755 SS = D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(f). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is NOT MET as evidenced by: Based on interview and record review, the facility failed to obtain and ensure accurate administration of medications for 3 of 4 residents (R1, R3, R4) reviewed for medications. Findings include R1's diagnoses list dated 4/29/26 included traumatic subdural hemorrhage (blood collection on the brain), disorder of urea cycle metabolism (liver disfunction which leads to build-up of ammonia in the blood), hepatic encephalopathy (decline in mental	F0755	F755 Pharmacy Services/Procedures/Pharmacist/Records Immediate Corrective Action: R1's rifaximin and levothyroxine were available in the facility and given per order. R3's Advair disk was ordered from the pharmacy. R4's levothyroxine order was changed to 0700 administration time. Providers were notified of missed doses. Corrective Action as it applies to others: All policies and procedures related to transcription of physician orders, medication administration, the rights of medication administration, reporting discrepancies and medication not available to administer were reviewed and remain current. All current resident medications reviewed to ensure medications are available and administered per order. If unavailable, ensure procedure is followed to address. Audits will be completed on missed medications 5 times weekly for 4 weeks, then weekly for 3 months. Audits will be completed for 5 residents weekly for 4 weeks, then monthly x3 months to ensure that medications are available to administer. Date of Compliance: 5/1/26 Recurrence will be prevented by: All policies and procedures related to transcription	05/01/2026

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F0755 SS = D	Continued from page 6 function caused by severe liver disease), unspecified convulsions, alcoholic cirrhosis of liver with ascites and hypothyroidism (underactive thyroid). R1's admission Minimum Data Set (MDS) dated 4/9/26 indicated no cognitive impairment. R1's provider order dated 4/3/26 instructed rifaximin (medication used to reduce risk of hepatic encephalopathy) 550 milligrams (mg), give one tablet by mouth two times daily for hepatic encephalopathy. R1's medication administration record (MAR) for April 2026 identified R1 did not receive nine doses of rifaximin from 4/3/36 through 4/7/26 as indicated by a "9" which instructed see nurse note. R1's nursing notes from 4/3/26 through 4/7/26 indicated a medication "not available", "on order", "not available, arriving tonight", and "unavailable, on order" but the specific medication was not named. R1's nursing note dated 4/7/26 indicated pharmacy was contacted regarding resident's Rifaximin 550mg tablet that had not been delivered yet. Pharmacist stated the medication was on tonight's first delivery. R1's provider order dated 4/4/26 through 4/13/26 instructed Levothyroxine Sodium (synthetic thyroid hormone used to treat hypothyroidism) oral tablet 125 micrograms (mcg). Give one tablet by mouth in the morning related to hypothyroidism. Scheduled administration time was 6:00 a.m. R1's MAR for April 2026 identified R1 should have received 10 doses of Levothyroxine. R1 received Levothyroxine 125mcg on 4/4/26, 4/6/26, 4/7/26 and 4/8/26 as indicated by a checkmark with initials of the staff member administering the medication. The boxes were blank on 4/5/26, 4/9/26, 4/10/26, 4/11/26, 4/12/26, and 4/13/26. R1's medical record dated 4/4/26 through 4/13/26 did not identify if levothyroxine was administered on 4/5/26, 4/9/26, 4/10/26, 4/11/26, 4/12/26, or 4/13/26. R1's nursing note dated 4/13/26 at 1:25 p.m., indicated per medical doctor (MD), thyroid stimulating hormone poorly controlled. MD ordered Levothyroxine 125mcg to be discontinued and changed to 150mcg. R3's diagnoses list dated 5/1/26 included Parkinson's Disease, dyspnea (shortness of breath),	F0755	Continued from page 6 of physician orders, medication administration, the rights of medication administration, reporting discrepancies and medication not available to administer were reviewed and remain current. DON provided education on transcription of physician orders, medication administration, including the rights of medication administration, reporting discrepancies and the process to address unavailable medications with all licensed nurses, TMAs and Health Information staff. Audits will be completed on missed medications 5 times weekly for 4 weeks, then weekly for 3 months. Corrections will be monitored by: DON or Designee	05/01/2026

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F0755 SS = D	Continued from page 7 and chronic sinusitis. R3's annual MDS dated 2/4/26 indicated no cognitive impairment. R3's provider order dated 8/5/25 instructed Advair Diskus (medication used to prevent shortness of breath and wheezing) 100-50 mcg per dose. 1 inhalation every 12 hours related to chronic sinusitis. R3's care plan dated 2/11/26 included alteration in respiratory status related to shortness of breath with an intervention of administer medications as ordered and monitor for side effects R3's MAR for April 2026 identified R3 did not receive Advair on 4/23/26, 4/24/26, 4/25/26, 4/26/26 4/28/26 and 4/29/26 as indicated by a "9" which instructed see nurse note. R3's nursing note dated 4/23/26 at 7:00 a.m. indicated Advair Diskus was "not available." R3's nursing note dated 4/24/26 at 8:10 a.m. indicated Advair Diskus was "medication on order." R3's nursing note dated 4/27/26 at 7:09 a.m. indicated Advair Diskus was "not available." R3's nursing note dated 4/27/26 at 8:35 p.m. indicated Advair Diskus "will arrive on first run tomorrow per pharmacy." R3's nursing note dated 4/29/26 at 7:33 a.m. indicated Advair Diskus was "med on order." R3's care plan dated 2/11/26 included alteration in respiratory status related to shortness of breath with an intervention of administer medications as ordered and monitor for side effects During an interview on 4/29/2026 at 10:00 a.m., R3 stated he had not been receiving his inhaler recently. R4's diagnoses list dated 5/1/26 included type 2 diabetes mellitus, respiratory disorder, and hypothyroidism. R4's quarterly MDS dated 3/4/26 indicated moderately impaired cognition. R4's provider order dated 10/4/25 instructed Levothyroxine Sodium oral tablet 50mcg. Give one tablet by mouth in the morning related to hypothyroidism. Scheduled administration time was 6:00 a.m.	F0755		05/01/2026

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F0755 SS = D	Continued from page 8 R4's MAR for April 2026 identified R4 should have received 31 doses of Levothyroxine. R4 received 15 doses as indicated by a checkmark with initials of the staff member administering the medication. The boxes were blank on 4/1/26, 4/2/26, 4/3/26, 4/5/26, 4/9/26, 4/10/26, 4/11/26, 4/12/26, 4/13/26, 4/15/26, 4/16/26, 4/17/26, 4/23/26, 4/24/26, 4/25/26, 4/26/26, 4/27/26, 4/28/26, and 4/29/26. R4's medical record dated 4/1/26 through 4/29/26 did not identify if levothyroxine was administered on 4/1/26, 4/2/26, 4/3/26, 4/5/26, 4/9/26, 4/10/26, 4/11/26, 4/12/26, 4/13/26, 4/15/26, 4/16/26, 4/17/26, 4/23/26, 4/24/26, 4/25/26, 4/26/26, 4/27/26, 4/28/26, and 4/29/26. During an interview on 4/29/2026 at 12:40 p.m., trained medication assistant (TMA)-A stated when a medication was unavailable, she would first check to see if the medication had been reordered. If it had been ordered, TMA-A would let the nurse know so the pharmacy could be contacted. During an interview on 4/30/2026 at 10:24 a.m., licensed practical nurse (LPN)-A stated if a medication was unavailable for administration, she would check the emergency medication dispensing machine. If the medication was not available, LPN-A would call the pharmacy to see when it would be delivered. If the resident was going to miss a dose of medication, the provider should be notified. LPN-A stated a medication scheduled for 6:00 a.m. would alert for the night shift nurse. If the medication was not administered, the day shift nurse would not receive a notification. During an interview on 5/1/2026 at 8:11a.m., registered nurse (RN)-B stated the 6:00 a.m. medications pop up with the AM range medications which were yellow indicating the need to be administered. RN-B did not administer the 6:00 a.m. or the AM range medications unless the resident had specifically requested early medication administration. RN-B stated she was unaware R1 and R4's levothyroxine administrations only alerted on the night shift and did not flow to day shift. No one had alerted RN-B of the missing medication administrations. During an interview on 4/30/2026 at 1:27 p.m., director of nursing (DON) stated a blank box on the MAR indicated nothing was documented and the medication was not administered. DON was not aware R1's and R4's levothyroxine were not being administered. Not administering a medication was	F0755		05/01/2026

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F0755 SS = D	Continued from page 9 considered a medication error and DON should be notified right away. If a medication could not be located in the medication cart, the TMA should notify the nurse and together they would check the other medication cart and the medication rooms. If the medication cannot be located, the nurse should call the pharmacy to see when the medication will be delivered and check the medication dispensing machine to see if the correct medication and dose are available. If a dose will be missed, the resident's provider should be updated. During an interview on 4/30/2026 at 12:52 p.m., MD stated the facility should contact the provider when a resident misses a dose of medication. Persistently missed doses of Levothyroxine could lead to fatigue, heart rate changes, weight gain and dry skin. Suddenly receiving scheduled doses could lead to an "amped up" feeling with elevated heart rate, diarrhea, and a general warm feeling. Missed doses of Advair could lead to increased inflammation, and shortness of breath. The facility had not notified R1's or R4's provider about the missing doses of levothyroxine nor R3's provider for the Advair. During an interview on 5/1/2026 at 9:33 a.m., consultant pharmacist (CPh) stated consistency is important when administering levothyroxine. To achieve the full therapeutic effect, the medication must be administered at approximately the same time each day. A resident receiving levothyroxine would need periodic laboratory blood work. A provider reviewing the results would assume the resident had been receiving the medication as prescribed and may update the medication order based on the lab work which may result in the resident receiving more medication than was actually needed. Medication should always be offered to a resident unless there is a provider order stating otherwise. All resident refusals of medication or if a medication was held based on a provider order should be documented. The Medication Administration policy reviewed 4/24/26 instructed medications are administered as prescribed in accordance with food nursing principles and practices and only by persons legally authorized to do so. Five rights -right residents, right drug, right dose, right route and right time are applied for each medication administered. If a dose of regularly scheduled medication is withheld refused, not available, or given at a time other than the scheduled time, documentation of the unadministered dose is done as instructed by the procedures of use of the MAR system. If [XX consecutive doses] of a vital medication are	F0755		05/01/2026

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F0755 SS = D	Continued from page 10 withheld, refused, or not available the physician is notified. Nursing documents the notification and physician response.	F0755		05/01/2026

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20000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 4/29/26 through 5/1/26 and 5/4/26, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with MN State Licensure, and the following licensing orders were issued. Please indicate in your electronic plan of correction you have reviewed these orders and identify the date when they will be completed. The following complaints were reviewed: H54711618C (2992542) and H54711782C	20000		05/19/2026

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

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20000	Continued from page 1 (2668408) with a licensing orders issued at 21550. 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		05/19/2026
21550	Adminiatration of Medications; Pharmacy Serv. CFR(s): MN Rule 4658.1325 Subp. 1 Subpart 1. Pharmacy services. A nursing home must arrange for the provision of pharmacy services. This LICENSURE REQUIREMENT is NOT MET as evidenced by:	21550	Corrected	05/01/2026

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21550	Continued from page 2 Based on interview and record review, the facility failed to obtain medications and failed to ensure accurate administering of medications for 3 of 4 residents (R1, R3, R4) reviewed for medications. Findings include R1’s diagnoses list dated 4/29/26 included traumatic subdural hemorrhage (blood collection on the brain), disorder of urea cycle metabolism (liver disfunction which leads to build-up of ammonia in the blood), hepatic encephalopathy (decline in mental function caused by severe liver disease), unspecified convulsions, alcoholic cirrhosis of liver with ascites and hypothyroidism (underactive thyroid). R1’s admission Minimum Data Set (MDS) dated 4/9/26 indicated no cognitive impairment. R1’s provider order dated 4/3/26 instructed rifaximin (medication used to reduce risk of hepatic encephalopathy) 550 milligrams (mg), give one tablet by mouth two times daily for hepatic encephalopathy. R1’s medication administration record (MAR) for April 2026 identified R1 did not receive nine doses of rifaximin from 4/3/36 through 4/7/26 as indicated by a “9” which instructed see nurse note. R1’s nursing notes from 4/3/26 through 4/7/26 indicated a medication “not available”, “on order”, “not available, arriving tonight”, and “unavailable, on order” but the specific medication was not named. R1’s nursing note dated 4/7/26 indicated pharmacy was contacted regarding resident's Rifaximin 550mg tablet that had not been delivered yet. Pharmacist stated the medication was on tonight's first delivery. R1’s provider order dated 4/4/26 through 4/13/26 instructed Levothyroxine Sodium (synthetic thyroid hormone used to treat hypothyroidism) oral tablet 125 micrograms (mcg). Give one tablet by mouth in the morning related to hypothyroidism. Scheduled administration time was 6:00 a.m. R1’s MAR for April 2026 identified R1 should have received 10 doses of Levothyroxine. R1 received Levothyroxine 125mcg on 4/4/26, 4/6/26, 4/7/26 and 4/8/26 as indicated by a checkmark with initials of the staff member administering the medication. The boxes were blank on 4/5/26, 4/9/26, 4/10/26, 4/11/26, 4/12/26, and 4/13/26. R1’s medical record dated 4/4/26 through 4/13/26	21550		05/01/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **05/04/2026**

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21550	Continued from page 3 did not identify if levothyroxine was administered on 4/5/26, 4/9/26, 4/10/26, 4/11/26, 4/12/26, or 4/13/26. R1's nursing note dated 4/13/26 at 1:25 p.m., indicated per medical doctor (MD), thyroid stimulating hormone poorly controlled. MD ordered Levothyroxine 125mcg to be discontinued and changed to 150mcg. R3's diagnoses list dated 5/1/26 included Parkinson's Disease, dyspnea (shortness of breath), and chronic sinusitis. R3's annual MDS dated 2/4/26 indicated no cognitive impairment. R3's provider order dated 8/5/25 instructed Advair Diskus (medication used to prevent shortness of breath and wheezing) 100-50 mcg per dose. 1 inhalation every 12 hours related to chronic sinusitis. R3's care plan dated 2/11/26 included alteration in respiratory status related to shortness of breath with an intervention of administer medications as ordered and monitor for side effects R3's MAR for April 2026 identified R3 did not receive Advair on 4/23/26, 4/24/26, 4/25/26, 4/26/26 4/28/26 and 4/29/26 as indicated by a "9" which instructed see nurse note. R3's nursing note dated 4/23/26 at 7:00 a.m. indicated Advair Diskus was "not available." R3's nursing note dated 4/24/26 at 8:10 a.m. indicated Advair Diskus was "medication on order." R3's nursing note dated 4/27/26 at 7:09 a.m. indicated Advair Diskus was "not available." R3's nursing note dated 4/27/26 at 8:35 p.m. indicated Advair Diskus "will arrive on first run tomorrow per pharmacy." R3's nursing note dated 4/29/26 at 7:33 a.m. indicated Advair Diskus was "med on order." R3's care plan dated 2/11/26 included alteration in respiratory status related to shortness of breath with an intervention of administer medications as ordered and monitor for side effects During an interview on 4/29/2026 at 10:00 a.m., R3 stated he had not been receiving his inhaler recently.	21550		05/01/2026

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21550	Continued from page 4 R4's diagnoses list dated 5/1/26 included type 2 diabetes mellitus, respiratory disorder, and hypothyroidism. R4's quarterly MDS dated 3/4/26 indicated moderately impaired cognition. R4's provider order dated 10/4/25 instructed Levothyroxine Sodium oral tablet 50mcg. Give one tablet by mouth in the morning related to hypothyroidism. Scheduled administration time was 6:00 a.m. R4's MAR for April 2026 identified R4 should have received 31 doses of Levothyroxine. R4 received 15 doses as indicated by a checkmark with initials of the staff member administering the medication. The boxes were blank on 4/1/26, 4/2/26, 4/3/26, 4/5/26, 4/9/26, 4/10/26, 4/11/26, 4/12/26, 4/13/26, 4/15/26, 4/16/26, 4/17/26, 4/23/26, 4/24/26, 4/25/26, 4/26/26, 4/27/26, 4/28/26, and 4/29/26. R4's medical record dated 4/1/26 through 4/29/26 did not identify if levothyroxine was administered on 4/1/26, 4/2/26, 4/3/26, 4/5/26, 4/9/26, 4/10/26, 4/11/26, 4/12/26, 4/13/26, 4/15/26, 4/16/26, 4/17/26, 4/23/26, 4/24/26, 4/25/26, 4/26/26, 4/27/26, 4/28/26, and 4/29/26. During an interview on 4/29/2026 at 12:40 p.m., trained medication assistant (TMA)-A stated when a medication was unavailable, she would first check to see if the medication had been reordered. If it had been ordered, TMA-A would let the nurse know so the pharmacy could be contacted. During an interview on 4/30/2026 at 10:24 a.m., licensed practical nurse (LPN)-A stated if a medication was unavailable for administration, she would check the emergency medication dispensing machine. If the medication was not available, LPN-A would call the pharmacy to see when it would be delivered. If the resident was going to miss a dose of medication, the provider should be notified. LPN-A stated a medication scheduled for 6:00 a.m. would alert for the night shift nurse. If the medication was not administered, the day shift nurse would not receive a notification. During an interview on 5/1/2026 at 8:11a.m., registered nurse (RN)-B stated the 6:00 a.m. medications pop up with the AM range medications which were yellow indicating the need to be administered. RN-B did not administer the 6:00 a.m. or the AM range medications unless the resident had specifically requested early medication	21550		05/01/2026

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21550	Continued from page 5 administration. RN-B stated she was unaware R1 and R4's levothyroxine administrations only alerted on the night shift and did not flow to day shift. No one had alerted RN-B of the missing medication administrations. During an interview on 4/30/2026 at 1:27 p.m., director of nursing (DON) stated a blank box on the MAR indicated nothing was documented and the medication was not administered. DON was not aware R1's and R4's levothyroxine were not being administered. Not administering a medication was considered a medication error and DON should be notified right away. If a medication could not be located in the medication cart, the TMA should notify the nurse and together they would check the other medication cart and the medication rooms. If the medication cannot be located, the nurse should call the pharmacy to see when the medication will be delivered and check the medication dispensing machine to see if the correct medication and dose are available. If a dose will be missed, the resident's provider should be updated. During an interview on 4/30/2026 at 12:52 p.m., MD stated the facility should contact the provider when a resident misses a dose of medication. Persistently missed doses of Levothyroxine could lead to fatigue, heart rate changes, weight gain and dry skin. Suddenly receiving scheduled doses could lead to an "amped up" feeling with elevated heart rate, diarrhea, and a general warm feeling. Missed doses of Advair could lead to increased inflammation, and shortness of breath. The facility had not notified R1's or R4's provider about the missing doses of levothyroxine nor R3's provider for the Advair. During an interview on 5/1/2026 at 9:33 a.m., consultant pharmacist (CPh) stated consistency is important when administering levothyroxine. To achieve the full therapeutic effect, the medication must be administered at approximately the same time each day. A resident receiving levothyroxine would need periodic laboratory blood work. A provider reviewing the results would assume the resident had been receiving the medication as prescribed and may update the medication order based on the lab work which may result in the resident receiving more medication than was actually needed. Medication should always be offered to a resident unless there is a provider order stating otherwise. All resident refusals of medication or if a medication was held based on a provider order should be documented. The Medication Administration policy reviewed	21550		05/01/2026

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21550	Continued from page 6 4/24/26 instructed medications are administered as prescribed in accordance with food nursing principles and practices and only by persons legally authorized to do so. Five rights -right residents, right drug, right dose, right route and right time are applied for each medication administered. If a dose of regularly scheduled medication is withheld refused, not available, or given at a time other than the scheduled time, documentation of the unadministered dose is done as instructed by the procedures of use of the MAR system. If [XX consecutive doses] of a vital medication are withheld, refused, or not available the physician is notified. Nursing documents the notification and physician response. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review policies and procedures for medication administration to include processes related to how medication is ordered, process for medications not available, and accurate administration of medications. Staff could be educated on medication administration policies and procedures. The DON or designee could review all current resident medication orders to ensure accuracy and availability of medication and audit new medication orders per recommendation from the Quality Assurance Performance Improvement (QAPI) committee for a determined amount of time. Those results could be taken back to the QAPI committee to determine compliance or the need for further monitoring. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21550		05/01/2026