STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245425	A. Building B. Wing	01/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Thorne Crest Retirement Center	1201 Garfield Avenue Albert Lea, MN 56007

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to provide sufficient staffing to ensure residents received care and assistance in a timely manner, when 15 of 47 residents (R3, R5, R7, R13, R15, R17, R22, R24, R25, R28, R34, R36, R39, R43, R47) reviewed for sufficient staffing, experienced excessively long call light wait times, and/or missed breakfast, or experienced a delay in getting to breakfast or delay in receiving care. This deficient practice had the potential to affect all 47 residents who resided in the facility. Findings include: Refer to F676- Based on observation, interview, and document review, the facility failed to provide assistance to complete personal hygiene care for 1 of 1 resident (R3) reviewed who needed assistance with fingernail care. Refer to F677 – Based on observation, interview and document review, the facility failed to provide timely toileting for 1 of 1 resident (R36) who was dependent upon staff for assistance with activities of daily living (ADL). Refer to F684 – Based on observation, interview, and document review, the facility failed to ensure necessary care and services were provided for 1 of 1 resident (R2) reviewed for non-pressure skin concerns, when staff failed to appropriately assess, treat, and manage bilateral lower-extremity wounds. This included failure to timely notify the provider and obtain and implement wound care orders following a change in skin condition, and failure to ensure wound care was provided as needed. These failures resulted in R2 going multiple days without wound care and placed the resident at risk for worsening skin breakdown, infection, and complications related to delayed treatment. Further, the facility failed to complete and monitor daily weights, monitor blood pressures, and administer medications in accordance with provider-prescribed blood pressure parameters and treatment orders for 1 of 1 resident (R2) reviewed for edema. In addition, the facility failed to follow physician orders for obtaining daily weights and applying elastic compression bandages to legs for 1 of 1 resident (R26), reviewed for edema. MDS/Care plan: R3's quarterly Minimum Data Set (MDS) dated [DATE], indicated R3 was cognitively intact, no rejection of care, utilized a wheelchair, required substantial/maximal assistance with personal hygiene, upper body dressing, dependent on staff for toileting hygiene and transfers; diagnoses included hemiplegia or hemiparesis, depression, dependence on renal dialysis. (continued on next page)

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 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

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	R3's care plan dated 1/2/26, mobility needs assist with transfers and bed mobility due immobility related to right side hemiparesis, chronic renal disease, severe malnutrition, and mild cognitive impairment unable to ambulate. R5's quarterly MDS assessment dated [DATE], indicated moderately impaired cognition, clear speech, could understand and be understood. R5 required substantial assistance or was dependent upon staff for most activities of daily living (ADLs), including wheelchair mobility. R5 did not walk. R7's quarterly MDS dated [DATE], indicated no cognitive impairment, utilized a wheelchair, independent with eating, dependent on staff for toileting, dressing, personal hygiene, and transfers. R13's admission MDS dated [DATE], indicated intact cognition, use of wheelchair, partial/moderate assistance with personal hygiene, dependent for toileting hygiene and lower body dressing. R15 quarterly MDS dated [DATE], indicated cognitively intact, utilized a wheelchair, supervision or touching assistance with eating, dependent on staff for toileting, dressing, toilet transfer, and chair/bed-to-chair transfer. R15's care plan dated 12/10/25, at risk for injury related to history of falls, poor balance, unsteady gait d/t (due to) decline in physical function, provide 2 assist transfer at night d/t increased weakness I need assist with ambulation, transfers, and bed mobility due to weakness and cognitive impairment, able to feed myself independently, following staff setup, need cues from staff at times for eating, staff to provide setup assist with feeding, set up tray; pour liquids, cut foods, and apply condiments with each meal, eating: sit at feeder table, supervision and cuing, bring to dining room, staff to sit with resident and provide cueing and assistance as needed. R15's nutrition - amount eaten- document amount ate for all meals dated 1/26/26, failed to indicate R15 ate breakfast. R17's quarterly MDS dated [DATE], indicated severe cognitive impairment, utilized a wheelchair, required supervision or touching assistance with eating, substantial/maximal assistance with transfers. R17's care plan dated 12/29/25, nutritional status at risk for wt (weight) loss due to poor PO (oral) intake, limited to extensive assistance with feeding at all meals, staff to provide total assistance with eating and drinking food and fluids at meals toilet hygiene, toilet every 2-3 hours assist onto toilet upon rising, before/after meals and before bedtime mobility: need assist with ambulation, transfers, and bed mobility due to dementia and weakness. R17's nutrition - amount eaten- document amount ate for all meals dated 1/26/26, failed to indicate R17 ate breakfast. R22's annual MDS dated [DATE], indicated moderately impaired cognition. R24's annual MDS dated [DATE], indicated R24 was cognitively intact, no behaviors, no rejection of care, utilized a walker and wheelchair, required partial/moderate assistance with toileting hygiene, personal hygiene, dressing, toilet transfer, chair to bed transfer, independent with sit to lying and rolling. R24's care plan dated 1/2/26, indicated mobility: minimal assist with transfers and bed mobility (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	due impaired mobility related to Rheumatoid Arthritis, will self-transfer a lot of times without asking for assistance. R25's quarterly MDS dated [DATE], indicated no cognitive impairment, utilized a wheelchair, independent with eating, dependent on staff for toileting, dressing, and transfers. R25's care plan dated 12/19/25, indicated mobility: assist with transfers and bed mobility due limited mobility provide assistance with bed mobility as necessary chair / bed-to-chair transfer- dependent with hoyer lift (mechanical equipment) and 2 assist, every 2-3 hours in chair and in bed. R28's quarterly MDS dated [DATE], indicated R28 had severe cognitive impairment, utilized a wheelchair and walker, independent with eating, required partial/moderate assistance with lying to sitting, sit to stand. R28's care plan dated 11/24/25, falls: at risk for injury due to weakness, poor safety awareness related to cognitive impairment and a history of falls, will self-transfer without waiting for staff assistance. falls intervention: keep w/w (wheeled walker) within reach at all times as patient will self-transfer, ambulate and toilet regardless of if w/w is in reach, evening shift to check at end of shift mobility, need assist with ambulation, transfers, and bed mobility due weakness, tend to self transfer myself without putting on call light d/t (due to) cognitive impairment, eating: independent after set-up R34's quarterly MDS dated [DATE], indicated R34 was rarely/never understood, utilized a wheelchair, required setup or clean-up assistance with eating, substantial/maximal assistance with toileting, dressing, and transfers. R34's care plan dated 12/29/25, dietary dx (diagnosis) w/Parkinson's disease, with altered mental status and dementia.currently eating adequately but am at risk for wt loss as I decline; staff to provide setup assist with feeding, provide verbal cues, set up tray; pour liquids, cut foods, and apply condiments with each meal, encourage consumption of meals and assist as needed. R36's significant change MDS dated [DATE], indicated severe cognitive impairment, clear speech, rarely/never understood, usually understands. R36 was dependent upon staff for activities of daily living (ADLs) or required substantial assistance, did not walk. R36's care plan with revised date of 10/21/25, indicated R36 was incontinent of bladder and bowel and required assistance with toileting due to Alzheimer's disease, put on the toilet at these time frames: 5:00 a.m., upon rising, before/after meals, and HS (bedtime). R36's nutrition - amount eaten- document amount ate for all meals dated 1/26/26, failed to indicate R36 ate breakfast. R39's annual MDS dated [DATE], indicated severe cognitive impairment, utilized a wheelchair, supervision or touching assistance with eating, dependent on toileting, activities of daily living, sit to stand transfers, toilet transfers, and bed to chair transfer. R39's care plan dated 10/22/25, indicated am incontinent of bowel and bladder. need assistance with toileting tasks due to impaired cognition staff assist per mobility care plan for resident to transfer to the toilet, check and change every (2-3 hours)- document refusals. mobility: need assist with (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	transfers and bed mobility due weakness, immobility, and impaired cognition, unable to ambulate anymore, too weak to wheel myself in a regular wheelchair, chair / bed-to-chair transfer: dependent assist of two staff with use of EZ stand, use total lift if tired/weak. R39's nutrition - amount eaten- document amount ate for all meals dated 1/26/26, failed to indicate R39 ate breakfast. R43's quarterly MDS dated [DATE], indicated moderately impaired cognition, utilized a wheelchair, required supervision or touching assistance with eating, dependent on transfers, and substantial/maximal assistance with personal hygiene. R47's admission MDS assessment dated [DATE], indicated moderately impaired cognition, use of wheelchair, lower extremity impairment on one side, dependent for toileting hygiene, upper and lower body dressing, and substantial/maximal assistance for personal hygiene. Resident and Family Observations and Interviews: On 1/20/26 at 12:53 p.m., with R5 and family member (FM)-F, stated R5 used his call light to get in and out of bed; he required use of a lift, and it took two staff. FM-F stated sometimes it took over an hour for staff to respond and sometimes they would come into R5's room and shut the light off saying they would be back, but don't come back. FM-F stated, Everyone in here, meaning family members, complained about how long it took for staff to answer call lights, adding they were short staffed, and it was worse around mealtimes. FM-F stated, you don't want to use the call light at shift change in the afternoon as it took an especially long time. On 1/20/26 at 1:02 p.m., R3 was observed lying in bed and stated he required two staff to transfer from his wheelchair to bed. R3 stated that after breakfast he waited approximately two hours by the dining room door to be assisted back to his room. R3 reported he asked for help and observed two or three women walk by, but staff did not return with the required two-person assistance. R3 stated this situation happens every day. R3 further stated he did not attend lunch because it takes too long to get back to my room after lunch, and indicated prolonged wait times contributed to his decision not to attend lunch. On 1/20/26 at 2:03 p.m., R7 stated he waits almost daily for 30 or more minutes for assistance to get out of bed to use the bathroom and reported delays were worse around mealtimes. R7 stated there had been no management follow through regarding his concerns and reported weekends were worse due to agency staff unfamiliar with resident routines and equipment. R7 stated he had brought concerns to social services (SS)-A but reported no follow through. On 1/20/26 at 2:23 p.m., R13 stated she had to wait a long time for help from staff and sometimes had to have a bowel movement and did not make it in time because staff took too long. R13 further stated some days she did not go down to the dining room to eat because there were not enough staff to bring her back to her room so she would have to wait over an hour to get back to her room after meals. On 1/20/26 at 2:49 p.m., R47 stated it took a long time for staff to come when he turned his call light on. R47 stated he had to have a bowel movement in his brief while in bed because they did not come in time and he did not like having accidents in his brief. R47 further stated he had got used to telling the staff they better come quickly or they were going to be cleaning up a mess. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 1/20/26 at 7:49 p.m., the director of nursing (DON) was observed assisting R34 into his room via wheelchair and confirmed evening cares were delayed. The DON stated R34 typically went to bed at 7:00 p.m. On 1/26/26 at 11:03 a.m., R15 was observed seated in a wheelchair in the day room and stated she was hungry. LPN-A asked whether she wanted breakfast or preferred to wait for lunch since it was almost lunchtime. R15 stated she had not eaten breakfast and would wait for lunch. LPN-A stated R28 had just come to the day room and had not eaten breakfast and had gotten up late due to staffing shortages. Staff Interviews: During an interview on 1/20/26 at 7:28 p.m., LPN-A stated the facility had staffing issues and stated, we just don't have enough staff. LPN-A reported there were not enough nursing staff or nursing assistants (NAs) to meet resident needs including toileting, timely morning and bedtime cares, and answering call lights. LPN-A stated the facility was expected to have six NAs on the evening shift; however, only four NAs were present. LPN-A stated with only four NAs, residents were not assisted timely. LPN-A reported a resident fall earlier that day due to insufficient staff and stated falls had increased due to inadequate staffing and increased use of agency staff unfamiliar with residents' needs. LPN-A confirmed residents were not toileted timely and toileting schedules were not consistently followed unless residents requested assistance or exhibited behaviors. During an interview on 1/21/26 at 8:40 a.m., nursing assistant (NA)-H (agency) stated it was a good place to work but changes could be made. NA-H stated residents got left in bed for long periods, there should be more staff, so much going on, frequently need two NAs in a room and that makes other residents wait. HA-H stated there were a lot of call-in's – both employed staff and agency staff. NA-H stated she left work in tears the day prior because she had 11 residents by herself and six were two-person assists or mechanical lifts. NA-H stated the facility no longer provided walkie-talkies in order to communicate and had spent up to 15 minutes looking for another NA to help her. HA-H stated it was not uncommon for residents to miss breakfast because there was no one to get them up. By the time they did get up, it was almost lunchtime. On the night shift, NAs were supposed to reposition and check/change residents every two hours. NA-H stated there were only two NAs to do that and staff were lucky if they got two or three residents done, adding there were lot of residents with soaked beds in the morning. NA-H stated the evening shift NA's put residents to bed after supper and wasn't sure how often they were checked on. When the night shift came on duty and started rounds, they immediately had to change residents and soiled bedding. The day prior, NA-H asked registered nurse (RN)-A for help and her reply was, I don't understand what's going on – it's like that every day. NA-H took that to mean, what's the big deal – it's like this every day. NA-H stated employed staff were told by the director of nursing (DON) that other facilities of a similar size had the same amount of staffing, so we had nothing to complain about. NA-H stated she doubted the number of residents who were two-person assist had been included in the comparisons. During an interview on 01/21/26 at 11:28 a.m., NA-M stated the facility was expected to have six NAs on day shift but usually only had four or five due to call-ins that were not filled. NA-M stated with only four NAs, resident care was delayed, including answering call lights, toileting residents, and providing meals timely. During an interview on 1/21/26 at 12:57 p.m., registered nurse (RN)-B stated the facility was frequently short staffed and reported there were too many tasks assigned to nursing staff to provide (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	adequate resident care. RN-B stated nursing staff were responsible for medication administration, treatments, documentation, processing and entering physician orders, admissions, and responding to incidents, in addition to providing direct resident care. RN-B stated due to the volume of assigned duties and limited staffing, nursing staff were not always able to provide care in a timely manner. RN-B stated tasks were prioritized, which resulted in delays in treatments, answering call lights, and assisting residents with toileting and other care needs. RN-B indicated the current staffing levels and workload made it difficult to meet residents' needs consistently and adequately. During an interview on 1/21/26, at 1:30 p.m., health unit coordinator (HUC)-E, who was also the nursing staff scheduler, described her role in scheduling nursing staff and the process in completing schedules, filling open shifts, managing call-ins. HUC-E stated there had been a lot of call-ins by both employed and agency NAs. HUC-E stated while the facility had been gradually hiring more nurses and NAs, agency use was still high. HUC-E stated with each call in, they attempted to fill the shift with employed or agency NAs During an interview on 1/21/26 at 3:13 p.m., RN-C stated nursing staff were responsible for medication administration, treatments, paperwork, order entry, and admissions. RN-C stated staff did not always have time to provide timely treatments due to administrative workload. RN-C stated there were increased falls due to staff not being able to answer call lights timely or round regularly. During an interview on 1/21/26 at 1:46 p.m., the assistant director of nursing (ADON) stated floor nursing staff were responsible for medication administration, treatments, entering and processing orders, admissions, and managing incidents. The ADON stated due to workload demands, delays in care and untimely processing of orders were not uncommon. The ADON stated resident cares were rushed and nursing staff did not have dedicated time to process orders. The ADON reported nursing staff had brought concerns to leadership regarding inability to complete assigned tasks; however, there had been no change. The ADON stated a previous desk nurse position that assisted with order entry had been eliminated. The ADON further stated agency staff frequently worked in the facility and were not always familiar with resident routines, contributing to delays in care. During interview on 1/21/26 at 3:13 p.m., RN-C stated nursing staff were responsible for medication administration, treatments, paperwork, order entry, and admissions. RN-C stated staff did not always have time to provide timely treatments due to administrative workload. RN-C stated there were increased falls due to staff not being able to answer call lights timely or round regularly. During further interview on 1/21/26 at 4:15 p.m., with ADON stated after hours when the facility receptionist was off duty, the caller would be prompted to make a selection. If the caller selected the health care wing, the call went to the nurse's station. If no one answered, the caller could leave a message. ADON nurses were responsible to answer the phone if able but usually did not have time. Together with ADON looked to see how many voicemail messages were on the phone at the nurse's station. There had been 61 messages. RN-A stated nurses did not have time to listen to messages and return calls, and agency nurses would not know how. ADON had been unaware of the number of messages on the phone and didn't know how far back they went. ADON admitted many of the calls were likely from family requesting an update on their family member. During interview on 1/21/26 at 4:55 p.m., LPN-A stated evening cares were delayed due to staff shortages and lack of staff familiar with resident routines. LPN-A stated there were more falls in the morning due to staffing shortages and agency staff not familiar with residents, resulting in residents attempting to self-transfer due to delayed rounding. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During interview on 1/26/26 at 10:46 a.m., NA-F and NA-E stated they had not gotten R36 up yet for the day nor did he have breakfast. NA-F stated an agency NA called in so they were working short. Both NA-F and NA-E explained most of their residents required two staff assist. Between them, they had 10 residents requiring two NAs to get them up, dressed and to breakfast which took could take up to an hour. Both NA-F and NA-E stated it was not uncommon for residents to be gotten up late and miss breakfast – they could only do so much. NA-F stated when they had brought up the difficulty in getting their work done timely, the DON told them she had called other nursing homes, and no one was staffed better and that they were appropriately staffed. During interview on 1/26/26 at 10:58 a.m., HUC-E, who also served as the scheduler, stated she became aware of a staff shortage at 6:30 a.m. and reported six NAs were scheduled; however, only three were present until approximately 7:30 a.m. The HUC confirmed the facility was short staffed that morning. During interview on 1/26/26 at 10:54 a.m., NA-E stated residents were not provided breakfast on time and reported some residents had not yet eaten due to short staffing. NA-E stated all residents would have been expected to have eaten breakfast by that time. During interview on 1/26/26 at 1:00 p.m., NA-F confirmed the following residents did not receive breakfast: R17, R39, R43, R15, and R36. NA-F reported delays in breakfast service and stated R24 ate at 9:30 a.m., and R28, R25, and R34 ate at 10:00 a.m. During interview on 1/26/26 at 2:35 p.m., RN-K stated they were an agency staff who worked consistently at the facility, and stated they mainly worked the overnight shift and would frequently pick up and work a double shift during the day due to the shortage of staff. RN-K stated on overnights there was only one nurse for 48 residents and stated one nurse was not enough staff especially since they were agency staff and not familiar with the routines of the facility. RN-K stated the overnight nurse was responsible for medication administration, processing orders, stocking medications in the cart and further stated the facility had frequent falls and incident reports and stated one nurse on overnights was not enough staff to provide adequate resident care. Resident Council: During resident council interview on 1/21/26 at 2:13 p.m., R25 stated she had to wait one to two hours for her light to be answered sometimes. R7 stated he had to wait up to one hour, there was so much turnover of staff and the staff did not know the resident routines, so everything took longer. R22 stated a lot of agency staff was used and there were always new faces who did not know the routine. Call Light Response Times : Call light logs were requested for residents/resident representatives who reported long call light wait times. Logs indicated many instances of call light response times ranging from 20 minutes to over an hour. R25 Time frame 12/22/25 through 1/20/26. Call light activated 110 times, which indicated the following: (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	20-30 minutes = 9 x 31-40 minutes = 15 x 41-50 minutes = 1 x R13 Time frame 12/22/25 through 1/20/26. Call light activated 87 times, which indicated the following: 20-30 minutes = 9 x 31-40 minutes = 2 x 41-50 minutes = 2 x >60 minutes = 2 x R47 Time frame 1/9/26 through 1/20/26. Call light activated 90 times, which indicated the following: 20-30 minutes = 3 x 31-40 minutes = 9 x 41-50 minutes = 1 x >60 minutes = 1 x R7 Time frame 12/22/25 through 1/20/26. Call light activated 917 times, which indicated the following: 20-30 minutes = 72 x 31-40 minutes = 28 x 41-50 = minutes = 7 x 51-60 minutes = 3 x > 60 minutes = 5 x R5 Time frame 12/22/25 through 1/20/26. Call light activated 370 times, which indicated the following: (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	20-30 minutes = 28 x 31-40 minutes = 12 x 41-50 minutes = 10 x > 60 minutes = 5 (all were over 75 minutes) R3 Time frame 1/5/26 through 1/20/26. Call light activated 416 times, which indicated the following: 20-30 minutes = 21 x 31-40 minutes = 5 x 41-50 minutes = 3 x 51-60 minutes = 2 x > 60 minutes = 2 x Facility Assessment: Facility assessment updated 7/2025, indicated: Acuity - We have multiple mechanical lifts and multiple people with behavior issues and heavy load of hospice care. The assessment indicated 37 residents were dependent upon staff for ADLs (activities of daily living), and 10 were on hospice. Staffing parameters were an estimated range used for staffing consideration; individual extenuating circumstances e.g. needing one on one and would be reviewed and determined how to add additional staff. Staffing continued to be a challenge. The facility utilized an agency to help provide care and to prevent staff burn-out. Bonuses were used to attract new staff. Local recruitment fairs were attended by staff to promote the facility to possible new hires. Facility was engaged with ProCare to help with recruitment. The facility assessment identified a section titled Orientation which included 36 topics to be covered for all nurses and NAs. During an interview on 1/22/26 at 10:40 a.m. the DON and RN-D known as regional director of clinical services were informed of findings related to sufficient staffing and long call light response times. The DON stated the facility was appropriately staffed with nurses and NAs; she had called other facilities and their staffing was comparable. The DON stated the facility staffed according to PPD (per patient day) and did not adjust for the number of two-staff assists. The DON was informed that according to NAs on duty, 50% of their residents required a two-staff assist. In addition, the DON was informed the facility assessment updated July 2025, indicated, We have multiple mechanical lifts and multiple people with behavior issues and heavy load of hospice care. The DON acknowledged that was true. The DON was informed of observations including facility layout (significant distance staff were required to cover), no hand-held devices for staff to communicate when help was needed, and the number of two-staff assists made it a challenge for staff to complete their work timely. Further, the DON was informed of the long call light response times that were identified with review of call light logs. The DON was unaware of the call light response times, and stated their goal was to answer call lights in under five minutes. The DON stated call light response times were discussed at staff (continued on next page)

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	245425	A. Building B. Wing	01/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Thorne Crest Retirement Center	1201 Garfield Avenue Albert Lea, MN 56007

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	huddles and monthly meetings; the DON stated staff were reminded that everyone was to work as a team. If long call lights were identified, the DON stated they looked at what else was going on that day – maybe there was a reason. Requested in writing of the DON on 1/27/26, at 3:55 p.m., and not received: facility staffing plan, including now the number of NAs and nurses were determined for each shift. Facility Call Lights: Accessibility and Timely Response policy with copyright date 2025, indicated all staff members who saw or heard an activated call light were responsible for responding. If the staff member could not provide what the resident desired, the appropriate personnel would be notified.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to ensure 6 of 6 agency staff (nursing assistant (NA)-B, NA-C, NA-D, NA-G and registered nurse (RN)-G, RN-I) and 4 of 4 facility staff (NA-E, NA-J, RN-B, RN-J) received appropriate orientation and training prior to starting their first shift caring for residents. This had the potential to affect all 47 residents who resided in the facility.Findings include: Refer to F760: Based on observation, interview and document review, the facility failed to ensure medications were administered in accordance with prescriber orders when an incorrect dose of losartan (blood pressure medication) was administered incorrectly for three months, constituting a significant medication error for 1 of 5 residents (R44) reviewed for medication administration. Refer to F684: Based on observation, interview and document review, the facility failed to complete and monitor daily weights, monitor blood pressures, and administer medications in accordance with provider-prescribed blood pressure parameters and treatment orders for 1 of 1 resident (R2) reviewed for edema. In addition, the facility failed to follow physician orders for obtaining daily weights and applying elastic compression bandages to legs for 1 of 1 resident (R26), reviewed for edema. Refer to F698: Based on observation, interview, and document, the facility failed to ensure dialysis communication forms were consistently reviewed, addressed, and incorporated into the resident's medical record, and failed to ensure provider orders communicated by the dialysis provider were implemented in a timely manner for 1 of 1 resident (R3) reviewed for dialysis. Orientation Documentation: During an interview on 1/21/26 at 1:30 p.m., health unit coordinator (HUC)-E, who also helped facilitate staff orientation, stated floor staff trained new employees, both hired and agency staff; there wasn't a designated educator. HUC-E stated NAs received five shifts of orientation and nurses received seven shifts. For agency staff, HUC-E stated orientation was guided by an orientation binder at the nurses' desk, and a document titled Agency Staff Orientation Checklist/CNA. Upon review of the NA checklist, the only reference to resident cares included: use of transfer belt/lifts/oxygen, call lights, door codes, walkie talkie, restorative nursing program, vital sign monitor, reporting event to nurses, POC (point of care) charting, mealtime/feeding/water. Nothing regarding how to determine the unique and individualized needs of residents. During an interview on 1/22/26 at 10:04 a.m., with HUC-E, documentation of orientation was requested for the following agency staff and none were available: NA-B, NA-C, NA-D and NA-G, RN-G or RN-I. Personnel files revealed the following employed NAs did not have documentation of orientation: NA-E (hired 6/10/25), and NA-J (hired 9/12/25). The following employed nurses did not have documentation of orientation: RN-J (hired 9/12/25), and RN-B (hired 11/13/25). Resident Interview: R7's quarterly MDS dated [DATE], indicated no cognitive impairment, utilized a wheelchair, independent with eating, dependent on staff for toileting, dressing, personal hygiene, and transfers. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 1/20/26 at 2:03 p.m., R7 stated the facility frequently had agency staff who were not familiar with the facility routines and equipment. R7 stated he had brought concerns to social services (SS)-A but reported no follow through. Staff Interview: During an interview on 1/21/26 at 12:26 p.m., NA-G (agency) stated this was his first day; he arrived 45 minutes early and was shown around by another NA. NA-G received an assignment and was informed how his residents transferred. NA-G stated if he had questions, he would ask staff or residents. NA-G stated he had not been given a document such as a checklist to guide his orientation to ensure necessary topics were covered. During an interview on 1/21/26 at 1:46 p.m., the assistant director of nursing (ADON) stated agency staff frequently worked at the facility and may not be familiar with resident care routines. The ADON stated agency staff were expected to arrive 30 minutes prior to the start of their shift. The orientation process consisted of reviewing a training binder and receiving a list of assigned tasks. The ADON confirmed there was no formal, leadership-directed orientation program or competency-based validation process for agency staff. During an interview on 1/21/26 at 3:13 p.m., registered nurse (RN)-C stated the facility utilized a significant number of agency staff and that it was common for agency personnel to be unfamiliar with resident routines. RN-C confirmed agency staff were not provided with formal training. During an interview on 1/21/26 at 3:50 p.m., when shown the agency orientation binder referenced by HUC-E, NA-D (agency) stated she had never seen the binder before, nor had she completed an orientation checklist when she started on 11/29/25. During an interview on 1/21/26 at 4:55 p.m., licensed practical nurse (LPN)-A stated the facility frequently had more agency nursing assistants than employed staff. LPN-A reported agency staff were not familiar with residents' routines and were not provided formal orientation or training to ensure adequate resident care. During an interview on 1/22/26 at 10:40 a.m. the DON and RN-D know as regional director of clinical services informed of findings related nurse and NA competency, specifically the lack of a comprehensive orientation program for agency nurses and NAs, and some employed nurses and NAs. The facility lacked documentation of orientation to ensure relevant and essential topics were addressed. The DON stated they did not have a consistent person to provide orientation and training to staff. Both the DON and RDCS recognized there was a gap in training and admitted they did not have a comprehensive training process. The DON confirmed the facility utilized a significant number of agency nurses and NAs, and stated, Agency staff were not vested and lacked follow through. The DON stated agency staff came 30 minutes prior to start of shift and staff had them review the agency bible, which the DON described as a very large book which took a lot of time to put together, and which had policies and procedures in it. The DON stated agency staff were supposed to review the binder and ask floor staff if they had questions. The DON stated NAs could review paper copies of the Kardex located in a binder at the nurses station to learn individualized needs of residents. The DON was informed the binder did not have a Kardex for R26, and R36's was from November 2025, and had not been updated with interventions after a recent fall. The DON stated NAs could use their iPad to access resident information, but admitted each NA did not had one, nor did they fit in a pocket for ready access. The DON stated the facility did not utilize paper NA task sheets in order for NAs to have key information about (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	residents at their fingertips. The DON admitted agency and employed NAs did not have tools immediately available to them know about a residents unique and individualized needs. Staff meeting agenda provided by the DON for nurses dated 10/17/25, indicated five nurses in attendance and topic titled, training agency staff indicated: book at desk and then need to be escorted to see where things are and given codes needed. We need to be nice (they are helping us). During an interview on 1/22/26 at 4:10 p.m., NA-J (employed) who had been on orientation and following an agency NA stated she had not been given nor was she utilizing a tool to identify training areas to be covered, such as a checklist. NA-J stated she was on her fourth or fifth orientation shift and was still primarily observing. During an interview on 1/26/26 at 9:03 a.m., RN-B stated they had never received formal training or a competency checklist. RN-B stated that implementation of a formal training process would be helpful to ensure adequate care was provided to residents. During an interview on 1/26/26 at 11:53 a.m., HUC-E stated a nurse on duty was assigned to orientate a nurse and a NA to orientate a NA. When asked if nurses had time to take on this additional responsibility, HUC-E stated staff nurses were relied upon because leadership wasn't in the building from 5:00 p.m. until 8:00 a.m. If nursing staff wasn't compliant in providing orientation they were coached and if it continued, the nurse would get a verbal warning. During the same interview, HUC-E stated staff knew what to go over when orienting agency staff by using the orientation checklist and orientation binder at the nurses station. Together, went to the nurses station to view binder and checklist. HUC-E provided a binder titled, Agency Staff Orientation. The pages included abuse policy, unexplained injuries policy, resident rights, abuse, neglect, mistreatment, theft/misappropriation, PCC (Point Click Care - the facility electronic medical record) documentation, infection control topics, mandated reporting, assignments, HIPAA (Health Insurance Portability and Accountability Act), confidentiality and more. There were blank orientation checklists for NAs inside the binder, but none for nurses. HUC-E provided another binder titled Nursing Helper Binder which was utilized as a quick reference for all nurses (employed and agency) and included documentation guidelines, after hours call coverage, fall reporting, suspected infections, postmortem checklist, psychotic meds, skin issue to do list, bowel and bladder three-day tracking, wandering/elopement and more. HUC-E acknowledged their orientation program could be better, and that a new human resources director started in November 2025, and had planned to improve the orientation process. HUC-E admitted if nurses and NAs were not properly trained, it could pose a safety risk to residents. During an interview on 1/27/26 at 7:45 a.m., RN-E (employed) stated if agency nurses came early, they could provide some training such as care plans, and individual needs of the residents, but they did not come earlier enough to do much training. RN-E stated residents would benefit from that training. RN-E stated there was a binder at the nurses' desk agency nurses were supposed to go through, but Honestly, they don't – there isn't time. RN-E stated she had never seen an orientation checklist for agency nurses, but she had for hired nurses. Requested in writing of the DON on 1/27/26, at 3:55 p.m., the facility policy on orientation and training of nurses and NAs, employed and agency. Not received.