STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435115	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PALISADE HEALTHCARE CENTER	**920 4TH ST , GARRETSON, South Dakota, 57030**

(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 A complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 4/14/26 through 4/16/26. Areas surveyed included the quality of care and neglect of residents. Palisade Healthcare Center was found not in compliance with the following requirements: F600, F880, and F919.	F0000		
F0600 SS = SQC-H	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 the South Dakota Department of Health (SD DOH) facility-reported incident (FRI), record review, document review, observation, interview, and policy review, the provider failed to protect the resident's right to be free from neglect for three of three sampled residents (1, 2, and 3) whose incontinence (involuntary urine or bowel leakage) products were not changed timely and the residents were not repositioned per leadership expectations by three of three CNAs (C, E, and P), for one of one sampled resident (4) who reported an unidentified staff member did not change resident 4 for a long period of time and he developed skin irritation and	F0600	1. Resident (1,2,3,4,5) were assessed by a licensed nurse to ensure incontinent products were not heavily wet or soiled and no new skin issues were found. Resident (1,2,3,4,5) careplans were reviewed and updated to accurately reflect repositioning frequency, incontinent care needs, and skin integrity interventions. SDDOH FRI for resident (1) and resident (3) were submitted and accepted. CNA (P) and CNA(Q) are no longer employed. Physicians and responsible parties were notified for residents (1,2,3,4,5) regarding above care needs and skin concerns. 2. Residents with pressure ulcers, high risk Braden scores, incontinent episodes, or extensive assist needs have been reviewed for appropriate interventions and documentation to include care plans and resident assignment sheets. 3. Implementation of an individualized turning/ repositioning/incontinence care documentation sheet, staff education and audits of practice and adjusting staffing levels will help to ensure that the deficient practice will not reoccur. All staff will be educated by DON/Administrator/ Designee on roles/responsibilities and assigned tasks regarding abuse and neglect prevention, call light response time/expectation, and repositioning and incontinent care. All nursing staff will be educated by DON/designee on proper resident handling, documentation expectations, wound care scope of practice, peri-care and phone usage policy.	5/6/2026

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F0600 SS = SQC-H	Continued from page 1 open sores to his perineal area, from abuse for one of one sampled resident (3) whose perineal area (genital area) was cleaned roughly by one of one certified nursing assistant (CNA) (Q) and developed an open sore, from neglect for two of two sampled residents (1 and 5) who requested staff to assist them with care and they did not, and for one of one anonymous resident (15) who reported she was not changed when requested during the night shift by one of one CNA (H). Findings include: 1. Review of the provider's 2/1/26 SD DOH FRI report revealed that during the night shift on 2/1/26, resident 1 reported that CNA P refused to give her a pillow and a blanket, was rude to her when she asked to be repositioned, and CNA P was on the phone talking in a different language while providing her care. Resident 1 reported to the staff that CNA P was afraid of CNA P because she was unsure when CNA P might lose her temper. Resident 1 reported feeling comfortable with the other staff. The report indicated that on 2/1/26, resident 2 reported that night shift staff, CNA P, did not change her incontinence product overnight, and she did not have her call light device to alert the staff that she needed assistance. She reported to the staff that she was not afraid that night and felt comfortable with the other staff. The provider's final investigation stated that they interviewed other residents who resided down the same hallway, and no other residents had concerns and felt safe at the nursing home. They interviewed a staff member, and he reported that CNA P was sleeping while at work on either 1/31/26 or 2/1/26. The facility terminated CNA P's employment. 2. Review of resident 1's electronic medical record (EMR) revealed she admitted to the facility on 9/23/25. Her 2/12/26 Brief Interview for Mental Status (BIMS) assessment score was 15, which indicated her cognition was intact. Her 2/10/26 Braden scale (a tool used to assess the risk of developing pressure ulcers) assessment score was 12, which indicated she had a high risk for developing pressure ulcers. She had diagnoses including type two diabetes (a	F0600	The standardized turning/repositioning/ incontinence documentation sheet will be implemented for all residents requiring routine repositioning and extensive assistance with care and educated by DON/Adminstrator/Designee. All education will occur by 5/6/2026. Those not in attendance due to illness, vacation, or casual work status will be educated upon return to work during their next scheduled shift. Staffing levels reviewed and adjusted to add one CNA position on West Hall from 6:00am-6:30pm contingent upon agency availability or staff hiring. 4. DON/Administrator/Designee will review turning/repositioning/incontinence documentation sheets for 3x a week for 2 weeks, 1x a week for 4 weeks, 1x per month for 2 months. Peri-care observations will be completed by DON/designee for 5 random residents 3x a week for 2 weeks, 1x per week for 4 weeks, 1x per month for 2 months to ensure peri-care is completed appropriately, to validate that wound care is not being provided by CNA staff, and to ensure care being provided is free from abuse and aggressiveness. Turning/Repositioning/Incontinence observation audits will be completed by DON/ designee for 5 random residents 3x a week for 2 weeks, 1x a week for 4 weeks, 1x per month for 2 months to ensure care is being provided appropriately and free from abuse and aggressiveness. Timeliness of call light response time reflected in F919 POC. Results of this audit will be discussed by DON/ Administrator/Designee at the monthly QAPI meeting with IDT and medical director for analysis and recommendations for continuation, discontinuation or revision of audits based on findings. 5. Date of compliance 5/6/2026	

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F0600 SS = SQC-H	Continued from page 2 condition involving disruptions in how the body regulates blood sugar), spinal stenosis (narrowing of the spaces in the spine, putting pressure on the nerves and spinal cord), pain, muscle weakness, morbid obesity (excessive weight that significantly impacts health and well being), major depressive disorder (a mood disorder characterized by persistent feeling of sadness, emptiness, or loss of interest in activities that lasts for at least two weeks), and conversion disorder with motor symptoms or deficit (involuntary, distressing motor issues such as paralysis, weakness, tremor, gait problems that are incompatible with known neurological diseases). She had physician's orders on 12/14/25 for Furosemide (a diuretic), 8/25/25 for Spironolactone (a diuretic), and 10/7/25 for Duloxetine (for depression). Her 2/2/26 care plan indicated she required staff assistance with her care due to activity intolerance and weakness. She required one to two staff members to move her in bed and one staff member for her personal hygiene needs. Her care plan indicated her skin was at risk for impairment, and she was to have her heels propped on pillows, a pressure-reducing mattress, a wheelchair pressure-reducing cushion, use of a total body lift (a mechanical lift and sling used to lift a person's full body) for transfers between surfaces, and required two staff members for transfers. She had a history of having a pressure ulcer on her bottom. The staff were to follow facility policies and protocols for the prevention and treatment of skin breakdown and to reposition her frequently while she was resting. With each incontinence episode, she was to have her perineal area cleaned and a barrier cream (an ointment that protects skin from urine and feces) applied. The CNA urinary incontinence documentation from 3/30/26 to 4/13/26 revealed that she was incontinent of urine. Her incontinent product was documented as changed three times on 3/30/26, once on 3/31/26, twice on 4/1/26, three times on 4/2/26, twice on 4/3/26, once on 4/4/26, twice on 4/5/26, twice on 4/6/26, twice on 4/7/26, twice on 4/8/26, twice on 4/9/26, twice on 4/10/26, once on 4/11/26, three times on 4/12/26, and twice on 4/13/26.	F0600		

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F0600 SS = SQC-H	Continued from page 3 3. Review of the 4/13/26 report sheet (a document that indicated whether the resident was continent or incontinent, how they transferred, and any other special notes) indicated that resident 1 was incontinent of bladder and bowel, used the total body lift for transfers, and required two staff members for all of her care. 4. Observation and interview on 4/14/26 at 9:10 a.m. with resident 1 in her room revealed she was lying on her bed and positioned her back, was tired, and wanted to rest. 5. Observation at 1:11 p.m. of resident 1 in her room revealed she was lying on her bed and positioned her back. Her lunch tray was sitting on her bedside table. 6. Observation and interview on 4/14/26 at 2:06 p.m. with resident 1 revealed she felt "really tired", which was not normal for her. She had a pressure ulcer (skin and/or underlying tissue injury from prolonged pressure) in the past, but currently did not have one. She had a bariatric bed and mattress, which is wider for comfort and to enable ease with positioning. 7. Interview on 4/14/26 at 2:32 p.m. with CNA D revealed resident 1 required staff assistance for repositioning and changing her incontinent product. She usually activated her call light when her incontinence product was wet and needed to be changed, but if she did not alert the staff, then the staff would check on her. She was more tired today so she may not alert the staff when she became incontinent. Staff were to document every time residents were taken to the bathroom or their incontinence product was changed. 8. Observation on 4/14/26 at 3:28 p.m. of resident 1 in her room revealed she was lying on her bed and positioned on her back. 9. Interview review on 4/14/26 at 4:08 p.m. with CNA C revealed resident 1 was to be changed and repositioned every two hours. CNA C stated resident 1's incontinence product was last changed around 12:00 p.m. and that she usually allowed the staff to	F0600		

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F0600 SS = SQC-H	Continued from page 4 change and reposition her. CNA C verified that resident 1 was not changed or repositioned for four hours. She did not document that in the resident's EMR. 10. Observation on 4/14/26 at 4:28 p.m. of CNAs C and E providing care to resident 1 in her room revealed that resident 1 was lying on her bed and positioned on her back. The CNAs provided incontinence care and applied a barrier cream to resident 1's slightly red groin and buttocks. Her incontinence brief and lift sheet (a specialized fabric placed across the middle of a bed used to safely reposition a person), which was underneath her, appeared wet. The CNAs changed resident 1's hospital gown, lift sheet, and incontinence brief, and repositioned her on her right side. The CNAs did not prop her heels up on pillows. 11. Interview on 4/14/26 at 4:40 p.m. with CNA C revealed that resident 1 was more tired today. She applied barrier cream for residents during incontinence care and was not sure which cream she was supposed to use, so she applied whatever cream the resident had in their room. CNA C verified resident 1 was not changed or repositioned for almost four and a half hours. 12. Interview on 4/16/26 at 5:38 a.m. with CNA H revealed that resident 1 was last changed and repositioned on her back at 4:00 a.m. 13. Continued observations on 4/16/26 from 5:42 a.m. through 6:28 a.m. revealed that resident 1 was lying in her bed and positioned on her back. 14. Interview on 4/16/26 at 11:30 a.m. with registered nurse (RN) M revealed that on 2/1/26, resident 1 told her that resident 1 did not want CNA P to assist her anymore because CNA P was on her phone during resident 1's personal care and would not talk to her while providing the care. Resident 1 filled out a grievance form with the help of CNA E. 15. Interview on 4/16/26 at 12:30 p.m. with CNA E regarding the incident with resident 1 on 2/1/26 revealed that resident 1 told her that the night shift CNA P came into resident 1's room during rounds (checking on residents' status and assistance needs), she asked CNA P for a blanket, and CNA P	F0600		

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F0600 SS = SQC-H	Continued from page 5 did not acknowledge her. CNA P appeared rushed and was on a phone call, speaking in a different language. CNA E then helped resident 1 file a grievance regarding the incident. 16. Review of resident 2's EMR revealed she was admitted to the facility on 1/22/25. Her 3/5/26 BIMS assessment score was 9, which indicated her cognition was moderately impaired. Her 2/22/26 Braden assessment score was 15, which indicated she had a risk for developing pressure ulcers. Her diagnoses included urinary tract infection, Alzheimer's disease (a progressive and irreversible brain disorder that affects memory, thinking, social abilities, and body functions), major depressive disorder, stage IV pressure ulcer, type two diabetes, and pain. She had 1/28/25 physician orders to wear heel boots (specialized, cushioned protective coverings worn on the feet to help prevent bed sores) when in bed and 2/14/25 physician orders for a weekly skin audit. Her medication administration record (MAR) indicated that she had a 4/30/25 physician order for Venlafaxine 112.5 mg to be given daily (used to treat depression), a 3/13/26 physician order for Spironolactone 25 mg to be given daily, a 3/15/26 physician order for Furosemide 20 milligrams (mg) to be given daily, a 4/3/26 physician order Doxycycline 100 mg (antibiotic) to be given twice daily for ten days and on 4/14/26 to be given twice daily for eight days for her infected wound on her right buttock, and a 4/4/26 physician order for an intramuscular (IM) injection of ceftriaxone 1 gram (antibiotic) to be given daily for five days for an infected wound on her right buttock. Her treatment administration record (TAR) indicated she had physician's orders from 3/19/26 through 4/6/26 for the staff to paint resident 2's left heel blister with betadine (antiseptic used to kill germs) and wrap it with kerlix (gauze wrap) daily. She had a 3/27/26 physician's order for the staff to apply a wet-to-dry dressing twice a day to a wound on her right buttock. On 4/7/26 the physician ordered for the staff to paint resident 2's left heel blister with betadine and apply a foam	F0600		

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F0600 SS = SQC-H	Continued from page 6 dressing daily and as needed until the blister resolved. Her 1/29/26 weekly skin evaluation indicated that her right buttock pressure ulcer was 3.5 centimeters (cm) x (by) 3 cm. There was no depth documented on the assessment. The wound bed was black, did not have any drainage, had a slight odor, and there was no undermining (when tissue destruction happens under the skin at the edges of a wound, creating a pocket) or tunneling (narrow, deep channels or passageways that extend a wound bed into surrounding tissues). It indicated it was worsening, and new wound care orders were received when she was at the wound clinic. Her 2/3/26 weekly skin evaluation indicated that her right buttock pressure ulcer was 4.5 cm x 3 cm, and the depth was 1.2 cm with no undermining or tunneling and a slight odor. The wound bed was black and was described as "now open, draining black, green slime." It indicated it was worsening. Resident 2's 2/16/26 care plan indicated she required a full body lift for transfers, needed one staff member to help her with getting dressed, her call light was to be left within her reach, and the staff were to monitor her for pain. She was to be repositioned from side to side routinely by one staff member, have her heels elevated when lying in bed, have an air mattress on her bed, and have frequent toileting and barrier cream applied. When she was incontinent, the staff were to wash, rinse, and dry her perineal area. The CNA urinary incontinence documentation from 3/30/26 through 4/13/26 indicated resident 2 was incontinent of urine. Her incontinence product was documented as changed twice on 3/30/26, once on 3/31/26, twice on 4/1/26, three times on 4/2/26, twice on 4/3/26, once on 4/4/26, twice on 4/5/26, twice on 4/6/26, twice on 4/7/26, twice on 4/8/26, twice on 4/9/26, twice on 4/10/26, once on 4/11/26, and twice on 4/12/26 and 4/13/26. 17. Review of the 4/13/26 report sheet indicated that resident 2 was incontinent of bladder and bowel and required a full body lift for transfers. 18. Observation on 4/14/26 at 9:11 a.m. of resident	F0600		

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F0600 SS = SQC-H	Continued from page 7 2 in her room revealed she was in her bed sleeping, she had an air mattress, and was lying on her left side. 19. Observation and interview on 4/14/26 at 10:35 a.m. with CNA C and D while they were providing care to resident 2 in her room revealed that resident 2 had heel boots on, and there was a dressing on her left heel and her coccyx (tailbone). Resident 2 declined to have her bath, and the CNAs changed her incontinence product, repositioned her onto her left side, and gave her the call light. 20. Observation on 4/14/26 at 1:10 p.m. of resident 2 in her room revealed she was lying on her bed and was positioned on her left side. 21. Observation on 4/14/26 at 2:31 p.m. of resident 2 in her room revealed she was lying on her bed and was positioned on her left side. 22. Interview on 4/14/26 at 2:32 p.m. with CNA D revealed that resident 2 was usually dressed by this time, but they were waiting to get her dressed until after her bath, and she still did not want one. CNA D was planning on transferring resident 2 to her wheelchair once CNA C came back from lunch. 23. Observation on 4/14/26 at 2:56 p.m. of resident 2 in her room revealed she was lying on her bed and was positioned on her back. 24. Interview on 4/14/26 at 4:08 p.m. with CNA C revealed resident 2 was to be repositioned and her incontinence product was to be changed every two hours. She was repositioned and her incontinence product was changed around 2:40 p.m. She verified that she was not changed or repositioned from 10:35 a.m. until 2:56 p.m. 25. Observation and interview on 4/15/26 at 10:30 a.m. of licensed practical nurse (LPN) F, providing wound care for resident 2 in her room revealed the pressure ulcer on her left heel was calloused and dry and her pressure ulcer on her coccyx was a stage IV (4;open wound with full-thickness skin and tissue loss. bone, tendon, or muscle may be visible). Resident 2 was not to be positioned on her back due to her pressure ulcer.	F0600		

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=0600 SS = SQC-H	Continued from page 8 26. Interview on 4/16/26 at 5:38 a.m. with CNA H revealed resident 2 was repositioned and her incontinence brief was changed around 4:20 a.m. 27. Continued observations on 4/16/26 from 5:41 a.m. through 8:40 a.m. revealed that resident 2 was lying in her bed and positioned on her right side. 28. Observation and Interview on 4/16/26 at 8:40 a.m. revealed CNA E went into resident 2's room to get her ready for the day. Resident 2 had the same shirt on from the previous day. Resident 2 stated she requested her shirt to be changed last night and that CNA H would not change it. She stated that CNA H was rough with her and did not talk to her when CNA H repositioned her during the night. When resident 2's blankets were pulled back, her heel boots were sliding off her feet, and her heels were resting on the bed. She stated her left heel hurt. 29. Interview on 4/16/26 at 12:30 p.m. with CNA E regarding the incident involving resident 2 on 2/1/26 revealed that resident 2 was tearful when she told CNA E about the incident and resident 2 asked CNA E not to leave her alone because she was afraid. CNA E thought resident 2 was afraid because she did not have her call light that night to alert the staff for help. Resident 2 had described CNA P as the CNA that night. 30. Review of the providers 4/12/26 SD DOH FRI report revealed that on 4/12/26, resident 3 obtained an open area on her coccyx when CNA Q was cleaning her roughly. CNA E had to physically stop CNA Q from continuing to clean her. The provider's investigation regarding this incident was ongoing during the survey. 31. Review of resident 3's EMR revealed she was admitted to the facility on 6/16/25. Her 3/18/26 BIMS assessment score was 5, which indicated her cognition was severely impaired. Her 10/10/25 Braden assessment score was 12, which indicated she had a high risk for developing pressure ulcers. Her diagnoses included Alzheimer's disease, weakness, and type two diabetes.	F0600		

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F0600 SS = SQC-H	Continued from page 9 She had 7/23/25 physician's order for furosemide, and a 1/9/26 physician's order for a protective foam dressing to her coccyx and to the middle back of her back. The dressing was to be changed on her bath days, Tuesday and Friday, for her skin integrity. Resident 3's 1/19/26 care plan indicated she required the assistance of one staff member for bed mobility, getting dressed, and for her personal hygiene care. She was incontinent of bladder and bowel, and required the staff to assist her with frequent toileting and barrier cream application, including when she woke up, before and after her meals, at bedtime, during the night shift rounds, and as needed. She required two staff members to pull her up in bed using a lift sheet to prevent her skin from tearing, and for transfers using a total body lift. Resident 3 had a pressure injury to her coccyx from immobility and incontinence. She had an air mattress on her bed, a pressure-reducing cushion in her wheelchair, was to always wear heel boots, and have her call light within her reach. The CNA urinary incontinence documentation from 3/30/26 to 4/13/26 indicated that she was incontinent of urine. Her incontinence product was documented as changed twice on 3/30/26 and 3/31/26, three times on 4/1/26, twice on 4/2/26 and 4/3/26, once on 4/4/26, twice on 4/5/26, three times on 4/6/26, twice on 4/7/26, 4/8/26, 4/9/26, and 4/10/26, once on 4/11/26 and 4/12/26, and three times on 4/13/26. 32. Review of the 4/13/26 report sheet indicated resident 3 was incontinent of bladder and bowel, required a total body lift for transfers, and was on hospice. 33. Observation on 4/14/26 at 9:26 a.m. of resident 3 in her room revealed she had an air mattress on her bed, and she was sitting in a high-back wheelchair that had a pressure-reducing cushion. 34. Observation on 4/14/26 at 2:04 p.m. of resident 3 in her room revealed she was sitting in her wheelchair.	F0600		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435115	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/16/2026

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=0600 SS = SQC-H	Continued from page 10 35. Observation and interview on 4/14/26 at 2:40 p.m. in resident 3's room revealed resident 3 was sitting in her wheelchair. She stated she did not like to stay in her wheelchair all day and was unable to use the toilet in the bathroom. She felt her incontinence brief was "flooded" and her bottom was sore, but the "cover" on her bottom helped. She indicated that some staff members were rough while providing her care, but they were not mean. 36. Observation and interview on 4/14/26 at 3:43 p.m. with activity aid/CNA L and CNA C providing care for resident 3 in her room revealed that CNA C last changed resident 3's incontinence brief before lunch. Activity aid/CNA L and CNA C changed her incontinence brief and applied Remedy Moisturize skin cream to her bottom. 37. Interview and Kardex (a report of the resident's care needs and interventions) review on 4/14/26 at 4:08 p.m. with CNA C revealed resident 3 was to be repositioned and her incontinence brief was to be changed every two hours. She was last changed and repositioned around 11:00 a.m. If a resident had a pressure sore, they were to be repositioned every two hours. She knew that because it would be in the resident's Kardex. Resident 3's Kardex did not indicate how often she needed to be repositioned or changed. 38. Observation and interview on 4/15/26 at 10:10 a.m. of LPN F providing wound care to resident 3 in her room revealed she had a stage II (2; open wound or blister with partial-thickness skin loss) pressure ulcer on her coccyx, and had a foam dressing covering it. She did not have a dressing on the middle of her upper back, or have any other open areas. LPN F changed the foam dressing on resident 3's coccyx. 39. Observation and interview on 4/16/26 at 5:38 a.m. with CNA H revealed that resident 3 had a sore on her bottom, and she changed the dressing on her coccyx when it was wet and applied a barrier cream to her bottom when it was a "little" red. Resident 3 was repositioned and her incontinence brief was changed at 4:30 a.m. 40. Observation and interview on 4/16/26 at 6:54 a.m. with CNA E providing care to resident 3 in her	F0600		

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=0600 SS = SQC-H	Continued from page 11 room revealed that resident 3 was wearing the same shirt from the day before, had a foam dressing to her coccyx, and did not have a foam dressing to her upper back. CNA E stated that after CNA H worked, she noticed that residents in CNA H's care did not appear to have received appropriate resident care. 41. Interview and EMR review on 4/16/26 at 11:30 a.m. with RN M revealed resident 3 was supposed to have the foam dressing on the middle of her back and coccyx. 42. Interview on 4/16/26 at 12:00 p.m. with RN K regarding the incident involving resident 3 on 4/12/26 revealed that CNA E reported that CNA Q was cleaning her too hard and caused an open area on her coccyx. RN K completed a full skin assessment, measured the wound, cleaned it, and applied a barrier cream to it. She did not apply a dressing to it. She classified the wound as a stage II pressure ulcer and notified resident 3's hospice team, physician, and family. 43. Interview on 4/16/26 at 12:30 p.m. with CNA E regarding the incident involving resident 3 on 4/12/26 revealed she and CNA Q were assisting resident 3 with personal hygiene care while changing her incontinent brief. CNA Q cleaned resident 3's bottom using a dry wipe and a cleansing spray, and caused her healed pressure ulcer area to reopen. CNA E verbally tried to get him to stop, and when he did not listen, she physically positioned her arms and hands in front of the resident to stop him from cleaning her bottom. Resident 3 was quiet during the incident and CNA E reported the incident to RN K. CNA E stated that before this incident happened with CNA Q, she had reported to LPN G and RN M, her concerns that CNA Q was not nice to the residents, he was rough with them, and he did not consistently provide incontinence care to them, but she felt they did not listen to her. 44. Interview on 4/16/26 at 3:42 p.m. with hospice RN N revealed that she expected the facility staff to reposition resident 3 every two hours, and provide incontinence care every two hours or sooner if needed. Resident 3 was to have the foam dressing on her upper back for the prevention of pressure ulcers. She had a previous pressure ulcer to her coccyx that healed, but the skin was still fragile. After the incident on 4/12/26, the skin on her coccyx opened back up.	F0600		

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F0600 SS = SQC-H	Continued from page 12 45. Observation and interview on 4/14/26 at 9:27 a.m. with resident 4 revealed he was lying in his bed that had an air mattress, had one heel boot sitting on his wheelchair, and was positioned on his back. He stated his call light was consistently not answered by the staff for two hours, and sometimes it was not answered for four hours. He stated his incontinence brief was not changed "a week or two ago" for a long period of time, and he sat in urine for so long that he developed skin irritation and open sores to his perineal area. He stated that the staff applied a barrier cream to his skin when they changed his incontinence brief. He did not want to wear heel boots, and he felt he could reposition himself sometimes. 46. Observation and interview on 4/15/26 at 9:53 a.m. with LPN F providing wound care for resident 4 in his room revealed that his perineal area, inner upper thighs, and rectal area were bright red and had superficial open areas. Resident 4 stated he had had the sores for a few weeks. LPN F stated he had skin irritation and open sores to his perineal area, cleaned the area, applied nystatin (antifungal) powder, and a barrier cream with zinc in it. She educated him to notify the staff when he was wet. He stated he was not "always" able to feel when he urinated or was wet. LPN F stated the CNAs were supposed to check on him every two hours. 47. Interview on 4/16/26 at 5:38 a.m. with CNA H revealed that resident 4 needed assistance with repositioning and changing his incontinence brief every two hours. 48. Review of resident 4's EMR revealed he was admitted to the facility on 6/23/25. His 3/2/26 BIMS assessment score was 12, which indicated his cognition was moderately impaired. His 10/16/25 Braden assessment score was 12, which indicated he had a high risk for pressure injuries. His diagnoses included a stroke (when blood flow to part of the brain is interrupted either by blockage or a burst blood vessel) affecting his right side, quadriplegia (paralysis caused by a spinal cord injury resulting in partial or total loss of movement and sensation in all four limbs, and the torso), major depressive disorder, overactive bladder (involuntary	F0600		

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F0600 SS = SQC-H	Continued from page 13 bladder muscle contractions, creating a sudden, uncontrollable urge to urinate), and urinary incontinence. He had physician orders on 4/6/26 for nystatin powder to be applied to the perineal area twice daily and as needed, on 1/20/26 for Sertraline (an antidepressant), and on 10/6/25 for lactulose for constipation. Resident 4's 4/6/26 care plan revealed he required two staff members to transfer him with a full body lift, and one staff member to assist him with bed mobility, and personal hygiene care. His skin was at risk for impairment, and the staff was to turn and reposition him routinely. The staff was to ensure he was clean and dry, to check and change his incontinence brief, and use a barrier cream for protection as needed for incontinence. He required an air mattress on his bed and a cushion in his wheelchair. The CNA urinary incontinence documentation from 3/30/26 to 4/13/26 indicated that he was incontinent of urine. His incontinence product was documented as being changed twice on 3/30/26 and 3/31/26, three times on 4/1/26, twice on 4/2/26 and 4/3/26, once on 4/4/26 and 4/5/26, three times on 4/6/26, twice on 4/7/26, 4/8/26, 4/9/26, and 4/10/26, once on 4/11/26 and 4/12/26, and three times on 4/13/26. 49. Review of the 4/13/26 report sheet indicated he was incontinent of bowel and bladder, and required a full body lift for transfers. 50. Observation and interview on 4/16/26 at 5:38 a.m. with CNA H revealed she was sitting on a chair in the West resident hall. Resident 5 was calling out for help, and she entered and exited resident 5's room and stated that resident 5 wanted to get up for the day. She stated that she sometimes helps residents get up in the morning, but typically, the day staff would help get them up. At night, she would check on the residents every two hours and would change their incontinent product, assist them to use the toilet, or reposition them at that time. She documented every time a resident was assisted to the bathroom or if she changed their incontinent product.	F0600		

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F0600 SS = SQC-H	Continued from page 14 51. Observation on 4/16/26 at 6:03 a.m. revealed that resident 5 was again calling out for help. CNA H entered and exited her room and then stated that resident 5 needed to go to the bathroom. CNA H indicated she was going to find someone to help her with that. 52. Observation and interview on 4/16/26 at 6:13 a.m. with CNA E assisting resident 5 revealed she appeared restless, and her incontinence brief was wet. Resident 5 stated she needed to use the bathroom and that no one would help her. CNA E assisted her with getting on the bedpan and stated resident 5 was typically continent of urine and bowel. Her call light was at the foot of her bed, and CNA E stated that resident 5 could use her call light appropriately. There were two signs on her wall by her bed that stated that her call light was to be attached to her bed because she was at high risk for falling. 53. Review of resident 5's EMR revealed she was admitted to the facility on 2/23/26. Her 2/24/26 BIMS assessment score was 11, which indicated her cognition was moderately impaired. Her diagnoses included a stroke affecting her left side, Alzheimer's disease, anxiety (anticipation of future danger or misfortune with feelings of distress and/or sadness and symptoms such as restlessness or irritability), and depression. She had a 2/24/26 physician's order for escitalopram (a medication for anxiety and depression) and a 3/23/26 physician's order for physical therapy and occupational therapy (PT/OT)/speech therapy (ST). Review of resident 5's 4/8/26 care plan indicated she needed one staff to assist her with bed mobility, dressing, and personal hygiene care. She used a bedpan for her toileting needs. Her perineal area was to be cleansed after each incontinent episode. Staff were to follow facility policies and protocols for the prevention and treatment of skin breakdown. She needed a pressure-reducing mattress on her bed and a cushion in her wheelchair. She was to be transferred with the assistance of two staff members and a full body lift. Staff were to be sure the resident's call	F0600		

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F0600 SS = SQC-H	Continued from page 15 light was within reach and encourage her to use it for assistance. She was at risk for falls. Resident 5's CNA urinary incontinence documentation from 3/30/26 to 4/16/26 indicated that she was sometimes continent of urine. She was documented as being incontinent of urine twice on 3/30/26, incontinent of urine once on 3/31/26, incontinent of urine once and then did not urinate once on 4/1/26, incontinent of urine three times on 4/2/26, incontinent of urine twice on 4/3/26, continent of urine once and incontinent of urine once on 4/4/26, incontinent of urine once on 4/5/26, incontinent of urine three times on 4/16/26, incontinent of urine twice on 4/7/26, did not urinate once on 4/8/26, was continent of urine once and incontinent of urine twice on 4/9/26, continent of urine twice on 4/10/26, continent of urine once on 4/11/26, incontinent of urine once on 4/12/26, continent of urine once and incontinent of urine twice on 4/13/26, she did not urinate on 4/14/26, she was incontinent of urine once on 4/15/26, and had not urinated since 4/15/26 at 5:59 p.m. 54. The 4/13/26 report sheet indicated she was incontinent of bladder and bowel and used the full body lift for transfers. She was to be assisted to the restroom every two hours. 55. Interview on 4/16/26 at 6:29 a.m. with anonymous resident 15 revealed she felt that she did not get the help she needed during the night. She asked CNA H to change her incontinence product around 2:00 a.m., and the CNA told her that she would not change her until rounds at 4:00 a.m. She did not tell the nurse about that. She stated, "I have learned to live with it". She does not have a pressure ulcer, but had one in the past. She reported that some CNAs wore earbuds when they assisted her, and one CNA would talk to someone on her phone through her earbuds while providing her care. She stated she would ask for the staff to reposition her if her bottom started to hurt. 56. Interview on 4/14/26 at 10:25 a.m. with CNA C revealed there was one CNA assigned to work each hallway, and there was rarely a CNA assigned as a float, which meant they would help on all the hallways. Many residents down her assigned hallway, the West Hall, needed to be transferred with mechanical lifts (a medical device used to safely	F0600		

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=0600 SS = SQC-H	Continued from page 16 move people with limited mobility) and the assistance of two staff members for repositioning. She would ask the certified medication aids (CMA), activity staff, bath aids, and nurses for help with repositioning and transferring residents when needed. She thought the average call light response time was five minutes. She tried to meet the residents' needs the best she could and stated that some residents would get frustrated because sometimes by the time she could help them to the bathroom, they were incontinent. She was to document each time a resident was repositioned and every time their incontinent product was changed, or they were assisted to the bathroom. 57. Interview on 4/14/26 at 11:15 a.m. with administrator A revealed the facility did not have a policy regarding their rounding (checking on residents' status and assistance needs) process. She expected staff to round on residents every two hours. 58. Interview on 4/14/26 at 4:50 p.m. registered nurse (RN) J revealed he monitored the care provided by the CNAs for residents who needed to be repositioned and changed every two hours when he had time, which was "sometimes". 59. Interview on 4/14/26 at 4:58 p.m. with director of nursing (DON) B revealed she started at the facility two days ago. She expected residents, who required staff assistance with repositioning and incontinence care, to have it completed every two hours, or sooner if needed, and to document any care given. 60. Interview on 4/15/26 at 10:30 a.m. of with LPN F revealed she tried to monitor that care and repositioning was being completed by CNAs by being active on the floor, helping the CNAs with changing incontinent products and repositioning residents. Sometimes, in the morning, residents were found to be soaked with urine. If that occurred, the CNAs were good about letting her know so she could notify management. She stated that it was almost impossible for one CNA to reposition and change residents who need it, every two hours. She talked to CNA Q a week ago about being too aggressive when positioning residents, and he did	F0600		

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F0600 SS = SQC-H	Continued from page 17 not improve. He also had an instance where he was not providing resident care, so she reported it to management. If a resident who was to be repositioned and have their incontinence product changed every two hours, and it was not done, that would put the resident at risk for developing or worsening pressure ulcers, cause skin breakdown, and lead to infections. LPN F was in charge of the East and West Hallways. She stated that having one nurse for both halls was challenging. Usually, during the day, each resident hallway was assigned one CNA, and they rarely had a float CNA to help. She stated that the East Hallway had about five residents who required two staff to assist, and the West Hallway had around seven. The overnight shift was scheduled with one nurse and typically three CNAs for the entire building. 61. Interview on 4/16/26 at 11:30 a.m. with RN M revealed, she checked the CNAs documentation in the EMR to determine if they were providing care for the resident or not. She was unsure if CNAs documented when a resident was repositioned. Staff were to document every time a resident was taken to the bathroom or their incontinence product was changed. She expected residents who had pressure ulcers or those at high risk to be repositioned every two hours. Every morning, she went around the facility and checked resident rooms for cleanliness, if their call lights were in reach, their water was full, and their garbage was empty. If she noticed a call light was not in reach, she would talk to the CNA and remind them to leave it within reach. If it was an obvious issue, she would report it to administrator A or DON B. She was not aware if other audits being completed. 62. Interview on 4/16/26 at 12:30 p.m. with CNA E revealed she recalled there was an unidentified resident who used to yell for help during morning rounds between the night and day shift. She reported that CNA P rolled her eyes when she heard him yell for help, and she would not go help him. When CNA E helped him, she found that he did not have his call light within reach to alert staff that he needed help.	F0600		

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F0600 SS = SQC-H	Continued from page 18 CNA E stated that she tells the nurse, nurse managers, DON, or the administrator when a resident has concerns about the care they receive. 63. Interview on 4/16/26 at 2:30 p.m., 4:10 p.m., and 4:30 p.m. with wound nurse/LPN care coordinator G revealed she expected staff to check residents' incontinent products every two hours if they were incontinent and to reposition residents who were at high risk for pressure ulcers or who were unable to reposition themselves every two hours. When a resident was taken to the bathroom or had their incontinent product changed, staff were to document that every time. They do not document when a resident is repositioned. If a resident refused to be repositioned or changed, the CNA was to notify the nurse, and the nurse was to follow up with that resident, and if they continued to refuse, document that in the resident's EMR. She verified that resident 2 had her air mattress put on her bed on 2/5/26 according to her care plan. Events that would increase a resident's risk of a wound infection included not changing their dressing using clean technique, not being changed frequently enough, if it was located on a resident's bottom, and urine and stool incontinence. CNAs were to know to reposition residents every two hours, since they were CNAs, and nurses did not have time to make sure residents were being repositioned every two hours by the CNAs, because they did not have time to. She verified that the worsening of resident 2's pressure ulcer on her coccyx on 2/3/26 after the incident on 2/1/26 could have been due to the incident where she was not changed or repositioned appropriately. She verified that there were no performance improvement programs or audits being completed at the facility related to wounds, repositioning, or incontinence care of the residents.	F0600		

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F0600 SS = SQC-H	Continued from page 19 64. Interview on 4/16/26 at 4:40 with administrator A revealed that resident 1 and resident 2 did not have skin assessments completed after the incident on 2/1/26. She agreed that resident 2 not being changed or repositioned that night could have made her pressure ulcer worse, as indicated by her 2/3/26 wound assessment. She did not complete staff education after the incident. She expected residents who needed to be repositioned and changed every two hours to have it done that often. She verified that having one CNA on the high acuity hallways made it difficult for the CNAs to reposition and change residents who needed to be, every two hours. After the incident on 4/12/26, she started to complete education for staff regarding perineal care, abuse and neglect, and the incident reporting process. The education has not been completed with all staff at this time. 65. Review of the provider's March 2026 Skin Integrity policy revealed "... a resident having pressure ulcer/injury receives necessary treatment and services to promote health, prevent infection and prevent new sores from developing." 66. Review of the provider's March 2025 Abuse and Neglect Policy revealed that residents had the right to be free from abuse, neglect, and mistreatment. It included a person who did not provide goods or services that were necessary to achieve or maintain physical, mental, and psychosocial well-being. The facility was to develop policies and procedures so residents were not subject to abuse by staff. The policy defined abuse as "the willful infliction of injury... with resulting physical harm, or pain or mental anguish." The policy defined willful as "means the individual acted deliberately, not that the individual must have intended to inflict injury or harm." The policy defined neglect as the "failure of the Center, its employees or service providers to provide goods and services to a resident that are necessary	F0600		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435115	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/16/2026

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F0600 SS = SQC-H	Continued from page 20 to avoid physical harm, pain, mental anguish, or emotional distress. Neglect occurs when the facility is aware of, or should have been aware of, goods or services that a resident(s) requires but the facility fails to provide them to the resident(s), resulting in physical harm, pain, mental anguish, or emotional distress.	F0600		
F0919 SS = E	Resident Call System CFR(s): 483.90(g)(1)(2) §483.90(g) Resident Call System The facility must be adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area from- §483.90(g)(1) Each resident's bedside; and §483.90(g)(2) Toilet and bathing facilities. This REQUIREMENT is NOT MET as evidenced by: Based on observation and interview the provider failed to ensure call lights (a communication tool that enabled residents to alert staff for assistance) were within reach for 10 of 10 sampled residents (3, 5, 6, 8, 9, 10, 11, 12, 13, and 14) that would allow the residents to request assistance from staff promptly. Findings included: 1. Observation and interview on 4/14/26 at 9:04 a.m. revealed that resident 9 was slid down in her bed and needed help. Resident 9 stated she did not know where her call light was and never had access to it. Social Services Director (SSD) S entered the room and acknowledged that the call light was hung over the resident's headboard, not within reach of the resident. She moved the call light next to the resident, but thought she could have reached it when it was over the headboard. 2. Observation on 4/14/26 at 9:06 a.m. revealed resident 10 was in bed, and her call light was clipped to its own cord at the wall, not within reach of the resident. SSD S came to the doorway, acknowledged that the call light was not within the resident's reach, and moved it closer to the	F0919	1. Reidents (3,5,6,8,9,10,11,12,13,14) were assessed to ensure call lights functioning and within reach. 2. All residents are at risk for call light assessibility. All resident rooms checked to verify call light assessibility and functionality. Residents requiring specialized call light placement due to cognition, mobility limitations, fall risk, or positioning needs were reviewed and care plans reviewed and updated as needed to accurately reflect resident-specific call light interventions. 3. All staff educated by DON/Administrator/ Designee on resident call light response time and call light accessibility expectations and requirements. Daily rounding by leadership implemented to verify call lights are within reach. All education will occur by 5/6/2026. Those not in attendance due to illness, vacation, or casual work status will be educated upon return to work during their next scheduled shift. 4. DON/Administrator/Designee will monitor call light accessibility and response time. Audits will be completed 3x per week for 2 weeks, 1x per week for 4 weeks, 1x per month for 2 months. Results of this audit will be discussed by DON/ Administrator/Designee at the monthly QAPI meeting with IDT and medical director for analysis and recommendations for continuation, discontinuation or revision of audit based on findings. 5. Date of compliance : 5/6/2026	5/6/2026

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=0919 SS = E	Continued from page 21 resident. 4. Observation on 4/16/26 at 6:10 a.m. revealed Resident 13 was in bed sleeping, and her call light was hanging off her bed near the floor and was not within reach. 5. Observation on 4/16/26 at 6:10 a.m. revealed Resident 14 was in his bed. His call light was over his overbed table, which was pushed away from his bed and out of reach. 6. Interview on 4/16/26 at 6:10 a.m. Certified nursing assistant (CNA) U acknowledged that both residents' 13 and 14 call lights were out of reach. 7. Observation and interview on 4/16/26 at 6:13 a.m. revealed that resident 5 was calling out for help. CNA E went into her room to assist her. Resident 5 stated that no one would answer her call, and she needed to go to the bathroom. Her call light was lying at the foot of her bed. Two signs near her bed stated she was a high fall risk and that her call light was to be attached to her at all times. CNA E stated that resident 5 was able to use her call light appropriately, and she should have it within her reach. When she found call lights that were not left within a resident's reach, she reported it to the nurse. 8. Observation on 4/16/26 at 6:29 a.m. with certified medication aide (CMA) R revealed resident 11 was in his bed, asleep. His call light was lying over a basin on his bedside table, not in reach. CMA R acknowledged that the call light was not within reach and that it was a concern. 9. Observation and interview on 4/16/26 at 6:29 a.m. with CMA R revealed that resident 12 was in bed and his call light was clipped to his recliner, not within his reach. He acknowledged that the call light was not within reach and that it was a concern. 10. Observation on 4/16/26 at 6:46 a.m. revealed resident 8 was lying in her bed, and her call light was on the bedside table in front of her television, out of reach.	F0919		

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F0919 SS = E	Continued from page 22 11. Interview on 4/16/26 at 6:47 a.m. with registered nurse (RN) T revealed he completed his first rounds on his residents during his initial med pass. He expected residents to always have their call lights within reach and the CNAs to look in on each resident at least every 2 hours. 12. Observation on 4/16/26 at 6:47 a.m. revealed resident 6 was lying in her bed, and her call light was on the bedside table that was pushed away from her bed, out of reach. 13. Observation on 4/16/26 at 6:54 a.m. revealed resident 3 was lying in her bed, and her call light was on her end table, out of reach. 14. Interview on 4/16/26 at 7:11 a.m. with LPN I revealed that residents were to have their call lights left within their reach. 15. Interview on 4/16/26 at 4:40 p.m. with administrator A revealed she expected residents' call lights to be within their reach.	F0919		
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. §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;	F0880	1. Resident (7) suprapubic catheter has been flushed and will continue to be flushed using sterile techniques and supplies. 2. All residents who require catheter flushes will be completed using sterile technique and sterile supplies. 3. Ordered and received sterile catheter flush kits. Licensed nurses were educated on the importance of using sterile supplies and sterile technique. All education will occur by 5/6/2026. 4. DON/IP/Designee will complete observations of catheter care to ensure sterile nursing procedures are followed. Audits will completed for 5 random residents 3x per week for 2 weeks, 1x per week for 4 weeks, 1x per month for 2 months. Audit findings will be reviewed at monthly QAPI meeting with IDT and medical director for analysis and recommendations for continuation, discontinuation or revision of audits based on findings. 5. Date of compliance: 5/6/2026	5/6/2026

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=0880 3S = D	Continued from page 23 §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 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:	F0880		

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F0880 SS = D	Continued from page 24 Based on observation, interview, record review, and policy review the provider failed to ensure 1 of 1 resident (7) supra pubic catheter (a tube placed in the bladder to remove urine from the body) was irrigated (flushed) using a sterile graduated cylinder for the saline and vinegar solution that was used to flush her supra pubic catheter by licensed practical nurse (LPN) I. Findings include: 1. Observation and interview on 4/16/26 at 9:07 a.m. with licensed practical nurse (LPN) I revealed that resident 7's supra pubic catheter was flushed twice a day. She stated she reused the graduated cylinder, but that she would get a new syringe each time she flushed the catheter. She was trained that way but could not remember who trained her. The cylinder had been written on with a Sharpie, "sterile only for vinegar and water, not to empty urine from the catheter." 2. Interview on 4/16/26 at 2:34 p.m. with director of nursing (DON) B revealed she been the at the facility since 4/13/26. She understood that the container should be changed every single time. She was aware that resident 7 has had urinary tract infections. She stated they should have been using sterile technique and sterile supplies. 3. Interview on 4/16/26 at 3:11 p.m. with RN M revealed she was a nurse manager and was training for the infection preventionist position. She was not aware that the nurses were using a non-sterile graduated cylinder for resident 7's supra pubic catheter flushes. She was not sure where that had come from and stated LPN I knew that it was not sterile and that they had sterile catheter kits that should have been used. She stated and showed this surveyor that the urinary catheter kits that should have been used were sterile and available to the nurses. 4. Review of resident 7's record electronic medical record (EMR) revealed she had a physician's order from 4/10/26 to flush her catheter with 100 cc (cubic centimeters) of normal saline and 20 cc 5% (percent) vinegar twice daily and as needed related to a bladder disorder. The physician's order indicated to instill the saline and vinegar 60 ml (milliliters) and allow that to drain, and then instill the remaining 60 ml to drain.	F0880		

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F0880 SS = D	Continued from page 25 Resident 7's diagnoses were urinary retention, bladder disorder, overactive bladder, proteinuria, and bladder-neck obstruction. Resident 7's medications included cranberry capsules for urinary tract infection (UTI) prevention and methenamine Hippurate for UTIs. 5. Interview on 4/16/26 at 5:23 p.m. with administrator A revealed LPN I had been educated regarding the urine catheter kits and stated nurses should know what a sterile field was. 6. Review of the providers' undated indwelling catheter irrigation revealed to use the prescribed irrigation solutions and a sterile basin. Commercially packaged kits containing sterile irrigation solutions and a graduated receptacle, and a 50 milliliter (ML) catheter tip syringe may be available in some facilities.	F0880		