Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

September 15, 2025

Administrator
ST JOHNS ON FOUNTAIN LAKE
1771 EAGLE VIEW CIRCLE
ALBERT LEA, MN 56007

RE: CCN: 245635
Cycle Start Date: August 6, 2025

Dear Administrator:

On September 2, 2025, we notified you a remedy was imposed. On September 5, 2025, the Minnesota Departments of Health 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 09/03/2025.

As authorized by CMS the remedy of:

• Discretionary denial of payment for new Medicare and Medicaid admissions effective 09/17/2025 did not go into effect. (42 CFR 488.417 (b))

In our letter of September 2, 2025, 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 August 6, 2025. 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

Email: sarah.lane@state.mn.us

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September 15, 2025

Administrator
ST JOHNS ON FOUNTAIN LAKE
1771 EAGLE VIEW CIRCLE
ALBERT LEA, MN 56007

Re: Reinspection Results
Event ID: 1D29B7-H2

Dear Administrator:

On 09/05/2025 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 08/06/2025. At this time these correction orders were found corrected.

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
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Saint Paul, MN 55164-0900
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Electronically delivered
September 2, 2025

Administrator
1771 Eagle View Circle
Albert Lea, MN 56007

RE: CCN: 245635
Cycle Start Date: August 6, 2025

Dear Administrator:

On August 6, 2025, a survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted immediate jeopardy (Level J). The Statement of Deficiencies (CMS-2567) is being electronically delivered. Because corrective action was taken prior to the survey, past non-compliance does not require a plan of correction (POC).

This survey also found other deficiencies in your facility to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), whereby corrections are required.

REMOVAL OF IMMEDIATE JEOPARDY

On July 21, 2025, the situation of immediate jeopardy to potential health and safety cited at F0760 was removed.

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:

- Mandatory Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective November 6, 2025.

The CMS location will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective November 6, 2025. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective November 6, 2025.

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.

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

• Civil money penalty. (42 CFR 488.430 through 488.444)

SUBSTANDARD QUALITY OF CARE (SQC)

SQC was identified at your facility. Sections 1819(g)(5)(C) and § 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) requires 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 § 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, St John's on Fountain Lake is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective August 6, 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.

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 an "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

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.

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 - Health Regulation Division 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 February 6, 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

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.

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.

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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245635	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST JOHNS ON FOUNTAIN LAKE	1771 EAGLE VIEW CIRCLE , ALBERT LEA, Minnesota, 56007

(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 7/31/25, 8/1/25, 8/5/25, and 8/6/25, a standard abbreviated survey was conducted at your facility. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed. H56359915C (2565454) with a deficiency issued at F760 at IJ at past non-compliance; F684 and F755 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		09/03/2025
F0684 SS = D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review the facility failed to comprehensively assess and monitor signs/symptoms of fluid overload and failed to implement interventions including notification of changes to the physician for 1 of 3 residents (R3) who had diagnosis of congestive heart failure (CHF) reviewed for change of condition.	F0684	A significant change was identified on August 3, 2025. R3's primary provider was not available, teleEM visit was conducted on August 4, 2025. The visit resulted in provider encouraging the resident to go to emergency room. Resident went to the ER on August 4, 2025. Per ER notes from MD, to provide IV Lasix and send back to this facility if able to. Resident returned to facility on August 4, 2025 and had no further heart failure issues. R3's care plan reviewed August 6, 2025. On September 3rd care plan was further updated to include daily CHF monitoring that has been in place since 8/18/2025. All like residents' care plans were reviewed to ensure that their care plans included their heart failure diagnosis and weight monitoring on or before August 12, 2025. On September 3rd care plan were further updated to include daily CHF monitoring that has been in place since 8/18/2025.	09/03/2025

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: 245635	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/06/2025

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F0684 SS = D	Continued from page 1 Findings include: R3's face sheet dated 8/6/25, identified diagnoses of chronic diastolic heart failure (a condition in which the heart does not pump as well as it should), atrial fibrillation (an irregular, often rapid heart rate that commonly causes poor blood flow), and chronic kidney disease (longstanding disease of the kidneys leading to failure). R3's significant change MDS dated 5/10/25, identified R3 was independent with transfers, had intact cognition, and received diuretic medication. R3's cardiac focus care plan dated 4/21/25, included the following interventions: -fluid restriction: 2000 milliliters (ml) within 24 hours. -give cardiac medications as ordered. -monitor vital signs (weekly and as needed). Notify physician of significant abnormalities. -monitor/document/report as needed any signs/symptoms of congestive heart failure: dependent edema of legs and feet, periorbital edema, shortness of breath (SOB) upon exertion, cool skin, dry cough, distended neck veins, weakness, weight gain unrelated to intake, crackles and wheezes upon auscultation of lungs, orthopnea, weakness and/or fatigue, increased heart rate, lethargy and disorientation. -weight monitoring daily. R3's physician orders were as followed: -compression stockings on in morning and off at bedtime-start date of 4/23/25. -Daily weights-start date of 4/3/25 . -Fluid restriction of 2000 milliliters (ml) within twenty-four hours-start date of 4/1/25. -Furosemide (diuretic) 20 mg, give two tablets once daily-start date of 4/2/25 with end date of 5/23/25. -Furosemide (diuretic) 40 mg, give one tablet two times per day-start date 5/24/25 with end date of 7/18/25.	F0684	Continued from page 1 Change in Condition policy and procedure was reviewed by DON and Administrator on August 6, 2025, with additions made to include: If a significant change in the resident's physical or mental condition occurs, a comprehensive assessment of the resident's condition will be conducted as required by current OBRA regulations governing resident assessments and as outlined in the MDS RAI Instruction Manual. If reporting a change in condition to the physician – there should always be increased monitoring of whatever led to the reason for notification (if the physician says "continue to monitor" this needs to be clarified, and parameters set. For example: when does the monitoring end or under what circumstances). Medication Administration Policy and Procedure was reviewed by the DON, Administrator, and consultant pharmacist on August 12, 2025, with additional information included: only persons licensed or permitted by this state to prepare, administer and document the administration of medications may do so. The individual administering medications will follow the 7 rights of medication administration. Medications are administered in accordance with prescriber orders, including any required time frame. If medications are frequently held, staff will update provider and in conjunction with the interdisciplinary team, shall reevaluate the situation. If a resident is using PRN medications frequently, the attending provider and interdisciplinary team with support from consulting pharmacist shall reevaluate the situation, examine the individual as needed, determine if there is a clinical reason for the frequent PRN use, and consider whether a standing dose of medication is clinically indicated. All medication errors are documented, reported, and reviewed by the QAPI committee to inform process changes and the need for additional staff training. Medications are administered by resident needs and benefit, not staff convenience. Residents may self-administer medications if the attending provider in conjunction with the interdisciplinary care team, has determined that they have the decision-making capacity to do so safely. A specific chronic heart failure (CHF) or heart failure, training document with a competency, was developed to include integration of clinical decision-making, reviewing trending data (or early indicators), how to document or escalate, regulatory accountability, scenario-based learning, and triggers/actions.	

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F0684 SS = D	Continued from page 2 - Furosemide (diuretic) 20 mg tablets, give three tablets in the morning for congestive heart failure-start date of 7/19/25. -Ipratropium-Albuterol nebulizer (bronchodilators; opens airways to make breathing easier) four times per day for asthma-start date of 4/1/25. -Albuterol sulfate inhaler (bronchodilators; opens airways to make breathing easier)-give two puffs every 6 hours as needed for wheezing-start date of 4/1/25 -Albuterol sulfate nebulizer (bronchodilators; opens airways to make breathing easier)-administer three ml every 6 hours as needed for wheezing-start date of 4/1/25. In review of R3's weights from 7/15/25 through 8/4/25, identified R3's weights were taken according to the physician's order except on 7/30/25 and 8/3/25 and identified the following: -7/27/25: 322 pounds -7/28/25: 321 pounds -7/29/25: 321.5 pounds -7/30/25: weight not obtained. -7/31/25: 321 pounds -8/1/25: 319.5 pound -8/2/25: 318.5 pounds -8/3/25: No weight obtained (refused). -8/4/25: 320 pounds Review of R3's record between 7/15/25 through 8/5/25 did not identify that edema monitoring was consistently documented. R3's progress note dated 8/1/25 at 11:41 a.m., identified R3's weight had been trending up over the last three days. R3's lung sounds had slight wheezes, although this is his baseline and does have three plus pitting edema to bilateral lower extremities-although it is his baseline. Today his weight is down two pounds. Will monitor his weight over the weekend and if his weight goes up with get him in for an acute visit	F0684	Continued from page 2 A heart failure monitoring order was added to the eMAR on August 12, 2025, for all like residents as an additional way to ensure we are staying abreast of changes that may be occurring. A resource laminated card has been created and provided to licensed staff to be a quick tool for identifying early signs of CHF and notification to provider on or before August 18, 2025. The following information is included in this resource: Report Immediately If Resident Has: - Weight gain >2 lbs in 24 hours or >5 lbs in 1 week - New or worsening shortness of breath - New crackles or wheezing in lungs - Increased swelling in legs, ankles, or abdomen - Fatigue or weakness limiting normal activities - New or worsening cough - Decreased appetite or nausea - Nighttime shortness of breath (orthopnea/nocturnal dyspnea) What to Monitor Daily: - Weight (same time, same scale) - Blood pressure - Heart rate - Lung sounds - Edema - Urine output (if applicable) - Shortness of breath or fatigue - Appetite and intake Notify Provider Using SBAR:	

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F0684 SS = D	Continued from page 3 and will continue to monitor. R3's record between 4/1/25 through 8/4/25 did not identify R3's goal weight nor baselines of lower extremity edema. Although R3's record dated 8/1/25 identified R3 had bilateral 3+ pitting edema, it did not identify the locations/extent of the edema other than lower extremities. Even though vital signs (heart rate, blood pressure, oxygen saturations) were obtained once and were within normal limits, there was no indication a comprehensive respiratory assessment was completed nor evident R3 was assessed and/or administered an as needed (PRN) breathing treatment for "wheezing" in accordance with physician orders. Further not evident R3's physician was notified, nor evident monitoring for edema and respiratory assessments were completed until 8/3/25. R3's progress note dated 8/3/25 at 5:45 a.m., identified R3 had three plus pitting edema to left foot as well as swelling to left thigh. R3's right foot had two plus pitting edema. Audible wheezing noted and crackles (abnormal breath sounds characterized by clicking, bubbling, or crackling noise) in bilateral lungs, complaining of feeling tired, breathing fast and unable to catch his breath. R3 was coughing throughout the night and was given an as needed cough syrup. Nurse suggested to R3 that he be sent to the ED for evaluation, however, R3 refused. R3 was educated on the importance of following fluid restriction, elevating legs, and using incentive spirometer. R3's progress note dated 8/3/25 at 11:35 p.m., identified R3 had worsening congestive heart failure symptoms of increased shortness of breath, coughing, bilateral crackles, and bilateral edema to lower extremities. R3 was unable to catch his breath after walking from bathroom to the recliner. R3 was given scheduled nebulizer, given as needed cough syrup, offered oxygen, however, R3 refused the application of oxygen. R3 was offered to be sent to the ED and/or have a telehealth visit, however, R3 refused. R3 stated, "What are they going to do for me there, that you guys can't do for me here." R3 was provided education on the risk versus benefits of visiting ED and verbalized the understanding of the risks of worsening heart complications and worsening respiratory distress. Although R3's record dated 8/3/25 identified R3 had edema to specified location with the amount no further assessment was included even though there was an increase in edema in the left lower extremity with increased adventitious breath/lung sounds, coughing, rapid breathing with shortness of breath, and R3	F0684	Continued from page 3 S – Situation: Describe what you are seeing (e.g. 3 lb weight gain + SOB) B – Background: Resident has CHF, baseline weight is X A – Assessment: Lungs with crackles, O2 sat dropped R – Recommendation: Recommend evaluation, med review, possible adjustment. An additional resource laminated card for medications that can cause harm was created and provided to licensed staff and TMA's to know when to notify of significant medication error to the provider and nurse on duty. Training and education were initiated on August 6, 2025, by the DON or designee on the policies, procedures, competencies, and resource tools. All licensed staff will have this completed on or before August 18, 2025 (This excludes one nurse on-call). TMAs received training on the medication administration policy and procedure, with a specific focus on what to do if medications are held due to vital signs being outside the designated parameters (excludes one TMA on-call). They were instructed to notify the nurse so that a proper evaluation can be completed. Additional training from Consultant Pharmacist on "Medication Errors" and "Medication Administration" occurred with licensed nurses and trained medication aides (TMA's) on or before August 18, 2025. An audit will be conducted by the DON or designee on any resident change of condition to ensure appropriate assessment and notification to provider has been made and on any resident with heart failure to ensure evaluations are completed daily. This will be done M-F for 4 weeks, 1x weekly for 4 weeks, and monthly thereafter for one month. An additional audit will be conducted by the DON or designee on all residents with the diagnosis of CHF to ensure Weight, B/P, Heart Rate, Lung sounds, Edema, SPO2 (%), provider notified of any changes, family member, or POA notified, and if orders received and processed. This will be done M-F for 4 weeks, 1x weekly for 4	

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F0684 SS = D	Continued from page 4 complained of being tired, there was no indication the physician was notified. Additionally, there was no indication R3 was provided with as needed breathing treatments for wheezing and shortness of breath nor evaluation of the effectiveness of the education that was provided. Although, R3's vital signs were obtained twice and were within normal limits on 8/3/25, R3's record did not indicate any further monitoring and assessments of R3's congestive heart failure symptoms until 15 hours later on 8/4/25. Review of R3's medication administration record (MAR) from 8/1/25 through 8/4/25, identified R3 was administered as need cough syrup three times and did not identify any as needed albuterol inhaler and/or nebulizers were administered. R3's progress note on 8/4/25 at 2:30 p.m., identified a communication to physician was sent due to R3 having signs and symptoms of CHF: weight gain, bilateral lower extremity edema up to thighs, and increased shortness of breath. R3 had attempted to be sent to the emergency department (ED), but refused, therefore a telehealth (remote healthcare) visit was performed with a physician. R3's physician telehealth visit note dated 8/4/25, identified R3 has several months of increasing weight gain. Diuretic had been increased on 6/21/25, despite this R3 had gained three kilograms in the past two days (amount of weight. gain was not consistent with R3's weight record) with increasing shortness of breath and edema in lower extremities up to his thighs. At first discussed increasing R3's diuretic and having him seen by the nurse practitioner the next day, however, nursing was concerned about R3's symptoms and refusal for transfer to ED. R3 agreed to be sent to the ED for evaluation to receive IV diuretic and have blood work. R3's emergency department (ED) note dated 8/4/25, identified R3 had been seen due to concerns of increase weight and worsening shortness of breath. Vital signs in ED were notable for mild tachypnea (fast breathing) of twenty-nine breaths per minute, wheezes, and rhonchi (abnormal breath sound, often indicating presence of fluid or mucus in the airway). R3's chest X-Ray report dated 8/4/25, identified cardiogenic (something originating in or caused by the heart or a cardiac condition), pulmonary edema (a condition caused by excess fluid in the lungs) with associated small pleural effusion (a buildup of fluid between the tissues that ling the lungs and the chest). R3's breathing showed signs of improvement after receiving IV Lasix (diuretic) suggesting R3 may benefit from up	F0684	Continued from page 4 weeks, and monthly thereafter for one month. Results will be reported to QAPI.	

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F0684 SS = D	Continued from page 5 titration of his daily Lasix to help better manage his congestive heart failure and R3 was discharged back to the skilled nursing facility. During an interview on 8/5/25 at 2:33 p.m., licensed practical nurse (LPN)-C stated R3's weights had been trending up and she noted wheezing in his lungs. LPN-C informed registered nurse (RN)-F about R3's symptoms and was instructed to monitor R3's symptoms over the weekend, if he had worsening symptoms then she would have R3 seen for an acute physician visit on Monday. LPN-C was unsure of what exactly R3's baseline was for weights, lung sounds, and edema. LPN-C reviewed the progress note dated 8/1/25 that she wrote and was unable to articulate how she determined R3 was at his baseline for weights, edema, and lung sounds in the absence of information in the record. LPN-C stated when she came to work on 8/4/25, R3 was "worse" then when she had seen him on 8/1/25. R3 had worsening edema in his legs, cough, and shortness of breath. LPN-C felt R3 was very "unstable" and attempted to have R3 seen for an acute visit with a physician, but was unable to schedule, so had telehealth physician visit instead. During an interview on 8/5/25 at 2:23 p.m., LPN-G stated on 8/3/25 R3 was "not doing well". R3 had crackles in lungs, worsening edema, cough, and shortness of breath that would indicate worsening CHF. LPN-G did not notify the physician of her findings, however, did recommended to R3 he be seen in the ED for evaluation, but R3 declined to be sent to the ED in fear of being hospitalized. During an interview on 8/5/25 at 2:51 p.m., RN-C stated R3' s change of condition began on 8/1/25, however, the physician had not been notified until 8/4/25 and should have been notified sooner. RN-C further stated R3 should have been monitored closely for worsening symptoms of CHF and updated the physician accordingly and was unable to identify in R3's medical record consistent documentation of a comprehensive assessment or timely physician notification. During an interview on 8/6/25 at 3:22 p.m., family member (FM)-F stated when she met R3 at the ED on 8/4/25, R3 was pale in color, extremely short of breath, she could hear "rattling" in his chest and was completely "out of it". R3 had told the ED physician that this was his baseline, however, "that was not R3's baseline". FM-F stated R3 had a fear of being sent to the ED because he did not want to be hospitalized, however, he was getting in "trouble" when she saw him. FM-F stated when R3 was at home she would know he was having worsening heart failure symptoms when he began	F0684		

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F0684 SS = D	Continued from page 6 to have “noisy” breathing and would notify the physician right away to see if they could keep “on top” of his symptoms to possible avoid a hospitalization. During an interview on 8/5/25 at 12:41 p.m., physician assistant (PA) stated residents with a diagnosis of congestive heart failure need to be monitored closely to be able to identify worsening CHF and notify the physician promptly of any changes in their health to prevent further decline of the resident. A follow up interview on 8/6/25 at 11:00 a.m., PA stated if she had been notified sooner of R3's worsening edema and shortness or breath, it would not have changed the outcome for R3 and he still may have eventually needed to get the IV diuretic. During an interview on 8/5/25 at 12:06 p.m., director of nursing (DON) stated her expectation would be for the provider to be notified immediately of any change in the residents’ health status and to monitor the resident closely to possibly prevent decline. DON further stated she is in the process of training nursing staff on signs and symptoms of congestive heart failure and the correct procedures to perform in the event a resident has a change in condition. Review of the facility’s Change of Condition-Resident Physician/Nurse Practitioner (NP) Policy dated 8/23, identified the attending physician or nurse practitioner will be notified of changes in resident’s condition or health status. Definitions: -Short term change of condition: A change in the residents’ health or functioning that is expected to resolve or be reversed with minimal intervention or is an established, predictable, cyclical pattern associated with a previously diagnosed condition. -Significant change of condition: A major deviation from the most recent evaluation that may affect multiple areas of functioning of health that is not expected to be short term or imposes significant risk to the resident. -Examples, but not limited to, observations or changes of condition to be reported: • Changes in behavior/mental health • Cognitive &/or behavior changes	F0684		

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F0684 SS = D	Continued from page 7 • Change in sleep pattern • Pain /Fever • Eating/appetite changes • Change in ADL needs • Change in O2/Oxygen sat/breathing • Wounds/skin issues • New medications • Mobility changes • Falls • Change in hearing, vision, or speech • Bowel/bladder changes The facility identified a procedure with the following: -Seven days per week, attending physician/nurse practitioner (NP) or physician/NP on call is to be notified of condition or health changes via phone, fax, or NP board. Fax and phone numbers available in each nurse area. -Notify nurse on duty of any change of condition. Then nurse on duty will notify nurse manager or director of nursing (DON) if needed. -Notify family member of any change in condition. -Document time of call/fax to provider/NP, reason for call, and results/orders received. -Update resident care plan with new or additional changes in care.	F0684		
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.	F0755	F755 Pharmacy Services R1's medication disposal record was completed with four out of five medication cards with prescription numbers, amount remaining, reason, and date on 8/11/2025. All residents have the potential to be impacted by this practice.	09/03/2025

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F0755 SS = D	Continued from page 8 §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 observation, interview, and document review the facility failed to maintain documentation of actual disposition of medications to include: residents name, medication name, strength, prescription number, quantity, date of disposition, and involved staff and method of destruction for 1 of 5 residents (R1) reviewed for medication disposition. Findings include: R1's face sheet date 8/6/25, identified diagnoses of hypertensive heart disease with heart failure (a condition where high blood pressure that causes the heart to weaken), atrial fibrillation (irregular, often rapid heart rate that causes poor blood flow), prosthetic (artificial) heart valve , presence of a defibrillator (a device that provides an electric shock to the heart to get out of abnormal rhythm), and chronic liver disease (progressive deterioration of the liver). R1's physician orders included: -Torsemide (diuretic) forty milligram (mg) tablet give	F0755	Continued from page 8 This was an isolated incident. Medication Destruction Policy/Procedure was reviewed and updated to include "Medications that meet criteria will be appropriately disposed of using the MedSafe receptacle that is affixed and permanently placed" on August 6, 2025. A random audit of destroyed medication log was initiated on September 2, 2025 by nurse manager or designee to ensure process is being followed. Results will be reported to QAPI.	

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F0755 SS = D	Continued from page 9 1 tablet two times a day related to congestive heart failure. Hold if systolic blood pressure (top number in a blood pressure reading) was less than 100 mmHg. (start date of 5/19/25 through 7/9/25). -Torsemide 40 mg tablet give 1 ½ (60mg total) tablets two times per day for congestive heart failure. Hold if SBP less than 100 mmHg. (start date of 7/9/25 through 7/17/25). Facility pharmacy email dated 7/31/25, identified pharmacy record of a delivery on 7/9/25 of Torsemide prescription (RX) (# 2399736) containing 96 (20 mg) tablets. During an interview on 8/5/25 at 10:06 a.m., R1's physician (MD) on 7/16/25 discovered R1's 7/9/25 Torsemide prescription cards did not have any doses removed and a previously ordered Torsemide cards of 40mg twice daily were still present in R1's medication storage area. MD removed the cards and instructed nurse to give the cards to the director of nursing (DON) to assist in her investigation of a possible medication error. MD did take photos of the Torsemide cards and sent them to the DON on 7/16/25. Review of photo images of R1's Torsemide prescription that were taken on 7/16/25 identified the following: -Rx: 2369106-two cards of Torsemide 20 mg tablet with directions of take 2 tablets by mouth twice daily with 32 tablets remaining. (dispensed on 5/22/25) -Rx: 2399736 -two cards of Torsemide 20 mg tablets with directions to take 3 tablets by mouth twice daily with 96 tablets remaining. (dispensed on 7/9/25) R1's medication error report dated 7/16/25, identified R1 had been given Torsemide 40 mg instead of the prescribed Torsemide 60mg from 7/9/25 through 7/16/25. During an interview on 7/31/25 at 3:48 p.m., registered nurse (RN)-A stated when a medication is destroyed they complete a medication destruction log which contains the resident name, prescription numbers, quantity of medication destroyed. Once the form is filled out then the medications are place in the "Med Safe" (a medication disposal system) and then the completed log is scanned into the resident's chart. RN-A stated R1's medical record did not identify that R1's Torsemide was	F0755		

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F0755 SS = D	Continued from page 10 destroyed on the 7/23/25 log. During an interview on 7/31/25 at 3:59 p.m., DON stated after she completed an investigation into R1's Torsemide medication error, she proceeded to destroy four prescription cards into the medication destruction bin called "Med Safe", however, did not document the prescription numbers, quantity, and date of the destruction. During a follow up interview on 8/5/25 at 5:06 p.m., DON stated after a discussion with the consulting pharmacist (CPharm) she will be creating a medication destruction log for R1's Torsemide that was wasted, however, will be only including an undetermined quantity she destroyed. R1's medication destruction record dated 7/23/25, included multiple of R1 medications that had been destroyed however, did not identify documentation of the destruction of Torsemide (RX: 2369106 and 2399736). During an interview on 8/6/25 at 4:01 p.m., consulting pharmacist (CPharm) stated all medications that are delivered to the facility are property of the resident. When any medication needs to be dispositioned in the medication destruction bin, a log must be completed to include the resident name, date, prescription number, quantity, signature of staff responsible for the disposition, and the documentation of the medication disposition must be maintained in the resident's record. CPharm stated the DON informed him that R1's torsemide had not been properly documented at the time of destruction and he recommended to document that an unknown amount of R1's torsemide had been destroyed and placed in R1's medical record. Review of the facility's Medication Destruction Policy/Procedure dated 8/25, identified the following: -Non-controlled medications should be recorded in the medical record. A licensed nurse should record the name of the medication, prescription number, amount of medication, and date in the medical record. -Medications that meet criteria will be appropriately disposed of using the MedSafe receptacle that is affixed and permanently placed.	F0755		
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	F0760	"Past Noncompliance - no plan of correction required"	07/21/2025

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F0760 SS = SQC-J	Continued from page 11 medication errors. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review the facility failed to ensure medications were administered according to physician orders for 1 of 3 residents (R1) reviewed for medication administration. The facility's failures resulted in a significant medication error and an Immediate Jeopardy (IJ) situation for R1 who did not receive an increased dose of Torsemide (treat fluid overload related to heart or kidney disease) ordered by the physician. R1 was admitted to the hospital cardiac intensive care unit (ICU) for worsening congestive heart failure where she remained at the time of the survey. The IJ began on 7/9/25 when staff failed to administer an increased dose of Torsemide as ordered, due to not following the rights of medication administration. This resulted in 11 incorrect doses between 7/9/25 and 7/16/25. The Administrator and Director of Nursing were notified of the IJ on 8/6/25 at 1:22 p.m. The facility implemented corrective action prior to the survey on 7/21/25 to prevent reoccurrence, so the IJ was issued at past non-compliance. Findings include R1’s face sheet date 8/6/25, identified diagnoses of hypertensive heart disease with heart failure (a condition where high blood pressure that causes the heart to weaken), atrial fibrillation (irregular, often rapid heart rate that causes poor blood flow), prosthetic (artificial) heart valve , presence of a defibrillator (a device that provides an electric shock to the heart to get out of abnormal rhythm), and chronic liver disease (progressive deterioration of the liver). R1’s quarterly Minimum Data Set (MDS) dated 6/17/25, identified R1 was taking a diuretic and had moderate cognitive impairment. R1’s cardiac focus care plan revised on 3/28/25, identified R1 has congestive heart failure, atrial fibrillation, venous insufficiency, prosthetic heart valve, and a cardiac defibrillator. R1’s goals included, “will be free of cardiac complications.”. Corresponding interventions included, fluid restriction of 1500 ml, give cardiac medications as ordered, monitor intake and output, monitor vital signs (weekly and as needed), monitor and document sign and symptoms of congestive heart failure, and weight monitoring	F0760		

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F0760 SS = SQC-J	Continued from page 12 daily. R1's physician orders for cardiac management orders included: -Torsemide (diuretic medication) 40 milligram (mg) tablet give 1 tablet two times a day related to congestive heart failure. Hold if systolic blood pressure (top number in a blood pressure reading) was less than 100 mmHg (start date 5/19/25, stop date 7/9/25) -Torsemide 40 mg tablet give 1 ½ tablets (total of 60 mg) two times per day for congestive heart failure. Hold if SBP less than 100 mmHg (start date of 7/9/25, stop date 7/17/25) -Spironolactone (diuretic medication) oral tablet 25 milligram give 1/2 tablet by mouth in the morning. R1's physician assistant note dated 7/9/25, identified R1 had been seen due to crackles (abnormal breath sounds described as popping, bubbling, or crackling) in lungs and increase weights. R1's Torsemide (diuretic) was increased from forty milligram (mg) twice daily to Torsemide sixty mg twice daily. R1's progress note dated 7/16/25, identified R1's face was edematous, had become short of breath, and oxygen level was 86% (normal range is typically between 95-100%) and needed supplemental oxygen. R1 was seen by in house physician and sent to the emergency department (ED) for evaluation. R1's nursing home physician note dated 7/16/25, identified R1 had been seen due to increased oxygen needs and swelling of the face. R1 had a history of congestive heart failure and had been taking Torsemide (a diuretic) at 40mg twice daily. R1 was seen on 7/8/25 due to an exacerbation of congestive heart failure and Torsemide dose was increased to 60mg twice daily. A chest X-Ray obtained showed pleural effusions and cardiomegaly consistent of congestive heart failure. Since that time, R1's dose had not been increased to 60mg, and had several doses of blood pressure medications held due to blood pressures less than 100 systolic. R1 had not had weights recorded since 7/9/25, but she has gained several pounds since admission in March. R1 was markedly edematous with significant pitting edema to mid back, tense and distended abdomen, facial edema, and increased oxygen needs. R1 had not been receiving increased diuretic doses as ordered on 7/9/25 and needed urgent evaluation in the emergency department.	F0760		

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F0760 SS = SQC-J	Continued from page 13 R1’s emergency management services (EMS) note on 7/16/25, identified R1 had a new onset of shortness of breath and found to be hypoxic at 86% on oxygen at 2 liters/min (L/min). Nursing staff stated R1 had not been taking her diuretic as suspected to low blood pressure, but staff was unaware of how often R1 took the diuretic. R1 complained of shortness of breath and chest pain. R1 had reported the shortness of breath started the "last day or so". R1 also had pitting edema (2+) located in upper legs and abdomen. R1’s emergency department (ED) note dated 7/17/25, identified R1 presented to the ED due to increased shortness of breath and increased bilateral leg swelling. R1 was normally on 2 L/min of oxygen via nasal cannula and was increased to 3 L/min due to oxygen saturations at 86%. R1 had not been taking prescribed diuretics due “soft blood pressures” (hypotension). R1’s physical exam revealed pitting edema noted on upper legs and abdomen, abdominal distention with abdominal pain rated 10/10 on a pain scale, and course (abnormal lung sounds characterized by gurgling or bubbling noises) breath sounds. ED laboratory tests identified NT-Pro BNP (blood test used to diagnose and manage heart failure) was significantly elevated, increased from prior test and venous pCO2 (measure of the amount of carbon dioxide dissolved in venous blood) increased from baseline. R1’s computed tomography (CT) identified cardiomegaly (enlarged heart) with increased volume of ascites (excessive abdominal fluid), small bilateral pleural effusions, anasarca (generalized swelling), and interstitial pulmonary edema in lung bases. Findings suspicious for volume overload in the setting of congestive heart failure. R1’s hospital note dated 7/20/25, identified R1 presented in the ED on 7/16/25 with shortness of breath and was admitted to the intensive care unit for critical care for acute for decompensated heart failure, pleural effusions, and ascites. R1 received diuresis with intravenous Lasix (diuretic), R1 was at high risk for life threatening deterioration in condition. During an interview on 8/5/25 at 10:06 a.m., physician (MD) stated on 7/16/25 she was asked by the nursing staff to evaluate R1 due to increased shortness of breath and having a “puffy face”. MD explained she examined R1, R1’s edema was significant and recommended R1 be seen in the ED for evaluation. R1's swelling was significant and "shocking" that did not just happen overnight, she sent him to the ED for further	F0760		

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F0760 SS = SQC-J	Continued from page 14 evaluation. After R1 left with the ambulance she asked nursing staff to retrieve R1's Torsemide prescription cards to verify the dose she was receiving. MD discovered the prescription cards with the order date of 7/9/25 did not have any doses removed from the prescription cards and some older prescription cards of 40mg twice daily were still present in R1 medication storage area. MD notified the director of nursing (DON) immediately of the discovery and informed DON that R1 had not received any of the increased Torsemide order from the 7/9/25 increase, seven days. R1's medication administration record (MAR) for July 2025 identified the physician order that directed to administer 60 mg of Torsemide twice daily but hold if systolic blood pressure is below 100. Although the MD reported finding no 60 mg doses had been given after they were ordered, R1's MAR between 7/9/25 and 7/6/25, indicated 11 doses of 60 mg Torsemide had been administered and 4 doses were held due to low blood pressure for evening doses on 7/13/25, 7/14/25, and morning dose on 7/16/25. Facility pharmacy email dated 7/31/25, included medication delivery records of medications that the facility had returned for repackaging. The record identified on 5/22/25 the facility had returned195- 20 mg Torsemide tablets to have them repackaged to the Torsemide 40 mg twice daily which were returned to the facility later that day (accounting for 97 doses or 48 days of twice daily doses without doses held). During an interview on 7/31/25 at 3:14 p.m., licensed practical nurse (LPN)-B stated on 7/12/25 the trained medication aide had come to her to question R1's Torsemide 40 mg twice daily prescription card not matching the MAR, LPN-B looked at the card without looking at the physician order to verify the correct dose. LPN-B instructed the TMA to administer the wrong dose of Torsemide. Then on 7/16/25 MD had requested to see R1's prescription cards for her Torsemide orders and after observing the cards she identified some discrepancies on the cards verses what was ordered. R1's prescription card of the Torsemide 60 mg twice daily had no doses removed from it and R1 had not received any of the increase doses of Torsemide. During an interview on 8/1/25 at 1:28 p.m., registered nurse (RN)-E stated she had made two different medication errors for R1's Torsemide order on 7/11/25 and 7/15/25. RN-E reported to the DON she had administered the incorrect dose of 40 mg verses the ordered 60 mg for both errors. RN-E had made the error because the old prescriptions of R1's Torsemide had not	F0760		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245635	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F0760 SS = SQC-J	Continued from page 15 been removed from the medication storage, she must have just grabbed the wrong ones and not completed the rights of medication administration prior to giving them to R1. RN-E had not identified the medication card was the incorrect dose in contrast to the physician order. RN-E was unaware she had made an error until the DON brought it to her attention. After the notification, RN-E did not fill out a medication error report nor was she directed to. During an interview on 8/1/25 at 8:17 a.m., registered nurse (RN)-C stated the causal analysis of R1's medication error was due to the previous prescription card not being removed from the medication storage and that the nurses did not perform the rights of medication administration to ensure the correct dose was being given to R1. During an interview on 8/5/25 at 12:41 p.m., physician assistant (PA) stated she had increased R1's diuretic on 7/8/25 due to increased weights and crackles in her lungs. The missed doses of the diuretic could have added to her worsening congestive heart failure causing her to be hospitalized. This type of error would be considered a significant error because people with her type of heart failure could "die" if not given the correct medication. During an interview on 8/5/25 at 10:06 a.m., medical doctor (MD) stated a resident with congestive heart failure even just missing few doses of a diuretic could put them at risk for serious harm or even death. During an interview on 8/25/25 at 3:32 p.m., consulting pharmacist (CPharm) stated even if there were only a few missed or incorrect doses of a diuretic for a person who was on the verge of worsening CHF exacerbation would be considered a significant error due to risk of being hospitalized or even causing poor outcomes for the resident. CPharm further stated if the rights of medication administration had been followed this error could have been caught sooner and the facility needed to re-educate nurses to ensure the rights of medication administration are being followed. Review of the facility's Medication Error Reports 7/9/25 through 7/15/25 did not identify R1's medication errors that had been made between 7/9/25 and 7/15/25. R1's Medication Error Report dated 7/16/25, identified R1 was given Torsemide 40 mg twice daily. Medication error made by several different staff member and reason for error was the order was misread. In review of the medication error documentation there was no indication of development and implementation of corrective	F0760		

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F0760 SS = SQC-J	Continued from page 16 measures to prevent and/or mitigate the risk of recurrent errors until after R1's medication error was identified on 7/16/25. During an interview on 7/31/25 at 3:59 p.m., DON stated she was informed of R1's Torsemide medication errors by MD on 7/16/25. Upon completing an investigation into the error, she believed some of the nurses had administered the correct doses of 60 mg from an April 2025 medication card that had not been appropriately dispositioned tabs had been returned and repackaged. However, DON did not have any documentation of the prescription numbers or the exact doses she believed were administered. DON identified the cause of the error was the previous medication card of 40 mg twice daily was not removed from the med cart and staff were not performing the rights of medication administration. During a follow up interview on 8/5/25 at 12:00p.m., DON stated a system change had not been made prior to R1's medication error on 7/16/25 even though there were errors regarding disposition of medication and the rights of medication administration. After identification of R1's medication errors, the facility began re-education nursing staff on the rights of medication administration/preventing errors and created a new order checklist to ensure that the medications disposition was being done with any new order. The facility also implemented medication pass audits weekly to ensure appropriate medication disposition and the rights of medication administration were followed. In addition, consulting pharmacist was scheduled to provide additional medication administration education to nursing staff. Review of the facility's Medication Administration Procedure Policy dated 5/2024, identified the purpose to ensure proper consistent medication administration. With the procedure as follows: -When in doubt about dosage or effect of medication, always refer to the original physician order, Drug Reference Book on nursing unit or to the Pharmacist. If there are any questions, HOLD the medication and consult the nurse in charge or attending physician. -Follow the Seven Rights when you are administering medication to the individuals you are caring for: Right Person; Right Medication; Right Dose; Right Time; Right Route; Right Reason; Right Documentation The Immediate jeopardy was issued at PNC (past non-compliance) after it was verified the facility implemented the following prior to the survey:	F0760		

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F0760 SS = SQC-J	Continued from page 17 -Re-educated all nursing staff on proper medication administration/preventing medication starting 7/17/25. -Order checklist had been created on 7/21/25 to ensure nurses remove old medication from the resident's medication storage. -Audits of medication passes and medication changes began on 7/21/25 to ensure the medication have been removed with no further errors identified. Plan for auditing will be done Monday-Friday for 4 weeks, and monthly thereafter and will report findings to QAPI. -Consulting pharmacist has an in-service scheduled for 8/11/25 to educate on medication administration/preventing medication errors.	F0760		

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

September 2, 2025

Administrator
ST JOHNS ON FOUNTAIN LAKE
1771 EAGLE VIEW CIRCLE
ALBERT LEA, MN 56007

Re: State Nursing Home Licensing Orders
Event ID: 1D29B7-H1

Dear Administrator:

The above facility survey was completed on 08/06/2025 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 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 31639	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/06/2025

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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 7/30/25, 8/1/25, 8/5/25, and 8/6/25, a standard abbreviated survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure, and the following licensing order(s) (was/were) issued. Please indicate in your electronic plan of correction you have reviewed these orders and identify the date when they will be completed	20000		09/03/2025

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

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20000	Continued from page 1 The following complaints were reviewed. H56359915C (2565454) with a licensing order issued at 0830. Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor's findings are the Suggested Method of Correction and Time Period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	20000		
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	20830	A significant change was identified on August 3, 2025. R3's primary provider was not available, teleEM visit was conducted on August 4, 2025. The visit resulted in provider encouraging the resident to go to emergency room. Resident went to the ER on August 4, 2025. Per ER notes from MD, to provide IV Lasix and send back to this facility if able to. Resident returned to facility on August 4, 2025 and had no further heart failure issues. R3's care plan reviewed August 6, 2025. On September	09/03/2025

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20830	Continued from page 2 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 and monitor signs/symptoms of fluid overload and failed to implement interventions including notification of changes to the physician for 1 of 3 residents (R3) who had diagnosis of congestive heart failure (CHF) reviewed for change of condition. Findings include: R3's face sheet dated 8/6/25, identified diagnoses of chronic diastolic heart failure (a condition in which the heart does not pump as well as it should), atrial fibrillation (an irregular, often rapid heart rate that commonly causes poor blood flow), and chronic kidney disease (longstanding disease of the kidneys leading to failure). R3's significant change MDS dated 5/10/25, identified R3 was independent with transfers, had intact cognition, and received diuretic medication. R3's cardiac focus care plan dated 4/21/25, included the following interventions: -fluid restriction: 2000 milliliters (ml) within 24 hours. -give cardiac medications as ordered. -monitor vital signs (weekly and as needed). Notify physician of significant abnormalities. -monitor/document/report as needed any signs/symptoms of congestive heart failure: dependent edema of legs and feet, periorbital edema, shortness of breath (SOB) upon exertion, cool skin, dry cough, distended neck veins, weakness, weight gain unrelated to intake, crackles and wheezes upon auscultation of lungs, orthopnea, weakness and/or fatigue, increased heart rate, lethargy and disorientation. -weight monitoring daily. R3's physician orders were as followed: -compression stockings on in morning and off at bedtime-start date of 4/23/25.	20830	Continued from page 2 3rd care plan was further updated to include daily CHF monitoring that has been in place since 8/18/2025. All like residents' care plans were reviewed to ensure that their care plans included their heart failure diagnosis and weight monitoring on or before August 12, 2025. On September 3rd care plan were further updated to include daily CHF monitoring that has been in place since 8/18/2025. Change in Condition policy and procedure was reviewed by DON and Administrator on August 6, 2025, with additions made to include: If a significant change in the resident's physical or mental condition occurs, a comprehensive assessment of the resident's condition will be conducted as required by current OBRA regulations governing resident assessments and as outlined in the MDS RAI Instruction Manual. If reporting a change in condition to the physician – there should always be increased monitoring of whatever led to the reason for notification (if the physician says "continue to monitor" this needs to be clarified, and parameters set. For example: when does the monitoring end or under what circumstances). Medication Administration Policy and Procedure was reviewed by the DON, Administrator, and consultant pharmacist on August 12, 2025, with additional information included: only persons licensed or permitted by this state to prepare, administer and document the administration of medications may do so. The individual administering medications will follow the 7 rights of medication administration. Medications are administered in accordance with prescriber orders, including any required time frame. If medications are frequently held, staff will update provider and in conjunction with the interdisciplinary team, shall reevaluate the situation. If a resident is using PRN medications frequently, the attending provider and interdisciplinary team with support from consulting pharmacist shall reevaluate the situation, examine the individual as needed, determine if there is a clinical reason for the frequent PRN use, and consider whether a standing dose of medication is clinically indicated. All medication errors are documented, reported, and reviewed by the QAPI committee to inform process changes and the need for additional staff training. Medications are administered by resident needs and benefit, not staff convenience. Residents may self-administer medications if the attending provider in conjunction with the interdisciplinary care team,	

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20830	Continued from page 3 -Daily weights-start date of 4/3/25 . -Fluid restriction of 2000 milliliters (ml) within twenty-four hours-start date of 4/1/25. -Furosemide (diuretic) 20 mg, give two tablets once daily-start date of 4/2/25 with end date of 5/23/25. -Furosemide (diuretic) 40 mg, give one tablet two times per day-start date 5/24/25 with end date of 7/18/25. - Furosemide (diuretic) 20 mg tablets, give three tablets in the morning for congestive heart failure-start date of 7/19/25. -Ipratropium-Albuterol nebulizer (bronchodilators; opens airways to make breathing easier) four times per day for asthma-start date of 4/1/25. -Albuterol sulfate inhaler (bronchodilators; opens airways to make breathing easier)-give two puffs every 6 hours as needed for wheezing-start date of 4/1/25 -Albuterol sulfate nebulizer (bronchodilators; opens airways to make breathing easier)-administer three ml every 6 hours as needed for wheezing-start date of 4/1/25. In review of R3's weights from 7/15/25 through 8/4/25, identified R3's weights were taken according to the physician's order except on 7/30/25 and 8/3/25 and identified the following: -7/27/25: 322 pounds -7/28/25: 321 pounds -7/29/25: 321.5 pounds -7/30/25: weight not obtained. -7/31/25: 321 pounds -8/1/25: 319.5 pound -8/2/25: 318.5 pounds -8/3/25: No weight obtained (refused). -8/4/25: 320 pounds	20830	Continued from page 3 has determined that they have the decision-making capacity to do so safely. A specific chronic heart failure (CHF) or heart failure, training document with a competency, was developed to include integration of clinical decision-making, reviewing trending data (or early indicators), how to document or escalate, regulatory accountability, scenario-based learning, and triggers/actions. A heart failure monitoring order was added to the eMAR on August 12, 2025, for all like residents as an additional way to ensure we are staying abreast of changes that may be occurring. A resource laminated card has been created and provided to licensed staff to be a quick tool for identifying early signs of CHF and notification to provider on or before August 18, 2025. The following information is included in this resource: Report Immediately If Resident Has: - Weight gain >2 lbs in 24 hours or >5 lbs in 1 week - New or worsening shortness of breath - New crackles or wheezing in lungs - Increased swelling in legs, ankles, or abdomen - Fatigue or weakness limiting normal activities - New or worsening cough - Decreased appetite or nausea - Nighttime shortness of breath (orthopnea/nocturnal dyspnea) What to Monitor Daily: - Weight (same time, same scale) - Blood pressure - Heart rate - Lung sounds	

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20830	Continued from page 4 Review of R3's record between 7/15/25 through 8/5/25 did not identify that edema monitoring was consistently documented. R3's progress note dated 8/1/25 at 11:41 a.m., identified R3's weight had been trending up over the last three days. R3's lung sounds had slight wheezes, although this is his baseline and does have three plus pitting edema to bilateral lower extremities-although it is his baseline. Today his weight is down two pounds. Will monitor his weight over the weekend and if his weight goes up with get him in for an acute visit and will continue to monitor. R3's record between 4/1/25 through 8/4/25 did not identify R3's goal weight nor baselines of lower extremity edema. Although R3's record dated 8/1/25 identified R3 had bilateral 3+ pitting edema, it did not identify the locations/extent of the edema other than lower extremities. Even though vital signs (heart rate, blood pressure, oxygen saturations) were obtained once and were within normal limits, there was no indication a comprehensive respiratory assessment was completed nor evident R3 was assessed and/or administered an as needed (PRN) breathing treatment for "wheezing" in accordance with physician orders. Further not evident R3's physician was notified, nor evident monitoring for edema and respiratory assessments were completed until 8/3/25. R3's progress note dated 8/3/25 at 5:45 a.m., identified R3 had three plus pitting edema to left foot as well as swelling to left thigh. R3's right foot had two plus pitting edema. Audible wheezing noted and crackles (abnormal breath sounds characterized by clicking, bubbling, or crackling noise) in bilateral lungs, complaining of feeling tired, breathing fast and unable to catch his breath. R3 was coughing throughout the night and was given an as needed cough syrup. Nurse suggested to R3 that he be sent to the ED for evaluation, however, R3 refused. R3 was educated on the importance of following fluid restriction, elevating legs, and using incentive spirometer. R3's progress note dated 8/3/25 at 11:35 p.m., identified R3 had worsening congestive heart failure symptoms of increased shortness of breath, coughing, bilateral crackles, and bilateral edema to lower extremities. R3 was unable to catch his breath after walking from bathroom to the recliner. R3 was given scheduled nebulizer, given as needed cough syrup, offered oxygen, however, R3 refused the application of oxygen. R3 was offered to be sent to the ED and/or have a telehealth visit, however, R3 refused. R3 stated,	20830	Continued from page 4 - Edema - Urine output (if applicable) - Shortness of breath or fatigue - Appetite and intake Notify Provider Using SBAR: S – Situation: Describe what you are seeing (e.g. 3 lb weight gain + SOB) B – Background: Resident has CHF, baseline weight is X A – Assessment: Lungs with crackles, O2 sat dropped R – Recommendation: Recommend evaluation, med review, possible adjustment. An additional resource laminated card for medications that can cause harm was created and provided to licensed staff and TMA's to know when to notify of significant medication error to the provider and nurse on duty. Training and education were initiated on August 6, 2025, by the DON or designee on the policies, procedures, competencies, and resource tools. All licensed staff will have this completed on or before August 18, 2025 (This excludes one nurse on-call). TMAs received training on the medication administration policy and procedure, with a specific focus on what to do if medications are held due to vital signs being outside the designated parameters (excludes one TMA on-call). They were instructed to notify the nurse so that a proper evaluation can be completed. Additional training from Consultant Pharmacist on "Medication Errors" and "Medication Administration" occurred with licensed nurses and trained medication aides (TMA's) on or before August 18, 2025. An audit will be conducted by the DON or designee on any resident change of condition to ensure appropriate assessment and notification to provider has been made and on any resident with heart failure to ensure evaluations are completed daily. This will be done M-F for 4 weeks, 1x weekly for 4 weeks, and monthly	

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20830	Continued from page 5 “What are they going to do for me there, that you guys can’t do for me here.” R3 was provided education on the risk versus benefits of visiting ED and verbalized the understanding of the risks of worsening heart complications and worsening respiratory distress. Although R3’s record dated 8/3/25 identified R3 had edema to specified location with the amount no further assessment was included even though there was an increase in edema in the left lower extremity with increased adventitious breath/lung sounds, coughing, rapid breathing with shortness of breath, and R3 complained of being tired, there was no indication the physician was notified. Additionally, there was no indication R3 was provided with as needed breathing treatments for wheezing and shortness of breath nor evaluation of the effectiveness of the education that was provided. Although, R3’s vital signs were obtained twice and were within normal limits on 8/3/25, R3’s record did not indicate any further monitoring and assessments of R3’s congestive heart failure symptoms until 15 hours later on 8/4/25. Review of R3’s medication administration record (MAR) from 8/1/25 through 8/4/25, identified R3 was administered as need cough syrup three times and did not identify any as needed albuterol inhaler and/or nebulizers were administered. R3’s progress note on 8/4/25 at 2:30 p.m., identified a communication to physician was sent due to R3 having signs and symptoms of CHF: weight gain, bilateral lower extremity edema up to thighs, and increased shortness of breath. R3 had attempted to be sent to the emergency department (ED), but refused, therefore a telehealth (remote healthcare) visit was performed with a physician. R3’s physician telehealth visit note dated 8/4/25, identified R3 has several months of increasing weight gain. Diuretic had been increased on 6/21/25, despite this R3 had gained three kilograms in the past two days (amount of weight. gain was not consistent with R3's weight record) with increasing shortness of breath and edema in lower extremities up to his thighs. At first discussed increasing R3’s diuretic and having him seen by the nurse practitioner the next day, however, nursing was concerned about R3’s symptoms and refusal for transfer to ED. R3 agreed to be sent to the ED for evaluation to receive IV diuretic and have blood work. R3’s emergency department (ED) note dated 8/4/25, identified R3 had been seen due to concerns of increase weight and worsening shortness of breath. Vital signs	20830	Continued from page 5 thereafter for one month. An additional audit will be conducted by the DON or designee on all residents with the diagnosis of CHF to ensure Weight, B/P, Heart Rate, Lung sounds, Edema, SPO2 (%), provider notified of any changes, family member, or POA notified, and if orders received and processed. This will be done M-F for 4 weeks, 1x weekly for 4 weeks, and monthly thereafter for one month. Results will be reported to QAPI.	

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20830	Continued from page 6 in ED were notable for mild tachypnea (fast breathing) of twenty-nine breaths per minute, wheezes, and rhonchi (abnormal breath sound, often indicating presence of fluid or mucus in the airway). R3's chest X-Ray report dated 8/4/25, identified cardiogenic (something originating in or caused by the heart or a cardiac condition), pulmonary edema (a condition caused by excess fluid in the lungs) with associated small pleural effusion (a buildup of fluid between the tissues that ling the lungs and the chest). R3's breathing showed signs of improvement after receiving IV Lasix (diuretic) suggesting R3 may benefit from up titration of his daily Lasix to help better manage his congestive heart failure and R3 was discharged back to the skilled nursing facility. During an interview on 8/5/25 at 2:33 p.m., licensed practical nurse (LPN)-C stated R3's weights had been trending up and she noted wheezing in his lungs. LPN-C informed registered nurse (RN)-F about R3's symptoms and was instructed to monitor R3's symptoms over the weekend, if he had worsening symptoms then she would have R3 seen for an acute physician visit on Monday. LPN-C was unsure of what exactly R3's baseline was for weights, lung sounds, and edema. LPN-C reviewed the progress note dated 8/1/25 that she wrote and was unable to articulate how she determined R3 was at his baseline for weights, edema, and lung sounds in the absence of information in the record. LPN-C stated when she came to work on 8/4/25, R3 was "worse" then when she had seen him on 8/1/25. R3 had worsening edema in his legs, cough, and shortness of breath. LPN-C felt R3 was very "unstable" and attempted to have R3 seen for an acute visit with a physician, but was unable to schedule, so had telehealth physician visit instead. During an interview on 8/5/25 at 2:23 p.m., LPN-G stated on 8/3/25 R3 was "not doing well". R3 had crackles in lungs, worsening edema, cough, and shortness of breath that would indicate worsening CHF. LPN-G did not notify the physician of her findings, however, did recommended to R3 he be seen in the ED for evaluation, but R3 declined to be sent to the ED in fear of being hospitalized. During an interview on 8/5/25 at 2:51 p.m., RN-C stated R3' s change of condition began on 8/1/25, however, the physician had not been notified until 8/4/25 and should have been notified sooner. RN-C further stated R3 should have been monitored closely for worsening symptoms of CHF and updated the physician accordingly and was unable to identify in R3's medical record consistent documentation of a comprehensive assessment or timely physician notification.	20830		

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20830	Continued from page 7 During an interview on 8/6/25 at 3:22 p.m., family member (FM)-F stated when she met R3 at the ED on 8/4/25, R3 was pale in color, extremely short of breath, she could hear “rattling” in his chest and was completely “out of it”. R3 had told the ED physician that this was his baseline, however, “that was not R3’s baseline”. FM-F stated R3 had a fear of being sent to the ED because he did not want to be hospitalized, however, he was getting in “trouble” when she saw him. FM-F stated when R3 was at home she would know he was having worsening heart failure symptoms when he began to have “noisy” breathing and would notify the physician right away to see if they could keep “on top” of his symptoms to possible avoid a hospitalization. During an interview on 8/5/25 at 12:41 p.m., physician assistant (PA) stated residents with a diagnosis of congestive heart failure need to be monitored closely to be able to identify worsening CHF and notify the physician promptly of any changes in their health to prevent further decline of the resident. A follow up interview on 8/6/25 at 11:00 a.m., PA stated if she had been notified sooner of R3's worsening edema and shortness or breath, it would not have changed the outcome for R3 and he still may have eventually needed to get the IV diuretic. During an interview on 8/5/25 at 12:06 p.m., director of nursing (DON) stated her expectation would be for the provider to be notified immediately of any change in the residents’ health status and to monitor the resident closely to possibly prevent decline. DON further stated she is in the process of training nursing staff on signs and symptoms of congestive heart failure and the correct procedures to perform in the event a resident has a change in condition. Review of the facility’s Change of Condition-Resident Physician/Nurse Practitioner (NP) Policy dated 8/23, identified the attending physician or nurse practitioner will be notified of changes in resident’s condition or health status. Definitions: -Short term change of condition: A change in the residents’ health or functioning that is expected to resolve or be reversed with minimal intervention or is an established, predictable, cyclical pattern associated with a previously diagnosed condition. -Significant change of condition: A major deviation	20830		

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20830	Continued from page 8 from the most recent evaluation that may affect multiple areas of functioning of health that is not expected to be short term or imposes significant risk to the resident. -Examples, but not limited to, observations or changes of condition to be reported: • Changes in behavior/mental health • Cognitive &/or behavior changes • Change in sleep pattern • Pain /Fever • Eating/appetite changes • Change in ADL needs • Change in O2/Oxygen sat/breathing • Wounds/skin issues • New medications • Mobility changes • Falls • Change in hearing, vision, or speech • Bowel/bladder changes The facility identified a procedure with the following: -Seven days per week, attending physician/nurse practitioner (NP) or physician/NP on call is to be notified of condition or health changes via phone, fax, or NP board. Fax and phone numbers available in each nurse area. -Notify nurse on duty of any change of condition. Then nurse on duty will notify nurse manager or director of nursing (DON) if needed. -Notify family member of any change in condition. -Document time of call/fax to provider/NP, reason for call, and results/orders received. -Update resident care plan with new or additional changes in care.	20830		

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20830	Continued from page 9 Suggested method of correction: DON/designee could review policies and procedures and best practices for monitoring and assessments. DON/designee could develop/revise systems and educate staff and determine competency. The facility could then develop and implement an auditing system to ensure ongoing compliance. a Time of correction: 21-days	20830		