STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355116	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKSIDE LUTHERAN HOME	501 3RD AVE W PO BOX 153, LISBON, North Dakota, 58054

(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 The standard Medicare/Medicaid recertification survey started on 12/08/25 and concluded on 12/11/25.	F0000		01/15/2026
F0600 SS = D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is NOT MET as evidenced by: Based on record review, review of facility policy, and staff interviews, the facility failed to identify an incident of verbal abuse for 1 of 1 sampled resident (Resident #8) who was subjected to name calling and sworn at by a staff member. Failure to ensure residents were free from verbal abuse resulted in Resident #8's experiencing emotional distress and placed him and other vulnerable residents at risk of potential and/or continued verbal abuse. Findings include: Review of the facility policy "Resident Abuse and Reporting" occurred on 12/11/25. This policy, revised on 04/16/24, stated, ". . . The resident has the right to be free from verbal . . . abuse . . . Residents must not be subjected to abuse by anyone, including, but not limited to, facility staff . . . Verbal Abuse: Refers	F0600	F660 Immediate action was taken for resident #8 on 11-11-25, resident #8 was removed from the dining room and CNA #2 was reassigned duties following disciplinary action. Director of Nursing reassessed resident #8 on 12-12-25 for lasting effects of any suspected verbal abuse. All residents residing in SNF could potentially be affected by this deficient practice. A thorough investigation was conducted on 12-12-25, interviewing 8 random residents from various households and 3 staff members who were present on 11-11-25. An in-service was conducted by DON with all direct care staff on 1-7-26 to review abuse policy and circumstances that require reporting. All staff are educated on abuse policy on hire and annually. The last all staff education was completed on 6-12-25. The Director of Nursing or designee will be responsible for auditing 3 random resident charts for potential abuse. Audits will occur weekly x4 weeks then monthly x2 months, then quarterly x2. The Director of Nursing will report results of monitoring at the quarterly facility quality assurance meeting with on-going frequency and duration to be determined through analysis and review of audit results by the QA committee.	01/15/2026

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355116	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/11/2025

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F0600 SS = D	Continued from page 1 to any use of oral . . . language that includes disparaging and derogatory terms directed towards residents . . . regardless of their age, ability to comprehend, or disability. . . . If abuse is witnessed . . . By the charge nurse or any member of the management team, the Administrator by means of this policy authorizes them to immediately suspend the employee which was seen abusing a resident. . . ." Review of Resident #8's medical record occurred on all days of survey. Diagnoses included anxiety, history of traumatic brain injury, major depressive disorder, and unspecified psychosis. The current care plan stated the following, ". . . Observe for s/sx [signs/symptoms] of depression and/or anxiety (IE: . . . agitation . . . etc) document and report to CN [charge nurse] . . . Offer emotional support . . . I receive counseling through [name of clinic] every 2 wks [weeks] . . ." A memo, dated 11/11/25 at 8:30 a.m., stated, ". . . Writer heard hollering and banging coming from CC [Cozy Cottage Unit] DR [dining room], [Resident #8] and [certified nurse aide (CNA) (#2)] were having a loud disagreement. Alot of name calling and swearing going back and forth. Writer removed res [resident] from DR and CN visited with CNA. [Resident #8] was very upset with [CNA (#2)], he couldn't really explain how it started, but he wanted coffee. . . ." Another memo, dated 11/11/25, stated, "During the meeting with [CNA (#2)], she stated that she was . . . waiting to serve breakfast to the residents . . . she glanced at her phone . . . and resident [#8] 'went off.' She was angry and started arguing back with him. She stated in hind sight [sic] she should have walked away from him and not engaged. She knows that it was wrong to have responded but he was calling her horrible names and using the 'N' [explicit content] word. . . . I [Administrative Nurse (#1)] informed her that the correct action would have been to ensure that he was safe and walk away." The 24-hour reports showed CNA (#2) was assigned to care for Resident #8 on November 11th, 13th, December 4th, and 8th, 2025. During an interview on 12/10/25 at 4:00 p.m., an administrative nurse (#1) indicated she did not report the incident to the State due to the fact the resident and staff member were immediately separated. She later conceded that the CNA's behavior met the definition of verbal abuse. During an interview on 12/11/25 at 10:53 a.m., Resident	F0600	Continued from page 1 Substantial compliance will be achieved by 1-15-26.	

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F0600 SS = D	Continued from page 2 #8 stated, "I don't like that one girl [CNA (#2)]." The facility failed to recognize a "loud disagreement, name calling, and swearing" as verbal abuse and protect Resident #2 during the investigation.	F0600		
F0609 SS = D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is NOT MET as evidenced by: Based on record review, review of facility policy, and staff interviews, the facility failed to immediately report an incident of verbal abuse for 1 of 1 sampled resident (Resident #8) subjected to name calling and sworn at by a staff member. Failure to report the incident to the state survey agency (SSA) placed Resident #8 and other vulnerable residents at risk of potential and/or continued verbal abuse. Findings include: Review of the facility policy "Resident Abuse and	F0609	F609 Immediate action was taken for resident #8 on 11-11-25, resident #8 was removed from the dining room and CNA #2 was reassigned duties following disciplinary action. Director of Nursing reassessed resident #8 on 12-12-25 for lasting effects of any suspected verbal abuse. All residents residing in SNF could potentially be affected by this deficient practice. A thorough investigation was conducted on 12-12-25, interviewing 8 random residents from various households and 3 staff members who were present on 11-11-25. An in-service was conducted by DON with all direct care staff on 1-7-26 to review abuse policy and circumstances that require reporting. All staff are educated on abuse policy on hire and annually. The last all staff education was completed on 6-12-25. The Director of Nursing or designee will be responsible for auditing 3 random resident charts for potential abuse. Audits will occur weekly x4 weeks then monthly x2 months, then quarterly x2. The Director of Nursing will report results of monitoring at the quarterly facility quality assurance meeting with on-going frequency and duration to be determined through analysis and review of audit results by the QA committee. Substantial compliance will be achieved by 1-15-26.	01/15/2026

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F0609 SS = D	Continued from page 3 Reporting" occurred on 12/11/25. This policy, revised on 04/16/24, stated, ". . . Any staff . . . witnessing . . . any act . . . involving mistreatment . . . or abuse . . . must immediately notify the charge nurse. The charge nurse will immediately notify the Administrator, Social Services Designee and/or Director of Nursing. The ND Department of Health will also be notified of reports of allegations of abuse and that an investigation is pending. The facility will notify the ND Department of Health the results of the investigation with [sic] 5 working days. . . ." A memo, dated 11/11/25 at 8:30 a.m., stated, ". . . Writer heard hollering and banging coming from CC [Cozy Cottage Unit] DR [dining room], [Resident #8] and [certified nurse aide (CNA) (#2)] were having a loud disagreement. Alot of name calling and swearing going back and forth. Writer removed res [resident] from DR and CN [charge nurse] visited with CNA. [Resident #8] was very upset with [CNA (#2)], he couldn't really explain how it started, but he wanted coffee. . . ." Another memo, dated 11/11/25, stated, "During the meeting with [CNA (#2)], she stated that she was . . . waiting to serve breakfast to the residents . . . she glanced at her phone . . . and resident [#8] 'went off.' She was angry and started arguing back with him. She stated in hind sight [sic] she should have walked away from him and not engaged. She knows that it was wrong to have responded but he was calling her horrible names and using the 'N' [explicit content] word. . . . I [Administrative Nurse (#1)] informed her that the correct action would have been to ensure that he was safe and walk away." During an interview on 12/10/25 at 4:00 p.m., an administrative nurse (#1) indicated she did not report the incident to the state. The facility failed to recognize a "loud disagreement, name calling, and swearing" as verbal abuse and report the allegation to the SSA.	F0609		
F0610 SS = D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations	F0610	F610 Immediate action was taken for resident #8 on 11-11-25, resident #8 was removed from the dining room and CNA #2 was reassigned duties following disciplinary action. Director of Nursing reassessed resident #8 on 12-12-25 for lasting effects of any suspected verbal abuse.	01/15/2026

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F0610 SS = D	Continued from page 4 are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is NOT MET as evidenced by: Based on record review and review of facility policy, the facility failed to investigate an incident of verbal abuse for 1 of 1 sampled resident (Resident #8) who was subjected to name calling and sworn at by a staff member. Failure to thoroughly investigate the incident placed Resident #8 and other vulnerable residents at risk of potential and/or continued verbal abuse. Findings include: Review of the facility policy "Resident Abuse and Reporting" occurred on 12/11/25. This policy, revised on 04/16/24, stated, ". . . All allegations must be thoroughly investigated by the designated department managers under the general direction of the Administrator. This may include, but is not limited to, interviewing all persons associated with the situation . . . The investigators will complete a written report and forward it to the Administrator or designee within 48 hours. . . ." A memo, dated 11/11/25 at 8:30 a.m., stated, ". . . Writer heard hollering and banging coming from CC [Cozy Cottage Unit] DR [dining room], [Resident #8] and [certified nurse aide (CNA) (#2)] were having a loud disagreement. Alot of name calling and swearing going back and forth. Writer removed res [resident] from DR and CN [charge nurse] visited with CNA. [Resident #8] was very upset with [CNA (#2)], he couldn't really explain how it started, but he wanted coffee. . . ." Another memo, dated 11/11/25, stated, "During the meeting with [CNA (#2)], she stated that she was . . . waiting to serve breakfast to the residents . . . she glanced at her phone . . . and resident [#8] 'went	F0610	Continued from page 4 All residents residing in SNF could potentially be affected by this deficient practice. A thorough investigation was conducted on 12-12-25, interviewing 8 random residents from various households and 3 staff members who were present on 11-11-25. An in-service was conducted by DON with all direct care staff on 1-7-26 to review abuse policy and circumstances that require reporting. All staff are educated on abuse policy on hire and annually. The last all staff education was completed on 6-12-25. The Director of Nursing or designee will be responsible for auditing 3 random resident charts for potential abuse. Audits will occur weekly x4 weeks then monthly x2 months, then quarterly x2. The Director of Nursing will report results of monitoring at the quarterly facility quality assurance meeting with on-going frequency and duration to be determined through analysis and review of audit results by the QA committee. Substantial compliance will be achieved by 1-15-26.	

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F0610 SS = D	Continued from page 5 off.' She was angry and started arguing back with him. She stated in hind sight [sic] she should have walked away from him and not engaged. She knows that it was wrong to have responded but he was calling her horrible names and using the 'N' [explicit content] word. . . . I [Administrative Nurse (#1)] informed her that the correct action would have been to ensure that he was safe and walk away." The facility failed to recognize a "loud disagreement, name calling, and swearing" as verbal abuse and failed to thoroughly investigate the incident, including interviewing other staff members and residents who were present in the dining room at the time of the incident.	F0610		
F0657 SS = E	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is NOT MET as evidenced by:	F0657	F657 Resident #2's care plan was reviewed and revised on 1-2-26 to include pain management. Resident #4's care plan was reviewed and revised on 1-2-26 to include chronic UTI management. Resident #5's care plan was reviewed and revised to include pain management on 1-2-26 smoking section was reviewed on 1-2-26 and is up to date. Resident #8's care plan was reviewed and in up to date with smoking interventions. Resident #41's care plan was reviewed and revised on 12-11-25 to include ileostomy reversal. All residents could potentially be affected by this deficient practice. All residents care plans will be reviewed and updated as needed on or before 1-15-25. Smoking Policy and Resident Smoking Agreement were reviewed and revised on 1-6-26 per IDT. Meeting held with all residents who currently smoke on 1-9-26 to review new policy, new smoking agreement was signed by residents. New safe smoking evaluation completed for all current	01/15/2026

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F0657 SS = E	Continued from page 6 Based on record review, review of facility policy, and staff interview, the facility failed to review and revise care plans to reflect the residents' current status for 5 of 12 sampled residents (Resident #2, #4, #5, #8, and #41). Failure to update care plans limited the staff's ability to communicate needs and ensure continuity of care. Findings include: Review of the facility policy titled "Care Planning – Interdisciplinary Team" occurred on 12/10/25. This policy, revised in December 2008, stated, ". . . Each resident's comprehensive care plan is designed to: Incorporate identified problem areas; Incorporate risk factors . . . Reflect treatment goals . . . objectives . . . Aid in preventing or reducing declines in the resident's functional status . . . assessments of resident are ongoing, and care plans are revised as information about the resident and the resident's condition change. . . ." Review of the facility policy titled "Smoking - Residents" occurred on 12/11/25. This policy, revised April 2012, stated, ". . . Any smoking-related privileges, restrictions, and concerns . . . shall be noted on the care plan . . ." - Review of Resident #2's medical record occurred on all days of survey. Diagnoses included atypical facial pain, low back pain, polyosteoarthritis, and generalized abdominal pain. The admission Minimum Data Set (MDS), dated 10/21/25, indicated moderate and frequent pain. Current physician's orders identified acetaminophen (a pain reliever) used for pain. Resident #2's care plan failed to include problems, goals, and interventions for pain management. During an interview on 12/11/2025 at 2:45 p.m., an administrative nurse (#1) confirmed staff failed to update resident #2 care plan. - Review of Resident #4's medical record occurred on all days of survey. Urinary tract infections (UTI) were identified on 12/16/24, 1/28/25, 7/8/25, 9/15/25, 10/20/25, and 11/28/25.	F0657	Continued from page 6 residents who smoke on 1-9-26. Education will be provided to all professional nursing staff on 1-7-25 on timely care plan review and revision to reflect resident current plan of care and status. Comprehensive care plan policy will be reviewed on 1-7-25. The MDS nurse and IDT shall be responsible to update care plans as changes occur and will be reviewed at a minimum of quarterly on the quarterly MDS, or with any admission/readmission, and any significant change. IDT to meet weekly to review care plans for accuracy. The Director of Nursing or designee will be responsible for auditing 3 random resident's comprehensive care plans for accuracy. Audits will occur weekly x4 weeks then monthly x2 months, then quarterly x2. The Director of Nursing will report results of monitoring at the quarterly facility quality assurance meeting with on-going frequency and duration to be determined through analysis and review of audit results by the QA committee. Substantial compliance will be achieved by 1-15-26.	

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F0657 SS = E	Continued from page 7 Resident #4's care plan failed to include problems, goals, and interventions for chronic urinary tract infections. During an interview on 12/11/25 at 2:41 p.m., an administrative nurse (#1) confirmed staff failed to revise Resident #4's care plan. - Review of Resident #5's medical record occurred on all days of survey. Diagnoses included left hip pain and other chronic pain. The significant change MDS, dated 10/09/25, identified pain almost constantly. Physician's orders included acetaminophen, Gabapentin (an anticonvulsant used to manage nerve pain), and Advil (a pain reliever) as needed for pain. A smoking assessment, dated 10/23/25, indicated Resident #5 as, "safe to smoke without supervision. Resident has not been returning cigarettes to nurse each time she comes back from smoking like she has been told to. . . ." The progress notes, dated October 18-22, 2025, identified Resident #5 failed to obtain her cigarettes from the nurse and/or turn them in after each smoking episode. Staff explained this was a violation of their safe smoking privileges and a safety concern that may result in her smoking privileges being revoked. Resident #5's care plan failed to include problems, goals, and interventions addressing pain management and behaviors related to smoking. - Review of Resident #8's medical record occurred on all days of survey. Diagnoses included tobacco use. A smoking assessment, dated 12/21/24, stated, ". . . He often times will not follow the policy/rules on where to smoke or returning his smoking materials to the nurse after he is done. Resident is safe to smoke but needs to be reminded of rules/policy around his smoking materials. . . ." Resident #8's care plan related to smoking failed to address behaviors related to smoking. - Review of Resident #41's medical record occurred on all days of survey. Diagnoses included ileostomy (a	F0657		

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F0657 SS = E	Continued from page 8 surgical created opening that allows stool and gas to exit). The care plan stated identified the presence of a colostomy (similar to an ileostomy). A progress note, dated 11/28/2025, stated, "Res [Resident] returned to facility from medical stay at [name of hospital]. Res underwent ileostomy reversal . . ." Resident #41's care plan failed to identify the ileostomy reversal. During an interview on 12/11/2025 at 2:45 p.m., an administrative nurse (#1) confirmed staff failed to update resident #41's care plan.	F0657		
F0658 SS = D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is NOT MET as evidenced by: Based on observation, record review, policy review, and staff interview, the facility failed to provide medication in accordance with professional standards for 1 of 1 resident (Resident #31) with a percutaneous endoscopic gastrostomy (PEG) tube (a tube inserted through the skin and abdominal wall directly into the stomach) observed during medication administration. Failure to accurately transcribe provider's orders may result in adverse health effects. Findings include: Review of the facility policy titled, "Physician Orders/Transcribing for New and Re-Admitted Residents" occurred on 12/11/25. This undated policy, stated, ". . . Each medication order must have a route, dose, frequency and related diagnosis. . . . The nurse who received the orders, checks that all of the above have been followed through . . . A second nurse will check all the orders written in the computer to the orders received from the MD [medical doctor] and queue that they are correct."	F0658	F658 Resident #31's morphine order was updated on 12-13-25 to include buccally or per PEG tube as per written order from 12-8-25. All residents with PEG tubes could potentially be affected by this deficient practice. Physician orders/Transcribing for New and Re-admitted Residents policy reviewed and education provided to professional nursing staff regarding accuracy and ensuring orders are transcribed according to how they are written on 1-7-26. The Director of Nursing or designee will be responsible for auditing 3 random resident's physician orders for accuracy. Audits will occur weekly x4 weeks then monthly x2 month, then quarterly x2. The Director of Nursing will report results of monitoring at the quarterly facility quality assurance meeting with on-going frequency and duration to be determined through analysis and review of audit results by the QA committee. Substantial compliance will be achieved by 1-15-26.	01/15/2026

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PARKSIDE LUTHERAN HOME	501 3RD AVE W PO BOX 153, LISBON, North Dakota, 58054

(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
F0658 SS = D	Continued from page 9 Review of Resident #31's medical record occurred on all days of survey and identified a PEG placement. A physician order, dated 12/08/25, included Morphine concentrate (a pain medication), administer buccally (area inside the mouth between the cheek and the gums) or per peg tube for pain or dyspnea. Review of Resident #31's December 2025 medication administration record (MAR) occurred on 12/10/25. The order entered on the MAR, dated 12/08/25, identified the route of administration as buccal and failed to include via PEG tube. Observation on 12/10/25 at 1:30 p.m. showed a nurse (#7) administered morphine through Resident #31's PEG tube. This administration route did not match the transcribed order in the MAR. During an interview on 12/11/25 at 2:45 p.m., an administrative nurse (#1) confirmed staff failed to transcribe the order accurately in the MAR.	F0658		
F0686 SS = D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is NOT MET as evidenced by: Based on record review, review of facility policy, and staff interview, the facility failed to provide the necessary treatment and services for 1 of 1 sampled resident (Resident #2) with a pressure ulcer. Failure to complete weekly assessments with measurements of pressure ulcers per facility policy, may result in new pressure ulcers, the deterioration of existing pressure	F0686	F686 Resident #2's care plan was reviewed on 1-2-26 and updated for current wound treatment/prevention interventions. Order added to TAR for resident #2 on 1-2-26 – weekly wound measurements and documentation. All residents with current skin issues or identified at risk for skin issues could be affected by this deficient practice. Care plans will be reviewed and revised of any residents identified to have current pressure ulcer as needed on or before 1-15-26. Weekly skin audits will be completed and documented on all residents on their bath day by a licensed nurse. A Braden scale for prediction of pressure sore risk assessment will be completed and documented upon admission, readmission or with a significant change weekly x3 and quarterly thereafter. Pressure sores – general policy and skin assessment policy reviewed with all professional nursing staff on 1-7-26. Education provided to all professional nursing staff regarding how to complete a head-to-toe body audit, skin observations, and the skin management	01/15/2026

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F0686 SS = D	Continued from page 10 ulcers, and delay healing. Findings include: Review of the facility policy titled "Documentation of Wound Treatments" occurred on 12/11/25. This undated policy, stated, ". . . Wound assessments are documented upon admission, weekly, and as needed . . . The following elements are documented as part of a complete wound assessment: a. Type of wound . . . Stage of the wound . . . Measurements: height, width, depth . . . Description of wound characteristics . . . Weekly progress towards healing . . ." Review of Resident #2's medical record occurred on all days of survey and identified a Stage 3 pressure ulcer to the right heel. Wound clinic assessments of Resident #2's right heel pressure injury showed the following: * 11/06/25 - 0.4 centimeter (cm) x 0.4 cm * 12/05/25 - 0.8 cm x 1 cm (29 days later) The medical record lacked weekly wound assessments of the right heel pressure ulcer with measurements. During interviews on 12/11/25 at 11:11 a.m. and 2:45 p.m., an administrative nurse (#1) confirmed Resident #2's medical record lacked weekly wound assessments and she expected staff to complete weekly wound assessments per wound treatment policy.	F0686	Continued from page 10 program on 1-7-26. The Director of Nursing or designee will be responsible for auditing 3 random residents noted to have pressure ulcers, skin issues, and/or identified as at risk for pressure ulcers. Audits will occur weekly x4 weeks, monthly x2 months, then quarterly x2. The Director of Nursing will report results of monitoring at the quarterly facility quality assurance meeting with on-going frequency and duration to be determined through analysis and review of audit results by the QA committee. Substantial compliance will be achieved by 1-15-26.	
F0690 SS = D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the	F0690	F690 Resident #31 is no longer a resident, expired 12-14-25. All residents who are incontinent could potentially be affected by this deficient practice. Care plans will be reviewed and revised for residents identified to be incontinent to ensure that they are on a toileting schedule and correct task applied in PCC as needed on or before 1-15-26. Incontinence policy was reviewed with all direct care providers on 1-7-26. Educated on the importance of ensuring residents are clean, dry and free from odor for skin health and dignity.	01/15/2026

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F0690 SS = D	Continued from page 11 resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is NOT MET as evidenced by: Based on observation, record review, policy review, review of a professional reference, and staff interview, the facility failed to provide appropriate toileting for 1 of 2 sampled residents (Resident #31) who required staff assistance with toileting. Failure to provide toileting may result in a loss of dignity and placed the resident at risk for skin breakdown, poor grooming/hygiene, decreased self-esteem, urinary tract infections, and at risk for falls and/or injuries. Findings include: Review of the facility policy titled "Incontinence" occurred on 12/11/25. This undated policy, stated, " . . . Residents that are incontinent of bladder or bowel will receive appropriate treatment to prevent infections and to restore continence to the extent possible." Review of Resident #31's medical record occurred on all days of survey and included a diagnosis of cerebral infarction (stroke) and Alzheimer's disease. The Minimum Data Set (MDS), dated 12/09/25, identified substantial/maximal assistance with toileting, frequently incontinent of urine and occasionally incontinent of bowel. The care plan, dated 11/26/25, stated, ". . . I need assistance with toileting." A nurse's note, dated 12/06/25 at 5:36 a.m., stated, " . . . During toileting cares Resident urine has strong	F0690	Continued from page 11 The Director of Nursing or designee will be responsible for auditing 3 random residents noted to have incontinence for appropriate toileting schedule. Audits will occur weekly x4 weeks, monthly x2 months, then quarterly x2. The Director of Nursing will report results of monitoring at the quarterly facility quality assurance meeting with on-going frequency and duration to be determined through analysis and review of audit results by the QA committee. Substantial compliance will be achieved by 1-15-26.	

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F0690 SS = D	Continued from page 12 odor. . . ." Review of Resident 31's bladder elimination task record, dated November 27 through December 10, 2025, showed a toileting gap of three or more hours each day. November 27, 2025, showed an eight-hour toileting gap from 1:07 p.m. to 9:10 p.m., and December 2, 2025, showed an eight-hour toileting gap from 3:26 p.m. to 11:49 p.m. Observation on all days of survey identified a urine odor in Resident #31's room. Observation on 12/10/25 11:17 a.m. showed a certified nurse aide (CNA) (#2) assisted Resident #31 out of her and to the toilet. Resident #31's pants were visibly wet and smelled of urine and feces. The CNA (#2) removed the soiled pants and brief, completed perineal cares, applied a new incontinence brief and pants, and transferred Resident #31 to the recliner visibly wet from urine. The CNA (#2) failed to provide timely toileting assistance and failed to ensure a clean recliner. During interviews on 12/11/25 at 11:11 a.m. and 2:45 p.m., an administrative nurse (#1) stated she expected staff to assist residents with toileting needs every two to three hours and as needed unless they are independent with toileting, replace the wet recliner while the soiled recliner is cleaned, and at least a place a barrier between the resident and a wet recliner.	F0690		
F0812 SS = E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices.	F0812	F812 The entire Kitchen floor and baseboards will be cleaned with an acid solution on or before 1/10/2026. Immediate action was taken to clean the grate of the ice machine, the grates of the reach in cooler and freezer, the flour and sugar containers as well as the base of the blender and the two beverage carts. The employee food tray was moved immediately to the appropriate location. The bag of shrimp and chicken fried steak were moved to an appropriate location so as they were not touching the ceiling in the walk-in freezer. Replacement Food storage racks for the walk-in cooler will be replaced on or before 1/15/2026.	01/15/2026

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F0812 SS = E	Continued from page 13 (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is NOT MET as evidenced by: Based on observation, review of professional reference, review of facility policy, and staff interview, the facility failed to ensure safe food practices and failed to maintain a clean and sanitary kitchen environment for 1 of 1 kitchen and 2 of 2 freezers on the Cozy Cottage Unit. Failure to properly store food items and maintain a clean and sanitary kitchen, food preparation, and storage areas has the potential for contamination of food and may result in a foodborne illness to residents, visitors, and staff. Findings Include: The 2022 Food and Drug Administration (FDA) Food Code, Chapter 3-16, Section 3-305.11 Food Storage, stated, ". . . FOOD shall be protected from contamination by storing the FOOD: (1) In a clean, dry location; (2) Where it is not exposed to splash, dust, or other contamination . . ." Annex 3 Page 100, stated, ". . . 3-305.12 Food Storage, Prohibited Areas. Pathogens can contaminate and/or grow in food that is not stored properly. Drips of condensate . . . can be sources of microbial contamination for stored food. . ." Chapter 4-6, Section 4-601.11 Equipment, Food-Contact Surfaces, Nonfood-Contact Surfaces, and Utensils, stated, " (A) EQUIPMENT FOOD-CONTACT SURFACES and UTENSILS shall be clean to sight and touch. . . . (C) NonFOOD-CONTACT SURFACES of EQUIPMENT shall be kept free of an accumulation of dust, dirt, FOOD residue, and other debris." Review of the facility policy "Food Storage" occurred on 12/10/25. This policy, revised January 2004, stated, ". . . Staff foods/fluids will not be stored in the kitchen refrigerator/freezer . . ." Observation on 12/08/25 at 11:45 a.m. with a dietary manager (#3) showed an accumulation of food/dirt/grime debris in the following areas in the kitchen;	F0812	Continued from page 13 The walls in the Kitchen that are exposed to food particle splashes will be covered in a Fiberglass reenforced panel or painted by 1/14/2026. This will make them more readily cleanable. The AM and PM cook duties were revised on 1/7/2026 to include cleaning the walls of any splatters, cleaning the blender base and beverage carts Daily. The weekly cleaning list was updated to include checking and cleaning of all storage containers such as the sugar and flour containers as well as weekly cleaning of the grates of the ice machine, reach in cooler and freezer. The Kitchen staff was educated on these changes on 1/8/2026 to take into effect immediately. The facilities "Food Storage" Policy was reviewed on 12/30/25 and the kitchen staff was educated on the policy on 1/8/2026. The food bags under the under the condenser fan in the walk-in freezer were immediately moved to a new location and a pan was placed under the condenser fan. The Condenser lines were immediately cleared of the ice and frost build up as well as the ice particles formed in front of the fan. On or before 1/15/2026 the condenser fan defrost cycle will be adjusted to ensure it runs long enough and frequently enough to eliminate frost build up and ice particles forming. The dietary manager or designee will conduct random audits of the kitchen and its equipment three times per week for the next month to verify cleanliness including the areas of concern listed above. If 100% compliance is achieved the audits will be then conducted weekly for the next six months. The results of the audits will be reported to the Dietary Manager at the facility at the Quarterly Quality Assurance meeting. At the conclusion of six months the QA committee shall determine the frequency of the audits for the next six months dependent upon compliance achievement success.	

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F0812 SS = E	Continued from page 14 * The entire kitchen floor, the tiled baseboards on the wall, the grate of the ice machine, the grate below the front door of the reach-in refrigerator and freezer, and on the large flour and sugar containers. * All kitchen walls contained splashes of food particles with areas of a sticky yellow substance. * The walk-in cooler showed food storage racks had surface material peeling, coated with a dirt/rust or grime substance, and employee food items stored alongside resident food items. * The walk-in freezer showed the condenser line with thick ice and frost built up. Ice droplets formed in front of the ceiling fan and the ice particles, 2-inch-wide by 8-inch-long, dropped onto a package of food under the fan. Observation on 12/08/25 at 1:00 p.m. showed cold packs for resident use stored next to food items in the freezer on Cozy Cottage Unit. Observation of the kitchen on 12/10/25 at 12:34 p.m. with a dietary manager (#3) showed the following: * The base of a blender covered with food particles and a sticky substance. *Two beverage cup carts covered with dirt/debris. * A package of fried steak and a bag of cooked shrimp touched the ceiling in the walk-in freezer. During an interview on 12/10/25 at 12:34 p.m., the administrative dietary manager (#3) confirmed the kitchen needed thorough cleaning and understood the potential for food contamination.	F0812		
F0880 SS = D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.	F0880	F880 Resident #2's record was reviewed and enhanced barrier precautions was deemed necessary on 9-30-25. PPE placed outside of resident room so it is readily available on 9-30-25 for use when providing high-contact care activities along with instructions for when to use. Resident #31 no longer resides in the facility.	01/15/2026

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F0880 SS = D	Continued from page 15 §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents	F0880	Continued from page 15 All residents who are identified as having wounds and/or indwelling medical devices could potentially be affected by this deficient practice. All residents meeting the above criteria have been identified and proper PPE is placed for use in resident's rooms. Enhanced barrier policy reviewed and education provided when PPE is required at direct care staff in-service 1-7-26. Hand hygiene policy reviewed and education provided on proper hand hygiene at the direct care staff in-service on 1-7-26. The Infection Preventionist or designee will be responsible for auditing 2 random residents for proper enhanced barrier precautions in place and staff compliance. Audits will occur weekly x4 weeks, monthly x2 months, then quarterly x2. The infection preventionist will report results of monitoring at the quarterly facility quality assurance meeting with on-going frequency and duration to be determined through analysis and review of audit results by the QA committee. The infection preventionist or designee will be responsible for auditing 4 random CNAs for proper hand hygiene. Audits will occur weekly x4 weeks, monthly x2 months, then quarterly x2. The infection preventionist will report results of monitoring at the quarterly facility quality assurance meeting with on-going frequency and duration to be determined through analysis and review of audit results by the QA committee. Substantial compliance will be achieved by 1-15-26.	

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F0880 SS = D	Continued from page 16 identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is NOT MET as evidenced by: Based on observation, record review, review of facility policy, and staff interview, the facility failed to follow standards of infection control and prevention for 2 of 2 residents (Resident #2 and #31) in enhanced barrier precautions (EBP). Failure to practice infection control standards related to EBP and hand hygiene has the potential to spread infection throughout the facility. Findings include: Review of the facility policy titled "Enhanced Barrier Precautions" occurred on 12/11/25. This policy stated, ". . . Initiation of Enhanced Barrier Precautions: . . . An order for enhanced barrier precautions will be obtained for residents with any of the following: i. Wounds . . . and/or indwelling medical devices . . . Implementation of Enhanced Barrier Precautions: . . . PPE (Personal Protective Equipment) for enhanced barrier precautions is only necessary when performing high-contact care activities . . . High-contact resident care activities include: . . . c. Transferring. d. Providing hygiene. f. Changing briefs or assisting with toileting. g. Device care or use: . . . feeding tubes . . . Enhanced barrier precautions should be used for the duration of the affected resident's stay in the facility or until resolution of the wound or discontinuation of the indwelling medical device that placed them at higher risk." Review of the facility policy titled "Hand Hygiene" occurred on 12/11/25. This policy, dated 10/2009, stated, " . . . situations that require hand hygiene: . . . before and after resident contact . . . before and after handling peripheral vascular catheters and other invasive devices . . . before and after assisting a resident with toileting . . . after removing gloves . .	F0880		

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F0880 SS = D	Continued from page 17 . " - Review of Resident #2's medical record occurred on all days of survey. The physician's orders, dated 10/01/25, stated, "Advanced Barrier Precautions every shift . . ." Observation on 12/08/25 at 2:01 p.m. showed two certified nurse aides (CNAs #5 and #6), performed hand hygiene, applied gloves, and without applying gowns, transferred Resident #2 from the wheelchair to the toilet using a mechanical lift, and assisted with toileting needs. The CNAs failed to apply gowns as per the EBP policy. - Review of Resident #31's medical records occurred on all days of survey. The physician's orders, dated 11/25/25, stated, "Enhanced Barrier Precautions . . ." Observation on 12/10/25 at 11:17 a.m. showed the CNA (#2) applied gloves, and without applying a gown assisted Resident #31 to the toilet. After completing perineal care, the CNA removed the soiled gloves and assisted the resident back to the recliner. Without performing hand hygiene, the CNA applied clean gloves, took garbage and dirty clothing bags down the hallway and placed them in appropriate bins. The CNA (#2) returned to room, removed the soiled gloves and performed hand hygiene. The CNA clipped the call light to the resident's sweatshirt sleeve, plugged the power cord back into the tube feeding device, and exited the room without performing hand hygiene. The CNA (#2) failed to wear a gown as per the EBP policy, failed to perform hand hygiene when removing soiled gloves and before applying clean glove, and before exiting the room. Observation on 12/10/25 at 1:20 p.m. showed a nurse (#7) entered Resident #31's room and administered medication through the percutaneous endoscopic gastrostomy (PEG) tube. The nurse failed to apply a gown as per EBP policy. During an interview on 12/11/25 at 2:45 p.m., an administrative nurse (#1) stated she expected staff to perform hand hygiene, wear gowns and gloves for residents on enhanced barrier precautions during all close contact care and medication administration through a PEG tube.	F0880		