STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245238	A. Building B. Wing	03/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mahnomen Health Center	414 West Jefferson Avenue Mahnomen, MN 56557

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. Based on interview and document review, the facility failed to accurately submit the payroll-based journal system (PBJ) staffing data to Centers for Medicare and Medicaid Services (CMS). This had the potential to affect all 31 residents residing in the facility.Findings include:The facilities PBJ data submitted to CMS for 10/1/25, through 12/31/25 (Q4 25), identified the facility was triggered for failure to submit data for the quarter.On 3/10/26 at 10:40 a.m., the chief financial officer (CFO) stated the staff member that submitted the PBJ data in 2025 no longer worked for the facility as of 2026. The staff member had access to the PBJ submission program, however there wasn't anyone else in the facility with access and the staff member had not submitted Q4 2025 data prior to leaving their position. The CFO stated by the time they realized the data hadn't been submitted, the timeframe had passed, and they were unable to submit. The CFO stated they have a plan to move forward to ensure the data will be submitted in a timely manner.A policy regarding submitting data to the Centers for Medicare and Medicaid (CMS) was requested but not received.

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

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

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F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly Based on interview and document review the facility failed to ensure the Quality Assessment and Assurance (QAA) committee failed to ensure the medical director was present quarterly and attendance of key members was documented. In addition, the facility infection preventionist (IP) failed to provide comprehensive infection control and antibiotic infomration as required for proper QAA analysis. These findings had potential to affect all 29 residents residing within the facility. Findings include:The Quality Assurance and Performance Improvement (QAPI) meeting minutes from the last standard survey dated 6/4/25 were reviewed and identified the following:June 2025 meeting minutes failed to identify who attended the meeting. The director of nursing (DON), medical director or their designee, and at least three other staff members are required, one of which must be either the administrator, owner, board member or other individual in a leadership role along with the infection preventionist (IP)July/August 2025 meeting identified the following were in attendance: DON who is also the IP, the administrator, case manager, maintenance, therapy, dietary, and two licensed practical nurses had attended the meeting. The medical director was not identified as attending the meeting.September/October 2025 meeting minutes failed to identify who attended the meeting. November/December 2025 meeting minutes failed to identify who attended the meeting. January 2026 meeting identified the following people attended the meeting: DON/IP, case manager, maintenance, therapy, dietary, and two licensed practical nurses had attended the meeting. The medical director and the administrator did not attend were not identified as attending.February 2026 meeting identified the DON/IP, the administrator, case manager, maintenance, therapy, dietary, and two licensed practical nurses attended the meeting. The medical director was not identified as attending the meeting.The QAPI meeting minutes from the last standard survey dated 6/4/25 were reviewed for infection prevention and identified the following information was presented to the QAA committee members for review:June 2025, there was one resident had a urinary tract infection (UTI) and was treated for five days but lacked name of medication and analysis of urine cultures. Another resident was started on an antibiotic due to possible aspiration but lacked the name of the medication and noted they were not having any symptoms.July/August 2025, there were five UTIs of which all were treated with identified medications, two urine cultures did not grow any bacteria, but treatment continued, and one had symptoms but did not specify. Once resident was receiving an antibiotic for an infected toe, and one resident was being treated for pneumonia.September/October 2025, there were five UTIs and two pneumonias but lacked any identification of bacteria or treatment.November/December 2025, there were five UTIs, one prophylactic for UTI, and two wounds but lacked any other information. January 2026, notes identified a covid outbreak and stated to see outbreak for information. There were seven UTIs of which six identified culture results (three with an identified organism, two with mixed flora (contamination from the skin or genital area during collection rather than a true UTI), one with no growth), five identified the medication used. Under analysis it identified Many UTI's February 2026, there was one UTI, one resident on prophylaxis for chronic UTIs, one skin infection and one jaw infection.The QAPI meeting minutes provided by the IP was not comprehensive and lacked a comprehensive review of outcome surveillance to include trending and analysis. It also lacked a comprehensive review of antibiotic use and resistance data to ensure the QAA attendees could adequately review bench markers and when to develop an action plan for quality infection control and antibiotic stewardship problems. During an interview on 3/11/26 at 3:15 p.m., the director of nursing (DON), who was the facility IP, stated the QAPI meeting was held at least quarterly. It was supposed to be attended by the DON who is also the acting infection preventionist, the administrator, the medical director and care coordinators. Activities, dietary, maintenance and other department head also joined. Attendance was taken at each meeting and entered into the meeting minutes and stated the medical director would join the meeting if able but (continued on next page)

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F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	would have to review the meeting minutes to see when he had last attended. The DON stated QAPI meeting minutes going back to eight months did not identify attendance by the medical director and also that they were still trying to figure out what was needed with QAPI regarding infection control information and follow up needed with areas of concern. During an interview on 3/11/26 at 4:50 p.m., the medical director stated he attended the QAPI meetings sometimes but could not clearly recall the last time he had attended a meeting; however,, reviewed the meeting minutes. See also F880: Based on interview and document review the facility failed to establish and implement a surveillance plan to track, trend and analyze resident actual and potential infections. This had the potential to affect all 29 residents that resided in the facility. See also F881: Based on interview and document review, the facility failed to implement their comprehensive antibiotic stewardship program to help reduce unnecessary antibiotic use and infections; and implement a facility-wide system to monitor the use of antibiotics for 2 of 2 residents (R5, R16) in the sample who were prescribed antibiotics. The lack of a follow through on a program had the potential to affect all residents prescribed antibiotics. The facility's Quality Assurance and Improvement Plan for Long Term Care policy dated 1/22/26, identified the QAPI committee was to be attended by the medical director.

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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. Based on interview and document review the facility failed to establish and implement an outcome surveillance program to track, trend and analyze resident actual and potential infections. This had the potential to affect all 29 residents that resided in the facility. Findings include:The last three months of infection control tracking, trending and analysis were requested and not received. On 3/9/26 at 5:11 p.m., the director of nursing (DON), who also worked as the infection preventionist, stated she did not have a system to track resident symptoms or infections. She stated she reviewed the resident's medical records and communicated with the nursing staff to help identify symptoms of illnesses or infections.On 3/10/26 at 8:20 a.m., the DON stated although she had not been formally tracking infections, she did have interdisciplinary (IDT) notes and Quality Assessment and Performance Improvement (QAPI) minutes to show what she had been doing regarding infections.The QAPI meeting minutes from the last standard survey dated 6/4/25 were reviewed and identified the following:June 2025, there was one resident had a urinary tract infection (UTI) and was treated for five days but lacked name of medication and analysis of urine cultures. Another resident was started on an antibiotic due to possible aspiration but lacked the name of the medication and noted they were not having any symptoms.July/August 2025, there were five UTIs of which all were treated with identified medications, two urine cultures did not grow any bacteria, but treatment continued, and one had symptoms but did not specify. Once resident was receiving an antibiotic for an infected toe, and one resident was being treated for pneumonia.September/October 2025, there were five UTIs and two pneumonias but lacked any identification of bacteria or treatment.November/December 2025, there were five UTIs, one prophylactic for UTI, and two wounds but lacked any other information. January 2026, notes identified a covid outbreak and stated to see outbreak for information. There were seven UTIs of which six identified culture results (three with an identified organism, two with mixed flora (contamination from the skin or genital area during collection rather than a true UTI), one with no growth), five identified the medication used. Under analysis it identified Many UTI's February 2026, there was one UTI, one resident on prophylaxis for chronic UTIs, one skin infection and one jaw infection.The minutes did not contain comprehensive data collection for tracking including but not limited to identify resident name, if facility acquired, location, signs and symptoms, testing, results, organism, if precautions were implemented and lifted and when the infection was resolved. The only infections identified were those requiring antibiotics and not any potential infections. There was no analysis of infections for trending to try and midigate infections in the facility.During interview on 3/11/26 at 11:59 a.m. the DON reviewed the QAPI minutes and had to look up each resident and identify signs and symptoms and the progression of the infection as it was not tracked, trended and analyzed.During an interview on 3/11/2026 at 1:22 p.m., the DON gave the following information about the facility UTI's. During September 2025 and October 2025, five residents had UTI's. We noticed the bathtub was not draining properly. The interdisciplinary team (IDT) and discussed the infections, the tub not draining properly, and discussed the possibility of the tub being the cause of the UTI's. Maintenance cleaned the drain, and staff were educated regarding proper cleaning after each use. The facility failed to have the drain tested for bacteria, and the microorganisms were not investigated for possible trends and did not look for a pattern of same organism. During November 2025 through December 2025, there were five residents with UTI's. The DON stated she had not documented any other possible reasons for the continued UTI's. Reviewing the infections one-by-one was an eye-opener because most of the residents' symptoms had not met Loeb's criteria for UTI. The DON stated she should have followed Loeb's criteria because it was important to treat an infection when the resident needed it and overtreating infections could lead to resistant microorganisms. The DON failed to analyze the microorganisms for patterns to ensure effective mitigation. The medical director returned a phone call after facility exit on 3/11/26 at 4:48 p.m. and stated he oversaw the review of the facility policies and procedures for resident care. The medical director stated he reviewed the (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	infection control QAPI minutes but was unable to identify when he last attended a meeting. The facilities Infection Control Surveillance Plan dated 5/22/25, identified infection control was used to identify and reduce the risk of acquiring and transmitting disease among patient, staff and visitors. Infection control included surveillance, which included measuring outcomes, analyzing data, and providing information to members of the health care team to assist in improving outcomes.The facilities Infection Prevention policy revised 5/27/25, identified the Infection Prevention and Control Program (IPCP) to prevent infections in patients and employees. The Infection Preventionist was responsible and accountable for IPCP. The priority services included prevention strategies, managing data and information and policies and procedures to prevent infections in patients and employees, and referred to the Infection Control Surveillance Plan.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Implement a program that monitors antibiotic use. Based on interview and document review, the facility failed to implement their comprehensive antibiotic stewardship program to help reduce unnecessary antibiotic use and infections; and implement a facility-wide system to monitor the use of antibiotics for 2 of 2 residents (R5, R16) in the sample who were prescribed antibiotics. The lack of a follow through on a program had the potential to affect all residents prescribed antibiotics. Findings include:R5:R5's progress notes dated 12/25/26 through 12/26/26, identified R5 had confusion and weakness, and on 12/26/26, was sent to the emergency room (ER). Later that same day, R5 returned to the facility with a diagnosis of UTI (urinary tract infection) and new orders for outpatient intravenous (IV) Rocephin (antibiotic). R5's UA (urine analysis) results dated 12/26/25, identified there was no predominant organism, and no further identification or susceptibility would be done.R5's ED notes dated 12/26/25, identified R5 received Rocephin (antibiotic) 1gm IV x 1 dose.R5's progress note dated 1/28/26, identified R5's IV antibiotics were discontinued and R5 started sulfamethoxazole-trimethoprim (antibiotic) 800-160 mg twice daily for 3 days on 12/27/25.The facility continued to treat R5 for a UTI even though the lab results showed no predominant bacterial growth.R16:R16's progress note dated 1/25/26, identified R16 was frequently requesting to use the bathroom. UA was sent to lab.R16's UA dated 1/25/26, identified no predominant organism and UC (urine culture) was not completed.R16's orders report dated 1/18/26 through 2/13/26, identified an order for Macrobid 100 mg take 1 capsule twice daily x 5 days for UTI dated 1/26/26.R16's 72-hour antibiotic time-out dated 1/28/26, identified R16 was prescribed Macrobid 100 mg twice daily for 5 days, end date 1/31/26. The facility continued to treat R16 for a UTI even though the lab results showed no predominant bacterial growth.On 3/9/26 at 5:11 p.m., the director of nursing (DON), who also worked as the infection preventionist, stated she did not have a tracking system to quickly identify resident symptoms or infections and reviewed the residents' medical record.On 3/11/2026 at 1:22 p.m., the DON stated for the most part the providers over prescribed antibiotics and many of the residents had not met Loeb's criteria for UTI. The DON stated Loeb's criteria was important to follow because they want to be able to treat an infection when the resident needed it. The medical director returned a phone call after facility exit on 3/11/26 at 4:48 p.m. and stated he oversaw the review of the facility policies and procedures for resident care. The medical director was uncertain how the facility tracked antibiotic use and one of the nurses would know more. Further, the facility uses an algorithm and communicates to the provider and either sends the resident to the emergency room or schedule an appointment with their provider; a lot of the mid-level practitioners prescribed 3-day antibiotics, and he and the physicians usually prescribed 5-day antibiotics. The facilities Antibiotic Stewardship Program revised 3/4/25, identified the facility would promote the appropriate use of antibiotics (right dose, drug, and duration) to treat infections that result in the best outcome with the least amount of toxicity and resistance. Antibiotic Stewardship actions included assessment of residents suspected of having an infection by considering the Loeb Criteria when considering initiation of antibiotics. Key Components of the Loeb Criteria for Urinary Tract Infection (UTI) - No Catheter included acute dysuria OR fever (100.2 F or greater) plus one of the following: urgency, frequency, suprapubic pain, gross hematuria, or costovertebral tenderness. A 72-hour antibiotic time-out is performed after initiation of antibiotic or first dose in the facility. The 72-hour timeout includes resident assessment for consideration of antibiotic need, duration, selection of antibiotic/change, and de-escalation potential.

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F 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home. Based on interview and document review the facility failed to ensure the infection preventionist (IP) had completed specialized training in infection prevention and control and received certification. This had the potential to affect all 29 residents residing in the facility. Findings include:See F880: Based on interview and document review the facility failed to establish and implement a surveillance plan to track, trend and analyze resident actual and potential infections. This had the potential to affect all 29 residents that resided in the facility. See F881: Based on interview and document review, the facility failed to implement their comprehensive antibiotic stewardship program to help reduce unnecessary antibiotic use and infections; and implement a facility-wide system to monitor the use of antibiotics for 2 of 2 residents (R5, R16) in the sample who were prescribed antibiotics. The lack of a follow through on a program had the potential to affect all residents prescribed antibiotics. The infection preventionist infection control certification was requested and not received. During interview on 3/10/26 at 4:50 p.m., the director of nursing (DON), who also worked as the facility infection preventionist (IP), stated she had worked as the IP nurse for two years. The DON stated she had completed the on-line courses for infection control last year; however, had not taken the certification test. The DON was unable to provide any documentation or certificate of completion of an approved infection prevention course.A copy of the facilities Infection Preventionist job description was requested and not received.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to ensure medications were coded correctly on the Minimum Data Set (MDS) for 2 of 5 residents (R5, R20) reviewed for unnecessary medications. Findings include: The MDS 3.0 Resident Assessment Instrument (RAI) Manual dated 10/25 directs facilities to document how many days the resident received the following classes of medications: antipsychotic, antianxiety, antidepressant, hypnotic, anticoagulant, antibiotic, diuretic, opioid, antiplatelet, hypoglycemic and none of the above. R5: During the MDS observation period from 1/29/26 through 2/4/26, R5's February 2026, medication administration record (MAR), identified R5 was receiving the following medications:Aldactone (a diuretic) (commonly known as a water pill) 25 milligrams (mg) every morning for congestive heart failure.Buspirone (an anti-anxiety medication) 7.5 mg twice a day for anxiety. R5's annual Minimum Data Set (MDS) dated [DATE], identified R5 had diagnoses of congestive heart failure, high blood pressure and anxiety. R5 was taking an antipsychotic, antidepressant and hypoglycemic. R5's MDS did not identify R5 received a diuretic or an anti-anxiety medication during the observation period.R20:During the MDS observation period from 1/31/26 through 2/6/26, R20's February 2026, MAR, identified R20 had received the following medication:Plavix (an antiplatelet medication) 75 mg once a day for heart attack. R20's admission MDS dated [DATE], identified R20 had a diagnosis of left hip fracture. The MDS identified R20 was taking antipsychotic, antianxiety, antidepressant, and opioid medications. R20's MDS did not identify they received an antiplatelet medication during the observation period. During an interview on 3/11/26 at 8:29 a.m., registered nurse (RN)-A, unit coordinator/MDS nurse, stated when they were completing a MDS they reviewed the residents' chart during the observation period and completed the MDS using that data. When the MDS for R5 and R20 were completed, RN-A stated the medications were missed and did not get entered into the MDS. During an interview on 3/11/26 at 11:09 a.m., the director of nursing (DON) stated it was the expectation each portion of the MDS would be completed correctly. It is important because it can affect care plans, payment and quality measures. A facility policy related to MDS accuracy was requested but not received.