STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245039	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Neilson Place	1000 Anne Street Northwest Bemidji, MN 56601

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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 0677

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Provide care and assistance to perform activities of daily living for any resident who is unable.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 40943

Based on observation, interview, and document review, the facility failed to provide routine oral care and shaving assistance to 1 of 5 residents (R23) reviewed for activities of daily living (ADLs) and who were dependent on staff for their care.

Findings include:

R23's quarterly Minimum Data Set (MDS) dated [DATE], identified R23 was cognitively intact, had a diagnosis that included hemiplegia (one side paralysis or weakness) due to a history of a stroke. R23 had an indwelling catheter and a feeding tube. R23 was dependent on staff for all care activities.

R23's care plan revised 12/3/24, identified R23 had a self-care deficit due to left sided hemiparesis related to a history of stroke. Staff were directed to provide assist of one for grooming. The care plan did not direct shaving on certain days or how often and when oral cares would be completed.

During an observation on 12/3/24 at 4:31 p.m., R23 was lying in bed with his head of bed elevated 45 degrees. R23 had a sheet covering R23 to his waist and R23 was not wearing a shirt. R23 was unshaven with approximately a 1/4 inch of beard growth.

During an observation on 12/5/24 at 9:46 a.m., nursing assistant (NA)-A and NA-B entered R23's room. After putting on a gown and gloves NA-A and NA-B provided morning care assistance to R23.

- At 10:08 a.m., NA-A and NA-B removed their gowns and gloves to exit R23's room, however, R23 was not offered shaving assistance or oral cares. NA-B stated R23 was always shaved on his bath day and sometimes R23 would shave on his own, but shaving should have been offered. NA-A stated they do oral cares for R23 throughout the day because R23 had a feeding tube, but oral cares should have been offered.

During an interview on 12/5/24 at 11:23 a.m., registered nurse (RN)-A stated all residents should be offered shaving and oral care assistance during cares.

During an interview on 12/5/24 at 2:33 p.m., the director of nursing stated shaving and oral cares should have been offered during cares.

During an interview on 12/5/24 at 4:59 p.m., the administrator stated shaving and oral cares should be offered during cares per policy.

(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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245039	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/05/2024
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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility policy Activities of Daily Living revised 12/4/23, identified the facility would ensure any resident who was unable to carry out activities of daily living would receive necessary services to maintain good nutrition, grooming and personal and oral hygiene.

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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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41575 Based on interview and document review the facility failed to comprehensively assess and develop interventions to reduce or prevent continued weight loss for 1 of 1 resident (R30) reviewed for nutrition. We should also righ notification to he Dr at F580 . jsut need peices of it the record showing weight losss and interviews they should notify dr. Findings include: R30's quarterly Minimum Data Set (MDS) dated [DATE], identified R30 had severe cognitive impairment and required moderate to maximum assist with all activities of daily living (ADLs). R30's weight was 114 pounds, Diagnoses included Alzheimer's and congestive heart failure. R30's MDS IDT assessment dated [DATE], identified R30 had no difficulty with chewing or swallowing and required one person assist to eat at times. R30's height, weight, weight loss or gain and appetite was not completed on the assessment form. R30's care plan dated 12/2/24, identified R30 had a potential for weight loss. R30 was to receive a regular diet and offer point of service choice of foods. R30 was weighed weekly with the following weights documented: - 6/7/24 123 lbs. - 7/12/24=117 lbs. (a 4.88% wt loss in one month) - 8/16/24=112 lbs. - 9/20/24=110 lbs. (a 13% wt loss in three months) -10/18/24=107 lbs. -11/15/24=106 lbs. R30's medical record lacked evidence her ongoing weight loss was assessed and evaluated. There was no evidence dietary assessments were completed at admission, quarterly or with a identified decrease in weight. On 12/04/24, at 12:10 PM R30 was seated in dining room eating her lunch. R30 had eaten all her desert of cake and was trying to eat some of the lunch meal provided. R30 attempted to use her fork and poke two slices of bread and bring it to her mouth to eat. The bread was too heavy for the fork and kept dropping onto R30's lap. After several attempts, R30 picked the bread up with her hands and took two bites. Staff were in the dining room; however, did not offer R30 assistance to eat. (continued on next page)

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	245039	A. Building B. Wing	12/05/2024

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	When interviewed on 12/4/24, at 11:20 a.m. trained medical assistant (TMA)-A stated staff could not do much to get R30 to eat. It just depended on what kind of day R30 was having. Some days she would not eat a thing and other days she would. During interview on 12/4/24, at 5:50 p.m. registered nurse (RN)-D stated they had a dietician on staff that the facility shared with other facilities. The dietician did a lot of her documentation on paper and not sure where any of it was. The facility just hired a new dietician in the past three or four weeks and the new dietician was reviewing all the resident charts to see where all the residents were at. RN-D stated the nursing assistants obtained resident weights weekly on their bath days. They were supposed to notify the nurse when a weight loss was noted; however, the aides did not get a good look at all the resident weights and so would not necessarily know when a weight loss occurred week to week. The nurses inputted the weights on the resident's medication administration record (MAR) and when they brought up the MAR to enter the weight, the residents previous wt was listed. The nurses were also able to click on the history and review more weights for a quick look back. RN-D was not sure why the weight los was not noted by the nurses when they entered them on the MAR weekly. The nurses should have noted the significant weight discrepancies and requested the nursing assistants to reweigh the patient. If determined accurate, the nurses should have reported to the unit manager and/or dietary. On review now, RN-D did see R30 had lost weight. During interview on 12/5/24, at 11:22 a.m. the dietician stated she monitored resident weights on a monthly basis. R30's quarterly assessment identified a 7.5% weight loss, which would have put her on high risk. When the dietician identified a high-risk resident, she monitored them at least monthly and documented a progress note for resident. Dietary assessments were required on admission and with quarterly MDS assessments. The dietician did not see a dietary assessment had been completed at all for R30, so she assessed R30 today and documented a progress note. The progress note dated 11/5/24, identified a review of R30's weights and intakes, with possible consideration of initiating a nutritional supplement. When interviewed on 12/5/24, at 11:50 a.m. RN-C stated the floor nurses were supposed to be evaluating resident weights when they entered them in to the resident's MAR. RN-C was surprised dietary assessments were not completed as one should have been done when R30 was admitted . The previous dietician was keeping an eye on resident weights and RN-C would collaborate with the dietician and discuss new interventions as well as notifying the residents primary care provider. RN-C would have also expected a dietary assessment to have been completed during R30's quarterly review in September. The previous dietician would discuss weight loss with residents or residents that should be monitored but the previous dietician did not always document her findings in the resident's charts. During interview on 12/5/24, at 4:13 p.m. RN-D stated she generally notified the physician as soon as she noticed a resident's weight was going down. The weight loss did not even have to be significant, as she just wanted to give the provider a heads up, even if it was just noticing their food intake had declined. When interviewed on 12/5/24, at 4:27 p.m. the director of nursing (DON) stated she would have expected nurses to evaluate a resident's weight weekly and notify the provider for resident weight loss or gains. R30's weight loss should have been addressed during her quarterly reassessment. The facility expected residents to have dietary assessments to be completed on admission and with quarterly reassessments at the minimum. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview with the administrator and administrator designee on 12/5/24, at 4:50 p.m. the administrator stated he would expect dietary assessments to be completed on admission and with all reassessments. The facility expected nurses to monitor resident weights and report any concerns to dietary. The facility policy Weight and Height dated 10/15/24, identified the purpose was to ensure the resident maintained acceptable parameters of nutritional status regarding weight. Based on comprehensive assessment the facility would ensure that a resident would maintain appeasable parameters of nutritional status such as body weight, unless their clinical condition demonstrated it was not possible. The licensed nurse would notify the director of food and nutrition (DFN) within 24 hours regarding any significant weight change. A significant weight change was defined as five percent in 30 days, 7.5% in 90 days and 10% in 180 days. The licensed nurse should immediately notify the medical provider of any significant weight change.

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Post nurse staffing information every day. 41575 Based on observation, interview, and document review, the facility failed to ensure required nurse staffing information was consistently posted on a daily basis. This had potential to affect all 72 residents, staff, and visitors who could wish to review this information. Findings include: On 12/3/24, at 6:45 a.m. adjacent to the front doors was a wall-mounted, particle board which had a paper document hung with a thumbtack titled Daily Staffing for Tuesday November 26, 2024 and identified a census of 70. The document listed staff scheduled hours per shift for each nursing job class. However, the posting was dated 11/26/24, seven days prior. When interviewed on 12/5/24, at 2:40 p.m. medical records (MR)-I stated she was responsible for the daily staffing posting. MR-I thought she had posted for the holiday weekend but must not have done so. MR-I was working on system to ensure she did not forget to post staffing daily. It was important to have the posting updated every day so staff, family and state knew how many residents were in the building and that the facility was sufficiently staffed. On 12/5/24, at 4:27 p.m. the director of nursing stated the facility expected the daily staff posting to be posted consistently every day. A joint interview with the administrator and administrator designee was conducted on 12/5/24, at 4:49 p.m. The administrator stated the staff posting was expected to be posted and updated daily. It was important as a way to communicate with family, visitors, and residents for staff ratio and census. A policy regarding the nurse staff posting was requested but not received.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41575 Based on interview and document review, the facility failed to ensure the consulting pharmacist (CP) identified the need for a gradual dose reduction (GDR) or medical justification of use for 1 of 5 residents (R3) reviewed for unnecessary medication. Findings include: R3's significant change Minimum Data Set (MDS) dated [DATE], identified R3 had severe cognitive impairment and R3 received antipsychotic medication daily. The MDS identified GDR was not attempted and there was no documentation that a GDR was contraindicated from R3's physician. Diagnoses included Alzheimer's, bipolar disorder, drug induced subacute dyskinesia (define), heart disease, and kidney failure. R3's most recent Physician Order Report dated 12/5/24, identified R3's current physician ordered medications. These included olanzapine five milligrams (mg) at bedtime for bipolar disorder with start date 3/31/22. R3's most recent Physician Progress note dated 10/25/24, identified R3 received olanzapine 5 mg daily for a diagnosis of bipolar. All medications were reviewed; however, the olanzapine was not identified to have medical justification of continued use by the physician. R3's Pharmacy Monthly Reviews were reviewed from 12/2023 to 11/2024, with no irregularities identified. R3's medical record was reviewed and lacked evidence a GDR had been attempted or identified a medical justification for continued use and R3 was at the lowest effective does within the past calendar year of R3's received olanzapine. During interview on 12/5/24, at 3:37 p.m. registered nurse (RN)-D stated there had been no pharmacy recommendation for a gradual dose reduction on R3's olanzapine. During telephone interview on 12/5/24, at 4:00 p.m. the consultant pharmacist (CP) stated he conducted monthly medication reviews for the residents. He should have asked the physician to review R3's dose of olanzapine to ensure minimal effective dosing. The pharmacy was trying to be more assertive with their recommendations to physicians and so he should have recommended to consider a GDR on R3's medication. When interviewed on 12/5/24, at 4:35 p.m. the director of nursing (DON) stated she would have expected the provider to have been notified of the need for GDR consideration of R3's olanzapine. A GDR for psychotropic medications was expected to be addressed annually. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A joint interview with the administrator and administrator designee on 12/5/24, at 4:50 p.m. The administrator stated he would have expected CP to have reviewed and requested a GDR on R3's medication olanzapine. It was important to review for a GDR to make sure the resident was receiving the lowest optimal dose. The facility policy Psychotropic Medications dated 12/6/23, identified a gradual dose reduction was the step wise tapering of a medication to determine whether symptoms, conditions, or risks could be managed by a lower dose or whether the medication could be discontinued. Based on comprehensive assessment of the resident, the facility must ensure residents who use psychotropic drugs receive gradual dose reductions and behavior interventions, unless clinically contraindicated, in an effort to discontinue those drugs.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41575 Based on observation, interview and document review, the facility failed to ensure a gradual dose reduction (GDR) was attempted and/or medical justification was provided to support ongoing use of an antipsychotic medication for1 of 5 residents (R3) reviewed for unnecessary medication use. Findings include: R3's significant change Minimum Data Set (MDS) dated [DATE], identified R3 had severe cognitive impairment and R3 received antipsychotic medication daily. A gradual dose reduction was not attempted and there was no documentation that a GDR was contraindicated from R3's physician. R3 was dependent with most activities of daily living (ADLs) and maximum assist with mobility. Diagnoses included Alzheimer's, bipolar disorder, drug induced subacute dyskinesia (a movement disorder associated with long term exposure to certain medications) , heart disease and kidney failure. R3's care plan dated 12/2/24, identified a potential problem related to psychotropic medication use with a goal for medication effectiveness with minimal side effects and long-term goal for reduction in targeted behaviors. The care plan listed interventions to help R3 meet this goal which included to administer medication as ordered, to monitor for side effects as well as adverse behaviors and periodic pharmacist review. R3's most recent Physician Order Report dated 12/5/24, identified R3's current physician ordered medications. These included olanzapine five milligrams (mg) at bedtime for bipolar disorder started 3/31/22. R3's Physician Progress note dated 10/25/24, identified R3 received olanzapine 5 mg daily for a diagnosis of Bipolar. All medications were reviewed; however the continued daily use of olanzapine was not discussed. R3's Pharmacy Monthly Reviews were reviewed from 12/2023 to 11/2024, with no irregularities identified. R3's medical record was reviewed and lacked evidence a GDR was attempted within the past calendar year R3 received olanzapine. Further, the medical record lacked evidence the ongoing use of olanzapine had been addressed by the medical provider to provide adequate medical justification. During observation on 12/03/24 at 4:46 p.m. R3 was seated in dining room at a table with another resident, eating supper. R3 was fully dressed and groomed and was eating her meal independently. No visible medication side effects were noted and R3 appeared comfortable. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 12/5/24, at 3:37 p.m. registered nurse (RN)-D stated there had been no pharmacy recommendation for a gradual dose reduction on R3's olanzapine. Nursing had not requested a GDR either. It would be expected to ask R3's physician to review her psychotropic medication and consider a dose reduction. RN-D stated RN-C completed the resident psychotropic medication program and would be the one to follow when GDR's were required. During telephone interview on 12/5/24, at 4:00 p.m. the consultant pharmacist (CP) stated he conducted monthly medication reviews for the residents. He should have asked the physician to review R3's dose of olanzapine to ensure minimal effective dosing. The pharmacy was trying to be more assertive with their recommendations to physicians and so he should have recommended to consider a GDR on R3's medication. During interview on 12/5/24, at 4:30 p.m. RN-C stated she was responsible to review residents' psychotropic medication use. RN-C usually relied on pharmacist recommendations to prompt her to ask the provider to consider a GDR for residents. Because the pharmacist had not made the recommendation to consider a GDR for R3, RN-C had not reviewed R3's psychotropic medication use with the provider and/or requested he consider a GDR for R3's olanzapine. RN-C did not have a process to track when resident's were due for consideration of a GDR and just relied on her chart review during her quarterly assessments to monitor for this. When interviewed on 12/5/24, at 4:35 p.m. the director of nursing (DON) stated she would have expected the provider to have been notified of the need for GDR consideration of R3's olanzapine. A GDR for psychotropic medications was expected to be addressed annually. A joint interview with the administrator and administrator designee was conducted on on 12/5/24, at 4:50 p. m. the administrator stated he would have expected nursing and/or the CP to have reviewed and requested a GDR on R3's medication olanzapine. It was important to review for a GDR to make sure the resident was receiving the lowest optimal dose. The facility policy Psychotropic Medications dated 12/6/23, identified a gradual dose reduction was the step wise tapering of a medication to determine whether symptoms, conditions, or risks could be managed by a lower dose or whether the medication could be discontinued. Based on comprehensive assessment of the resident, the facility must ensure residents who use psychotropic drugs receive gradual dose reductions and behavior interventions, unless clinically contraindicated, in an effort to discontinue those drugs.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40943 Based on observation, interview and document review, the facility failed to ensure medications were administered in accordance with physician orders and/or manufacturer guidelines for 2 of 6 residents (R23, R54) observed to receive medication during the survey. This resulted in a facility medication administration error rate of 6.9 percent (%). Findings include: R23's quarterly Minimum Data Set (MDS) dated [DATE], identified R23 was cognitively intact and included a had diagnosis of hemiplegia (one side paralysis or weakness) due to a history of a stroke. R23 exhibited pain and received scheduled and as needed pain medications. R23's Physician Order Report dated 12/8/23 identified R23 received Voltaren Arthritis Pain (diclofenac sodium) (an anti-inflammatory topical pain medication) gel 1%. Apply 4 gram (g) to affected area 4 times a day for back pain. During an observation on 12/4/24 at 6:52 p.m., registered nurse (RN)-B took R23's tube of Voltaren gel and apply approximately 1 inch to RN-B's gloved hand and then applied it to R23's left thigh/knee where R23 was complaining of discomfort. - At 7:11 p.m., RN-B stated R23's dose of Voltaren gel was 3 mg, but RN-B had no idea how to know the correct dose had been dispensed. RN-B then stated there was a dosing chart in the box. However, R23's Voltaren gel had been removed from the box and the box and/or dosing chart was no longer available. RN-B stated Voltaren gel could be hard on a person's kidneys if they were given too much. During an interview on 12/5/24 at 2:49 p.m., the director of nursing (DON) stated staff were expected to measure Voltaren gel per the manufacturer's instructions and apply the correct dosage because it's different dosages for different concerns. The Voltaren Gel Manufacturer's Instructions for Use dated 2023, instructed to use the provided dosing card to apply the following amounts: - Upper body areas (hand, wrist, elbow): 2.25 inches - Lower body areas (foot, ankle, knee): 4.5 inches 41575 R54's significant change MDS dated [DATE], identified R54 had severe cognitive impairment. Diagnoses included high blood pressure and hypokalemia (low potassium). R54's Physician Order Report dated 12/5/24, included an order for vitamin D3 50 micrograms (mcg) two tablets daily by mouth daily. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During observation of medication pass on 12/4/24, at 8:08 a.m. RN-E was preparing R54's medications for morning medication administration. RN-E took out a bottle labeled with R54's name. The label identified the medication was vitamin D3 50 mcg with instructions to administer two tablets by mouth daily. RN-E placed one tablet into the medication cup and continued to dispense the remaining morning medications ordered for R54. RN-E locked the medication cart and prepared to walk to R54's room to administer her medications. When asked to count how many pills were dished up for R54. RN-E identified the count was one pill short. RN-E checked each medication in the cup and had difficulty identifying what medication was missing. RN-E reviewed the label on the vitamin D3 label and compared the label to R54's Medication Administration Record (MAR). RN-E stated she should have dispensed two tablets of vitamin D3 and had only dispensed one tablet. RN-E then added another vitamin D3 tablet to R54's medication cup and administered R54's medications as ordered. When interviewed on 12/5/24 at 9:05 a.m. RN-E stated it was important to check medication labels and cross check the labels with the resident's MAR. This was done to ensure to administer the correct ordered dose. RN-E stated she had not crossed checked the bottle of D3 with R54's MAR and that was something she should have done. When interviewed on 12/5/24, at 4:24 p.m. the DON stated she would expect nurses to check prescription bottle labels and compare the bottle with the resident's MAR and to administer medications as ordered. A oint interview with the administrator and administrator designee on 12/5/24, at 4:49 p.m. The administrator stated he would expect nurses to go through the rights of medication administrations and administer all medications accordingly and as ordered. The facility policy Medication Administration dated 5/21/24, identified all medications were administered to residents according to the six rights: right medication, right dose, right resident, right route, right time and right documentation. Before medication administration staff were to perform three checks. Read the label on medication container and compare with the resident's MAR when removing the medication from the supply drawer, when placing the medication in the resident's medication cup and just before administering the medication. The facility policy Medication: Administration Including Scheduling and Medication Aides revised 5/21/24, directed staff to follow the Six Rights: right medication, right dose, right resident, right route, right time and right documentation. However, the policy failed to identify how staff were to administer a topical medication per manufacturer's instructions

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40943 Based on observation, interview, and document review, the facility failed to ensure the correct diet texture was served to 1 of 5 residents (R38) reviewed for pressure ulcers; and failed to accommodate dietary preferences of 1 of 1 resident (R58) reviewed for food choices. Findings include: R38 R38's quarterly MDS dated [DATE], identified R38 had severe cognitive impairment and a diagnosis of Alzheimer's disease. R38 was dependent on staff for all care activities. R38's care plan revised 12/26/23, identified R23 required a mechanically altered diet related to chewing and swallowing abilities. Staff were directed to encourage oral intake of food and fluids. R38's dietary order dated 8/23/24, identified R38 required a minced and moist texture (a minced and moist diet consists of soft and moist foods that are easy to chew and swallow. The food was minced or mashed before serving, with no big lumps, and requires little or no biting. Lumps should be no more than 4 millimeter (mm) in size for adults. Foods in this diet should be easy to form into a ball and must not contain any hard lumps) with thin liquids without a straw. R38's In-Patient Speech Therapy Clinical Swallow Evaluation Initial Evaluation dated 7/22/24, identified R23's food recommendations were a level 6 Soft & Bite Sized (NDD3) (This diet consists of many ordinary foods that are soft and easy to chew. Foods can be eaten with a fork or spoon. Foods are soft and fork-tender; they are moist, but there is no separate thin liquid present. Solid food pieces are 8mm or smaller for children or 15mm (about 1-2 inch) for adults) diet and thin liquids. Guidelines: alternate one bite solid with one sip liquid; assist with feeding; R23 was to sit fully upright for all oral intakes; reduce environmental distractions during oral intake; and provide frequent, thorough oral cares (slow rate, small bites/sips). During a meal service observation on 12/4/24 at 11:26 a.m., dietary aide (DA)-A placed pork on a plate and diced the pork with a fork and spoon. No sauce was added to the pork. DA-A then placed steamed broccoli and hot potato salad on R38's plate and served the meal to R38. R38's pork with stringy, with pieces approximately larger than 1 inch and the broccoli nor hot potato salad were minced. - At 12:13 p.m., DA-A provided a printed stack of dietary orders and stated staff went by those to determine what residents needed for meals. For example, some residents needed minced and moist. DA-A stated minced and moist meant staff chop it up and put either a sauce or a gravy on it. DA-A did not put a sauce or a gravy on R38's pork, but stated DA-A was dependent on the kitchen for what was available, and the kitchen did not send a sauce or gravy for this meal. Nursing assistant (NA)-A was observed to assist R38 with his meal. R38 did cough while eating but had no signs or symptoms of choking. R38's medical record did not idenify R38 had any choking episodes in the past. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the facilities manager (F)-A and DA-B on 12/5/24 at 10:22 a.m., DA-B stated preparation of the minced and moist diets would require the use of a food processer and some type of liquid to make the food moist. The kitchenettes had chicken or beef stock and homemakers would use that. During an interview on 12/5/24 at 11:09 a.m., the registered dietitian (RD) stated a minced and moist diet was a dysphagia (difficulty swallowing) diet, a step before a pureed diet. R38's food should have been pulse in the food processer and a liquid added to it, hence the moist. Not doing this could potentially increase the risk of a choking incident and/or aspiration. The RD stated R38's meal should have been prepped in the kitchenette and presented to R38 as prescribed. During an interview on 12/5/24 at 11:32 a.m., registered nurse (RN)-A stated she expected staff to be aware of resident dietary orders and to send the meal back if incorrect to prevent a risk for choking or aspiration. During an interview on 12/5/24 at 2:48 p.m., the director of nursing (DON) stated she expected nursing staff to report an incorrect meal type to dietary staff and request the correct meal. Additionally, the DON stated dietary staff had a list of prescribed resident diets and the DON expected dietary staff to follow that list during meal service to prevent the risk for choking or aspiration. R58 R58's admission Minimum Data Set (MDS) dated [DATE], identified R58 had a severe cognitive impairment and had diagnoses that included Type 2 diabetes. R58's care plan dated 11/18/24, identified R58 was at nutrition risk related to use of multiple medications, R58 was an ovo pescetarian (a dietary practice in which seafood and eggs were consumed in an otherwise vegetarian diet), and R58's weight was below his ideal body weight. Interventions included: 1. Regular diet per order - ovo pescatarian (will eat eggs, dairy and fish) 2. Monitor weight, labs, and intakes 3. Encourage fluids 4. Meals to the area dining room per his preference 5. Assist with meal set up as needed 6. Request addition of a dietary supplement to help meet his protein needs related to R58 did not eat meat 7. R58 liked cottage cheese, yogurt, peanut butter, eggs, chocolate or white milk, all vegetables, and all fruits 8. RD to make changes to his nutrition plan as needed. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 12/4/24 at 4:06 p.m., R58 was sitting in his wheelchair at the dining room table with FM-A. R58 was served a grilled cheese sandwich with a peeled mandarin orange. During an interview on 12/4/24 at 6:43 p.m., DA-C stated R58 was a vegetarian and did not want to eat meat. However, staff needed to give R58 something more filling than just vegetables. FM-A was good about telling staff what to give R58. Usually, DA-C made a grilled cheese sandwich and there was always some fruit available. Also, R58 like to eat dessert or some bread. Something that I know will fill R58 up for the night. During an interview on 12/5/24 at 11:13 a.m., the RD stated the facility had brought in the assistance of FM-A regarding R58's meal choices. FM-A made a menu selection for R58 that was posted in the kitchen. R58 liked grilled cheese sandwiches, cottage cheese, yogurt, eggs, and fish. FM-A brought nuts and those types of things for R58 as well. The RD stated staff should follow R58's food choices and ensure R58 received adequate nutrition. During an interview on 12/5/24 at 2:40 p.m., the DON stated staff were expected to provide all residents with their dietary needs as ordered. During an interview on 12/5/24 at 4:59 p.m., the administrator stated the dietary staff were expected to follow dietary menus and choices selected to allow resident rights and to prevent choking and/or aspiration. The facility policy Diet Orders revised 9/11/24, identified the facility would provide food and nutrition to encourage adequate nutrition intake for residents by promoting a liberalized diet approach while maintaining compliance with physician-ordered diets and accepted standards of menu planning. Procedure: 1. A list of diets an menu extensions available in the location is maintained with food and nutrition services and given to the nursing department. The list of diets available may vary from location to location based on community standards and practices. 2. The location's approved diet manual and the Society Menu Program Standards can be used as a guide in developing the list of diets available in the location. The list reflects liberalization of diets as recommended in current practice. Rehabilitation/skilled care ocations and assisted living locations that use the Society Menu Program can generate a custom diet spreadsheet. Diets and Nutritional Supplements is used for maintaining the list of diets at rehabilitation/skilled care locations. 4. Employees ensure that residents receive the most liberal approach their condition can tolerate. Ass:ss the risk/benefit of the liberalized approach. Stricter diets should only be considered based on resident outcome goals. a. Stricter diets are not shown to improve outcomes in long term care. b. Stricter diets may be required for some residents in the post-acute care setting (e.g., congestiV= heart failure, insulin-dependent diabetes). 5. There should not be diet as tolerated or thickened liquids as tolerated orders. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	6. All orders for thickened liquids should identify texture: 1 Slightly Thick 2 Mildly Thick 3 Moderately Thick 4 Extremely Thick 7. Physician's orders must include the name of the diet, including any therapeutic restrictions and texture alterations. a. Revised diet orders are complete and include any previous diet orders that are to remain. 8. When a physician request!: a diet order that is required for the plan of care but is not on the list of diets, location employees contact the dietitian for assistance with determining the course of action. a. The dietitian writes the initial menu extension or approves such menu extension. The dietitiar evaluates the menu extension using the menu planning guides in the approved diet manual or another reputable source. 9. If an individualized meal pan developed for any resident is in conflict with the current diet order, the director of food and nutrition services (DFN) requests a change in the diet order before implementing the meal plan. If an individualized meal plan is within the parameters for the physician ordered diet, no action is required prior to implemertation. 10. When a new diet order is received or an existing order is changed, food and nutrition services is notified, a. Rehabilitation/skilled care: The Diet Notification Form is completed and given to the food and nutrition department and other departments as needec. Any diets not listed can be written under Other using the appropriate terminology from the approved diet manual. Any orders for enteral (tube) feeding, medical nutritional supplements and any special requests are also communicated on the form. 11. AII pertinent records inducing diet lists, care plans, medication sheets, charts and diet tray cards must b: updated with the revised diet order. 12. A roster/list of physician-o-dered diets is maintained in the food and nutrition department. The diet list report from Society-approved software is acceptable for this purpose. 13. On a monthly basis, the diet roster should be compared to the physician's orders, diet tray cards and menu extensions to monitor compliance with the physician's diet order. If a discrepancy is found, correct it and check the care plan for accuracy. Update .:md/or correct the care plan as needed. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	14. The DFN, dietitian or dietetic technician (NDTR) provides in-service education to employees on the diets ottered in the location as needed.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40943 Based on observation, interview and document review, the facility failed to maintain clean and sanitary conditions of kitchen equipment and ensure hairnets were worn when preparing resident meals, to prevent the spread of food born illness. This had the potential to affect 69 out of 69 residents that received food out of the kitchen or kitchenette. Findings include: Mixer: During an initial tour of the main kitchen on 12/3/24 at 7:02 a.m., a large industrial mixer was on the counter. The underside of the mixer head, which sat over the mixing bowl, was coated in a tan colored food debris on the underside. There was a white dust covering the mixing bowl arms. During an observation of the large industrial mixer on 12/5/24 at 11:20 a.m., the underside of the mixer head continued to be coated with a tan colored food debris. DA-B stated, that's bad, really bad and equipment should be thoroughly cleaned after every use to prevent contamination of food. During an interview on 12/5/24 at 4:59 p.m., the administrator stated staff were expected to clean kitchen equipment after every use to prevent contamination of food and to prevent foodborne illness. Ice and Water Dispenser: During an observation on 12/4/24 at 11:26 a.m., the [NAME] units kitchenette's ice and water dispenser was dribbling water. Inside the clear acrylic spout was a black colored tar-like substance stuck to the ridges and corners. DA-A stated he did not how often the ice and water dispenser were cleaned because it was done by the maintenance department. DA-A stated he had no idea how long the black colored substance was in the spout and stated he was only responsible for cleaning the drip tray. During an interview with the facilities manager (F)-A and DA-B on 12/5/24 at 10:20 a.m., F-A stated the ice and water dispensers were cleaned by a contracted service quarterly; however, the front of the machine, including the spout was cleaned by dietary staff. The spout was removable and should be cleaned at least every couple of days. DA-B stated she was unaware the spout was removable and stated dietary staff would need education how to clean the ice and water dispenser. During an interview on 12/5/24 at 4:59 p.m., the administrator stated she expected a policy/procedure directing cleaning of the ice and water dispenser and staff education so that everyone was aware to complete the task to prevent transmission of foodborne illness. The facility policy Sanitation for Hosp and NH Kitchens revised 1/30/24, identified the facility would ensure a sanitary environment for storage of food in the floor kitchens by Weekly; an assigned NFS employee will clear all kitchenettes including a weekly sanitation checklist of the following: (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	- Removing any outdated foods and ensuring all foods are labeled and dated. - Cleaning and sanitizing refrigerators, including freezer compartment. - Cleaning and sanitizing microwave. - Straightening and sanitizing cupboards, drawers, and counter tops. - Restocking assigned items. - Coffee / hot water machine is cleaned per vendor recommendation. - Food belonging to a specific patient or resident will meet the same requirements as listed above. However, the policy failed to identify the cleaning procedure of the mixer and/or the ice and water dispenser. Hairnets During the initial tour of the main kitchen on 12/3/24 at 7:02 a.m., dietary aide (DA)-D was wearing a baseball cap with her long hair not fully contained under the cap and was not wearing a hairnet. DA-D was preparing bacon and potatoes. DA-D went into the bathroom and put her hair in a bun and covered with a hairnet and stated, every morning I put my hair up in a bun and the one time I don't of course state shows up. DA-D proceeded to pack up the bacon and potatoes to take the units for breakfast service. During an interview with the facilities manager (F)-A and DA-B on 12/5/24 at 10:22 a.m., DA-B stated staff were expected to wear a hairnet when preparing food to prevent foodborne illness. 41575 On 12/4/24, at 4:03 p.m. a brief tour of the kitchenette located on Elderberry Neighborhood was conducted. Dietary aide (DA)-E was preparing the area to begin supper service and had placed the supper food in the unit's steam tables. DA-E had short black hair and was not wearing a hair net to cover his hair. DA-E immediately took a hairnet from the container at the kitchenette entrance and put it on. DA-E stated he usually wore a hairnet and had just forgotten. The facility policy Employee Hygiene and Dress revised 6/12/24, identified hairnets or hair restraints and beard nets or beard restraints are used when cooking, preparing, assembling food or ingredients. This includes dish rooms and storage areas. Hair is to be covered completely. The 2022 FDA Food Code, identifies shall wear hair restraints such as hats, hair coverings or nets, beard restraints, and clothing that covers body hair, that are designed and worn to effectively keep their hair from contacting exposed food.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40948 Based on observation, interview and document review, the facility failed to develop and implement an infection control surveillance plan for identifying, tracking, monitoring for 2 of 2 residents (R277, R278) who had diarrhea; and failed to ensure all resident potential infection symptoms were tracked along with providing a monthly written analysis of infections; and failed to ensure enhanced barrier precautions (EBP) were followed for 1 of 1 residents (R10, R2) with wound care and indwelling medical devices; and failed to ensure staff utilized masks in the appropriate manner on 1 of 3 units affected by COVID-19 in an effort to reduce the potential spread of illness. This had the potential to affect 71 residents residing in the facility. Findings include: SURVEILANCE/ ANALYSIS: R277's admission Minimum Data Set (MDS) dated [DATE], identified no cognitive impairment. R277's diagnosis included UTI. R277's progress note dated 11/22/24, identified was having loose stools. During an interview on 12/5/24 at 4:46 p.m., registered nurse (RN)-B stated R277 had been having loose stools since the weekend and just received an order for loperamide (a medication used to treat various forms of diarrhea). The consistency of a bowel movement should be documented by either the nursing assistant or the nurse. It was not a required thing but should have been documented. Information regarding loose stools should have been reported to the day nurse. Then the day nurse would have reported them to the infection control nurse. R278's admission MDS dated [DATE], identified no cognitive impairment. R278 was continent of bowel and bladder. R278's diagnoses identified sepsis (severe infection in the body), UTI, and respiratory failure. R278's progress notes and bowel documentation lacked any identification of the consistency of bowel movements During an interview on 12/5/24 at 4:50 p.m., licensed practical nurse (LPN)-B (the infection preventionist) stated R278 was seen by a provider in the facility and ordered a lab test for C. Diff. due to R278 having loose stools. She was surprised because she was unaware of R278 had loose stools and was not documented. Further, LPN-B was not aware R277 was having loose stools the past few days. Both residents resided on the same unit. The facility provided monthly infection control (line list) the form identified the unit, resident name, type of infection, date of onset, testing performed and results, antibiotic or antimicrobial used, length of therapy, if criteria was met and time out was performed, and if it was facility acquired or community acquired. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	- The monthly infection control log (line list) for September 2024, identified six residents with pneumonia, four residents with a urinary tract infection (UTI), two residents with a tooth infection, two residents with a skin infection, one resident with a blood infection, one resident with a lower respiratory infection, one resident received a prophylactic antibiotic, three residents fromprevious month and carried forward but did not identify reason for antibiotic. All the residents were treated with an antibiotic. It identified eight residents with COVID and one was treated with an antimicrobial. There were no listed infections or resident infection symptoms which were not treated with antibiotics (i.e. common cold symptoms, viral infections). The facility failed provide an analysis of the infections to include patterns or what interventions were implemented to reduce incidences of further infection related to the COVID, pneumonia, or UTIs. The monthly infection control log (line list) for October 2024, identified eight residents with a UTI, three with osteomyelitis (a serious infection in the bone), two with pneumonia, one resident with clostridioides difficile (C. Diff) (a bacteria that causes diarrhea and colitis (an inflammation of the colon) and can be life-threatening), one resident with a lower respiratory infection. All the residents were treated with an antibiotic. It identified one resident with COVID and was treated with an antimicrobial. There were no listed infections or resident infection symptoms which were not treated with antibiotics (i.e. common cold symptoms, viral infections). The facility failed to provide an analysis of the infections to include patterns or what interventions were implemented to reduce incidences of further infection related to UTIs, or osteomyelitis. The monthly infection control log (line list) for November 2024, identified nine residents with a UTI, two with a skin infection, two with a COPD exacerbation, one with pneumonia, 4 on prophylaxis. All the residents were treated with an antibiotic. It identified three residents with COVID and were treated with an antimicrobial. There were no listed infections or resident infection symptoms which were not treated with antibiotics (i.e. common cold symptoms, viral infections). The facility failed to provide an analysis of the infections to include patterns or what interventions were implemented to reduce incidences of further infection including UTI's, respiratory, skin infections and COVID. The monthly infection control log (line list) for December 2024 was requested, but not received. During an interview on 12/5/24 at 4:50 p.m., (LPN)-B stated she did the infection prevention surveillance on a spreadsheet form. LPN-B tracked antibiotic usage and tracked COVID on the same form. There was a different spread sheet she would track high risk symptoms on, (a copy of the spread sheet was requested but not received). LPN-B got information daily from the day nurses on each of the units, by reading progress notes and looking for new antibiotics prescribed. LPN-B would have expected staff would chart pertinent information regarding resident showing sign or symptoms of illness. Which included fever, nausea, vomiting, diarrhea, cough. There were not any high-risk symptoms happening at this time and she was not tracking anything. It was important to monitor for loose stools when resident had been on antibiotics because they were at a higher risk to develop C. Diff. which is very contagious. LPN-B was not aware R277 was having loose stools the past few days and would have expected staff to share the information with her. She did not know of the residents who had loose stools and was not monitoring them. During an interview on 12/5/24, at 5:31 p.m., the director of nursing (DON) stated she would have expected staff to document signs and symptoms of infection and for the infection preventionist to have followed up to ensure health of all residents. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER: Neilson Place		STREET ADDRESS, CITY, STATE, ZIP CODE: 1000 Anne Street Northwest Bemidji, MN 56601	

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The facility's Surveillance policy dated 9/3/24 identified surveillance is designed to identify and report evidence of infection. Collecting, documenting and analyzing data will be done by the infection preventionist or the designated staff member. 40943 EBP: R10's significant change MDS dated [DATE], identfiied R10 was cognitively intact and had diagnoses that included quadriplegia, type 2 diabetes, and neuromuscular dysfunction of bladder. R10 had a stage 4 pressure ulcer, a colostomy and an indwelling catheter and was receiving intravenous medications. R10's care plan revised 11/19/24, identified R10 had an infection to a sacral wound (a region located at the base of the spine in the pelvic area) wound and had a need for enhanced barrier precautions due to indwelling urinary catheter and chronic wound. The following interventions were identified: - Post signage on door or wall outside of resident room - PPE available immediately outside of resident room. Staff to wash their hands upon entering and leaving room. PPE to be doffed prior to leaving resident room. - Provide education to resident or representative on the need for and duration of EBP. Encourage resident or representative to discuss feelings reoardino EBP. - Physical and occupational therapy to use EBP in common areas when therapy activities have risk for repeated contact, including but not limited to transfer practice, ambulation, balance training, toileting practice. - Standard precautions along with gown and gloves during high contact resident care activities such as: dressing bathing/showering, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, repositioning, device care or use (central line, urinary catheter, feeding tube, tracheostomy, etc.) and wound care (any skin opening requiring a dressing). PPE to be doffed prior to exiting room. R2's quarterly MDS dated [DATE], identified R2 had a severe cognitive impairment and diagnoses that included traumatic brain injury and quadriplegia. R2 used a feeding tube for all his nutritional needs. R2's care plan revised 10/16/24, identified R2 had a need for enhanced barrier precautions do to having a feeding tube. The following interventions were identified: - Post signage on door or wall outside of resident room - PPE available immediately outside of resident room. Staff to wash their hands upon entering and leaving room. PPE to be doffed prior to leaving resident room. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	- Provide education to resident or representative on the need for and duration of EBP. Encourage resident or representative to discuss feelings reoardino EBP. - Physical and occupational therapy to use EBP in common areas when therapy activities have risk for repeated contact, including but not limited to transfer practice, ambulation, balance training, toileting practice. - Standard precautions along with gown and gloves during high contact resident care activities such as: dressing bathing/showering, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, repositioning, device care or use (central line, urinary catheter, feeding tube, tracheostomy, etc.) and wound care (any skin opening requiring a dressing). PPE to be doffed prior to exiting room. During an observation on 12/4/24 at 10:39 a.m., there was an enhanced barrier sign and a plastic three drawer cart containing gowns outside R10's door. Nursing assistant (NA)-C entered R10's room without donning a gown and provided R10 with assistance for morning cares, emptied R10's colostomy bag into a graduate lined with a trash bag, provided catheter care came into close contact with R10 and R10's bed, wheelchair and belongings. - At 10:41 a.m., NA-C picked up R10's ceiling lift sling from the floor and placed the sling under R10. - At 10:56 a.m., NA-C provided R10 his call light and left the room. - At 10:58 a.m., NA-C returned to the room accompanied by NA-A. Neither NA-C or NA-A donned a gown and assisted to transfer R10 into his wheelchair via a full body mechanical lift. NA-C and NA-A came into close contact with R10 and R10's bed and wheelchair. - At 11:10 a.m., NA-C and NA-A left the room and went to R2's room. There was a enhanced barrier precautions sign and a plastic three drawer cart containing gowns outside R2's door. Neither NA-C or NA-A donned a gown. NA-C and NA-A assisted with repositioning R2 and NA-C left the room while NA-A assisted R2 with his hand/arm braces. - At 11:12 am., NA-C pointed to the enhanced barrier precautions sign hanging outside R2's door and stated whenever staff went into a room with that sign and there was a cart available, staff needed to put on a gown and gloves during cares. Staff always donned a gown and gloves every time, however, NA-C stated she must have forgot to donn a gown prior to entering R10 or R2's room. - At 11:16 a.m., NA-A pointed to the enhanced barrier sign outside R2's door and stated the only time staff needed to wear a gown was when staff changed R2's incontinent brief or something where you're going to have contact with bodily fluids. NA-A did not donn a gown prior to going into R10 or R2's room because I didn't get into anything like that. However, NA-A then pointed to the sign again and stated according to that, evidently you need to wear a gown for everything. During an interview on 12/5/24 at 8:09 a.m., licensed practical nurse (LPN)-A stated, when a resident was placed on enhanced barrier precautions, staff were expected to wear a gown and gloves whenever they're going to be in contact with the residnet; like cares. Anything where they're going to touch the resident. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 12/5/24 at 11:34 a.m., registered nurse (RN)-A stated staff were expected to follow enhanced barrier precautions guidelines to the prevent the potential transmision of microorganisms. During an interview on 12/5/24 at 2:35 p.m., the director of nursing (DON) stated staff were expected to follow enhanced barrier precautions guidelines for any resident with an invasive device, wound care and/or an multi-drug resistant organism (MDRO). Gowns and gloves were expected any time a resident needed care that required contact with the resident. The facility provided Multidrug-Resistant Organisms, MRSA VRE CRE and ESBL policy revised 4/12/24, identified Enhanced Barrier Precautions would be used for all residents with any of the following: - wounds an/or indwelling medical devices (e.g. central line, urinary catheter, feeding tube, tracheostomy/ventilator) regardless of MDRO colonization status - infection or colonization with a [NAME] or targeted MDRO when Contact Precautions did not apply Facilities may consider applying Enhanced Barrier Precautions to residents infected or colonized with other epidemiologically important MDROs based on facility policy The personal protective equipment (PPE) would be used during high contact resident care activities: - dressing - bathing/showering - transferring - providing hygiene - changing linens - changing briefs or assisting with toileting - device care or use: central line, urinary catheter, feeding tube, tracheostomy/ventilator) - wound care: any skin opening requiring a dressing The policy identified the PPE required included gown and glove prior to high contact care activity (change PPE before caring for another resident) (Face protection may also be needed if performing activity with risk of splash or spray) 42075 MASKS: (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 12/3/24 at 7:03 a.m., registered nurse (RN)-B stated there was one staff member and one resident that tested positive for COVID over the weekend. The facility tested the units where the staff member worked including [NAME], [NAME] and Strawberry. The three units were in outbreak status due to the positive staff member. All residents on these units tested negative on 12/1/24. One resident was positive prior to admission 12/1/24. An email to all facility staff from licensed practical nurse (LPN)-B dated 11/18/24, identified all neighborhoods/units remained in COVID outbreak status due to continued staff and resident positive cases and identified all staff were required to wear a mask in all neighborhoods. During interview on 12/4/24 at 11:36 a.m., LPN-B stated the facility was currently in a COVID outbreak due to multiple staff and a resident being positive. The most recent positive result was a staff member who completed a home test over the past weekend. During observation on 12/5/24 at 9:23 a.m., dietary aide (DA)-A was in the [NAME] unit kitchenette pouring drinks and dishing food onto a plate for a resident. DA-A's face mask was under the chin and not covering the mouth or nose. DA-A proceeded to carry the drink and plate of food to the table where residents were seated, returned to the kitchenette, poured a cup of liquid from the dispenser and carried the cup to the resident. DA-A was not observed to pull the mask over nose prior to dishing up or delivering the food, or upon returning to the kitchenette. On 12/5/24 at 9:25 a.m., DA-A was standing in the kitchenette and as state surveyor (SA) approached, DA-A pulled the mask over his mouth and nose. DA-A stated staff were supposed to wear face masks that securely covered the mouth and nose all the times including during prepping, cooking, dishing, and serving food, and when in close proximity to residents. DA-A stated he worked on all units in the facility and was aware that three of the units were required to wear PPE because of a COVID outbreak. DA-A stated he recently worked on [NAME], which was COVID positive at the time, but did not answer when asked the date he last worked on [NAME]. DA-A stated staff were to wear face masks to prevent the spread of germs to residents, themselves, and other staff. DA-A stated he worked on all units prepping, cooking and serving food to the residents. Further, DA-A stated he was not wearing his face mask over the mouth or nose while pouring drinks, prepping, or delivering food to residents and had only pulled the mask up because SA had approached. On 12/5/24 at 10:33 a.m., RN-A stated the facility was currently in COVID outbreak and all staff, including dietary staff, were required to wear face masks under the chin and over the nose whenever working at the facility. RN-A stated all staff had been trained on how to appropriately wear PPE including face masks. On 12/5/24 at 10:43 a.m., the facilities manager (F)-A stated the facility followed recommendations from the infection preventionist regarding when to wear PPE including face masks. Staff were directed to wear face masks at all times and to ensure the mask was under their chin and over their nose. the F-A stated dietary staff were educated and instructed to wear face masks at all times including when prepping, cooking, dishing food, serving food, at all times when they were in the kitchen/kitchenette and where residents were and especially now since the facility was currently in a COVID outbreak. A policy on mask use while in COVID outbreak status was requested and not received.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40948 Based on interview and document review, the facility failed to provide offer and provide risk vs benefits of receiving or declining immunizations per Center for Disease Control and Prevention (CDC) guidance for 1 of 5 residents (R38) reviewed for immunizations. Findings include: R38's quarterly Minimum Data Set (MDS) dated [DATE], identified R38 was [AGE] years old and had severe cognitive impairment with a diagnosis of malignant neoplasm of the prostate (cancer). R38's immunization record dated 12/8/23, identified the following immunizations were received at an outside care setting, COVID-19 vaccination on 2/23/21 and on 2/2/21; pneumococcal vaccinations on 7/13/16 and 1/1/99, however, did not indentify the type of pneumococcal vaccination received. R38's medical record lacked evidence the following vaccinations were offered/ in conjunction with the medical provider and educated on the risk versus benefits of the vaccination: most recent booser for COVID-19, annual influenza, and pneumococcal vaccinations including PCV15, PCV20 and or PCV21. During an interview on 12/5/24 at 4:49 p.m., licensed practical nurse (LPN)-B (the infection preventionist) identified the process for reviewing immunizations was upon admission and on a regular basis. When immunizations were discussed the resident or resident's representative theu document they received education regarding the immunizations and a consent form would be signed whether to receive or decline the immunizations. The consent form would have identified the education given and if the resident or resident's representative would agree to the immunizations. LPN-B stated she missed offering the immunizations and education the COVID-19 vaccination, influenza vaccination, or pneumococcal vaccinations and did not get a consent signed. During an interview on 12/5/24 at 5:31 p.m. the director of nursing (DON) expected the policy for immunizations would be followed. The facility's Immunizations/Vaccinations for Residents, Pneumococcal, Influenza, COVID-19, and other policy dated 11/20/24, identified the purpose is to provide the resident the opportunity to receive immunizations and provide guidance recommenced immunizations. Each resident's immunizations will be reviewed upon admission and on an ongoing basis. Provide the Vaccination Information Statement (VIS) for influenza, pneumococcal, and COVID-19. Document education on the benefits and potential side effects of the vaccinations for which the resident was eligible.