STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245283	A. Building B. Wing	11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Waterview Pines LLC	1201 8th Street South Virginia, MN 55792

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47263 Based on interview, observation and document reivew, the facility failed to ensure care was provided to preserve dignity for 1 of 3 residents (R52) that were reviewed for dignity. Findings include: R52's quarterly Minimum Data Set (MDS) dated [DATE], indicated R52 was cognitively intact with diagnoses of diabetes, depression, hemiplegia, and hemiparesis. Section GG -Functional Abilities and Goals indicated R52 required moderate assistance for personal hygiene and maximal assistance for shower/baths. R52's care plan last reviewed 10/8/24, included: -Focus area altered cognition related to anxiety - Resident will have all needs met by staff. Resident has a dx of anxiety and will not often utilize the call light or verbalize feelings or needs in fear of being a burden to staff. -Focus area altered elimination interventions identified resident is very shy and does not like to ask for help, she has a history of being very incontinent r/t not asking for assistance. -Focus area alterations in mood and behavior interventions resident is very shy and has difficult time asking for assistance. Staff to ask resident if she needs help q3-4 hours and prn and to anticipate resident needs. -Focus self-care deficit indicated R52 received a shower one time per week and required assistance with bathing and personal hygiene. During an interview on 11/18/24 at 11:45 a.m., [Monday] R52's hair appeared greasy. R52 stated their hair got greasy quickly and they only got to have a shower once a week on Thursdays. During an observation on 11/18/24 at 3:55 p.m., R52 was dressed, on her bed. R52's hair appeared greasy. During an observation on 11/19/24 at 12:13 p.m., R52's hair appeared greasy. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/20/24 at 9:43 a.m., R52's hair was pulled back with a hair band and appeared wet. R52 stated their hair was not wet from a shower, it was just greasy. R52 wished they could get a shower two times a week because their hair got dirty fast, and they just felt better when it was washed. They would be happy if they could even just get their hair washed, it wouldn't have to be two full showers a week. R52 stated it bothered them when their hair was greasy because they just didn't feel clean. R52 felt a little better about their hair today because one of the nursing assistants had fixed it so it wasn't in their face. During an interview at 11/20/24 at 12:25 p.m., nursing assistant (NA)-A stated the facility had kits like a shower cap for washing hair, so if they noticed a resident had greasy hair, they would wash it with a shower cap kit. It's a dignity thing people don't want to have dirty hair. During an interview on 11/20/2024 at 12:46 p.m., registered nurse (RN)-A stated if a resident had noticeably greasy hair staff should offer a shampoo or shower to the resident before their shower day, the resident should not have to ask for it. During an interview on 11/20/24 at 3:16 p.m., the director of nursing (DON) stated if a resident had greasy hair, the resident should not have to ask for their hair to be washed, they would expect staff to recognize that and offer to wash the resident's hair. It would be important for hair washing to be offered to R52 for dignity purposes. All policies related to dignity were requested. The received facility policy Activities of Daily Living (ADLs)/Maintain Abilities Policy dated 3/31/23, read Intent: it is the policy of the facility to specify the responsibility to create and sustain an environment that humanizes and individualizes each resident's quality of life by ensuring all staff, across all shifts and departments understand the principles of quality of life and honor and support these principles for each resident; and that care and services provided are person-centered, and honor and support each resident's preferences, choices, values and beliefs.

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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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47263 Based on observation, interview, and document review the facility failed to ensure resident preference of being dressed and eating breakfast in the dining room was honored for 1 of 1 resident (R32) reviewed for resident rights. Findings include: R32's quarterly Minimum Data Set (MDS) dated [DATE], Section C - Cognitive Patterns, did not include a completed Brief Interview for Mental status. R32's quarterly MDS dated [DATE], indicated R32 had significant cognitive impairment. R32's diagnoses included neurological disorders, heart failure and non-Alzheimer's dementia with depression and anxiety. Section GG identified R32 required maximal assistance to total dependence for ADL's and was dependent for transfers. R32's careplan last reviewed 8/14/24, identified R32 preferred to dine in the main dining room and instructed staff to encourage resident to attend meals in the dining room where he could visit with others. Further, R32's care plan identified R32 required assistance with ADLS and preferred to get ready by 8:00 a.m. During an interview on 11/17/24 at 2:01 p.m., R32 was shirtless in bed with a blanket covering the waist down. R32 stated, they tell me every day they don't have enough people so here I am with just a blanket on. R32 indicated they needed help to get dressed and get out of bed so they were not able go to the dining room on their own. R32 preferred to be dressed for breakfast, but instead stated they felt like a fool in bed with just their pajama pants and blanket on. On 11/17/24 at 2:20 p.m., nursing assistant (NA)-E knocked on the door, entered R32's room and told R32 they would be back shortly with another NA to get them (R32) up for the day. After NA-E exited the room, R32 stated they would like to be dressed and out and about so they could visit with people, but instead they were stuck in bed. During an interview on 11/17/24 at 2:30 p.m., NA-E confirmed they were just now getting to R32 to get them up for the first time that day. NA-E explained when they didn't have the staff, they could only do what they could do. R32 was also a two-person transfer, so they had to find another staff who was also getting their residents up to assist them with R32's transfer. At times we are staffed so low we can't get our residents taken care of as they should be. During an interview on 11/18/24 at 4:42 p.m., R32 stated, they didn't get me up until noon today. During an interview on 11/19/24 at 10:30 a.m., R32 stated, here I am sitting in bed again still. During an interview at 11/19/24 at 12:25 p.m., NA-E stated R32 liked to go to the dining room for breakfast and they would like to get R32 up for breakfast, but because R32 was a two person transfer, it was not always possible to do on days when only one NA was scheduled until 9:30 a.m. on the Meadows unit. (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/20/24 at 12:43 p.m., registered nurse (RN)-A stated if a resident wants to be up and dressed in the morning for breakfast then that preference should be honored. If a resident wanted to be up and dressed and instead was left in bed with just a shirt on, that would be a dignity issue. During an interview on 11/20/24 at 2:42 p.m., the director of nursing (DON) stated if it was a resident's preference to have a shirt on in bed, or to be up and dressed to have breakfast in the dining room, they would expect those preferences were met. The DON stated they knew R32 preferred to be up and out in the main area tooling around with his wife. The facility policy Activities of Daily Living (ADLs)/Maintain Abilities Policy dated 3/31/23, read Intent: it is the policy of the facility to specify the responsibility to create and sustain an environment that humanizes and individualizes each resident's quality of life by ensuring all staff, across all shifts and departments understand the principles of quality of life and honor and support these principles for each resident; and that care and services provided are person-centered, and honor and support each resident's preferences, choices, values and beliefs.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 42587 Based on observation, interview, and document review the facility failed to ensure equipment was not broken for 1 of 1 resident (R25) reviewed for environment. Findings include: On 11/17/24 at 2:03 p.m., R25 stated her toilet was broken and she was concerned about it. When facing the toilet the right side of the bowel was cracked near where the seat attached. On 11/19/24 at 1:06 p.m., licensed practical nurse (LPN)-A stated nursing assistants doesn't usually fill out a Tels slip, if something is broken they tell the nurse or call maintenance. On 11/19/24 at 1:08 p.m., LPN-B stated if staff see broken equipment they fill out a maintenance slip and it goes right into the computer to be fixed. LPN-B stated she was not aware of any residents complaining about a broken toilet. On 11/19/24 at 1:24 p.m., the regional director of maintenance (RDM)-A looked at the toilet and verified it was cracked. RDM-A stated the whole bowl needs to be replaced. RDM-A verified a request slip had not been filled out and stated he would have expected housekeeping to notice the cracked toilet and report it. On 11/19/24 at 1:24 p.m., housekeeper (H)-A looked at the toilet and stated, oh it's been like that but could not say how long. She verified she did not report it and said the thought the regular housekeeper would have reported it as broken. On 11/19/24 at 1:29 p.m., the housekeeping director (HD)-B stated she would expect staff to report broken equipment to her or maintenance. If reported to her she would have filled out the Tels slip. She was not aware of any cracked toilets. On 11/19/24 at 1:33 p.m., the associate administrator stated if staff see broken equipment they should tell the nurse manager. The regional director of operations (RDO) stated staff should put a note on broken equipment, remove it from service, and fill out a Tels slip for repair. The RDO stated cracked toilets should be fixed to prevent any injuries.

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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** 42587 Based on interview and document review, the facility failed to complete all sections on the Minimum Data Set (MDS) for 2 of 18 residents (R23, R14) reviewed for resident assessment. Findings include: The Centers for Medicare and Medicaid (CMS) Long-Term Resident Facility Assessment Instrument (RAI) 3.0 User's Manual dated 10/2024, identified The purpose of this manual is to offer clear guidance about how to use the Resident Assessment Instrument (RAI) correctly and effectively to help provide appropriate care. Providing care to residents with post-hospital and long-term care needs is complex and challenging work. Clinical competence, observational, interviewing and critical thinking skills, and assessment expertise from all disciplines are required to develop individualized care plans. The RAI helps nursing home staff gather definitive information on a resident's strengths and needs, which must be addressed in an individualized care plan. It also assists staff with evaluating goal achievement and revising care plans accordingly by enabling the nursing home to track changes in the resident's status. As the process of problem identification is integrated with sound clinical interventions, the care plan becomes each resident's unique path toward achieving or maintaining their highest practical level of well-being. Section C: identified cognitive patterns. Intent: The items in this section are intended to determine the resident's attention, orientation and ability to register and recall new information and whether the resident has signs and symptoms of delirium. These items are crucial factors in many care-planning decisions. Section D: mood. Intent: The items in this section address mood distress and social isolation. Mood distress is a serious condition that is underdiagnosed and undertreated in the nursing home and is associated with significant morbidity. It is particularly important to identify signs and symptoms of mood distress among nursing home residents because these signs and symptoms can be treatable. Social isolation refers to an actual or perceived lack of contact with other people and tends to increase with age. It is a risk factor for physical and mental illness, is a predictor of mortality, and is important to assess in order to identify engagement strategies. Section P: restraints and alarms. Intent: The intent of this section is to record the frequency that the resident was restrained by any of the listed devices or an alarm was used, at any time during the day or night, during the 7-day look-back period. Assessors will evaluate whether or not a device meets the definition of a physical restraint or an alarm and code only the devices that meet the definitions in the appropriate categories. R23's quarterly Minimum Data Set (MDS) dated [DATE], identified R23's diagnoses included cardiorespiratory condition, bipolar disease, and diabetes mellitus. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R23's quarterly MDS dated [DATE], MDS section C - identified cognitive patterns revealed the following: C 0100- Should Brief Interview for Mental Status be conducted? yes the sections following this question were marked as not assessed R23's quarterly MDS section D - mood revealed the following: D 0100- Should Resident Mood Interview be conducted? yes the sections following this question were marked as not assessed R14's annual MDS dated [DATE], identified R14 had diagnoses which included non-traumatic brain dysfunction, dementia, and depression. R14's annual MDS dated [DATE], section P - restraints and alarms revealed the following: P 0200 alarms E. wander/elopement 0 = Not used R14's care plan dated 1/6/22, identified wanderguard placed. On 11/19/24 at 11:34 a.m., registered nurse (RN)-A reviewed P23's quarterly MDS dated [DATE], and verified sections C and D were marked as not assessed. RN-A stated the assessments should have been completed to ensure the resident was getting the right medication and as part of the care plan. On 11/20/24 at 10:57 a.m., the director of nursing (DON) reviewed R23's quarterly MDS dated [DATE], and verified sections C and D were marked as not assessed. The DON reviewed R14's annual MDS dated [DATE], and verified section P did not identify R14 had a wanderguard in use. The DON stated accurate assessments were to ensure accurate billing and payment and to make sure elopement concerns were identified. The DON stated each department was responsible to fill out their assigned sections. The DON stated she would expect the MDS coordinator to call or email if information was missing prior to uploading the data to make sure residents were receiving proper medication and receiving any needed services. A policy on filling out resident assessments was requested but not provided.

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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** 42587 Based on observation, interview, and document review the facility failed to ensure activities of daily living (ADL) were addressed for 2 of 4 residents (R4, R32) reviewed for ADLs. Findings include: R4: R4's quarterly Minimum Data Set (MDS) dated [DATE], identified R4's diagnoses included traumatic brain dysfunction, diabetes mellitus, hemiplegia/hemiparesis (a symptom that causes partial or total paralysis on one side of the body/muscle weakness or partial paralysis on one side of the body), and traumatic brain injury (TBI). R4's quarterly MDS identified R4 was severely cognitively impaired, sometimes understood and sometimes understands, had unclear speech, and was dependent on staff for ADLs. R4's care plan dated 8/21/19, identified R4 had a self care deficit with dressing, grooming, and bathing related to weakness and TBI. Interventions included nursing assistant to perform nail care for hands and feet on bath day. Weekly skin care assessments dated 11/11/24, 10/28/24, and 10/14/24, documented fingernails and toenails not addressed. Weekly skin care assessment dated [DATE], documented fingernails and toenails not necessary. On 11/17/24, R4 was lying in bed his left hand was in a fist and the fingernails on both hands were approximately 1/2 inch in length. On 11/19/24 at 2:04 p.m., licensed practical nurse (LPN)-A looked at R4's hand and stated the nails needed to be cut, she also observed a brown substance under some of the fingernails, and stated the nails were about a 1/2 in length. On 11/20/24 at 11:06 a.m., the director of nursing (DON) stated nail care should be completed by the nursing assistants on their shower day, unless the resident is diabetic then the nail care should be completed by the licensed nurse. The DON stated this should be documented on the weekly skin assessment form. The weekly skin assessments were requested but not provided. 47263 R32: (continued on next page)

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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	R32's quarterly MDS dated [DATE], Section C - Cognitive Patterns did not include a completed Brief Interview for Mental status. R32's diagnoses included neurological disorders, heart failure and non-Alzheimer's dementia with depression and anxiety. Section GG indicated R32 required maximal assistance to total dependance for ADL's and was dependent for transfers. R32's careplan last reviewed 8/14/24, instructed staff to encourage resident to attend meals in the dining room where he could visit with others. The plan indicated R32 required assistance with ADLS and preferred to get ready by 8:00 a.m. The focus area alterations in mobility indicated R32 was a hoyer [total body lift] transfer of two. During an interview on 11/17/24 at 2:01 p.m., R32 was shirtless in bed with a blanket covering the waist down. R32 stated they tell me every day they don't have enough people so here I am with just a blanket on. R32 indicated they needed help to get dressed and get out of bed so they couldn't just go to the dining room on their own. They preferred to be dressed for breakfast, but instead they felt like a fool in bed with just their pj pants on and a blanket. On 11/17/24 at 2:20 p.m., nursing assistant (NA)-E knocked on the door, entered R32's room and told R32 they would be back shortly with another NA to get them (R32) up for the day. After NA-E exited the room, R32 stated they would like to be dressed and out and about so they could visit with people, but instead they were stuck in bed. On 11/17/24 at 2:34 p.m., NA-E and NA-C entered R32's room and stated they were ready to get R32 up for the day. During an interview on 11/18/24 at 4:42 p.m., R32 stated they didn't get me up until noon today. During an interview on 11/19/24 at 10:30 a.m., R32 stated here I am sitting in bed again still. During an interview on 11/20/24 at 12:43 p.m., registered nurse (RN)-A stated if a resident wants to be up and dressed in the morning for breakfast then that preference should be honored. During an interview on 11/20/24 at 2:42 p.m., the director of nursing DON stated if it was a resident's preference to have a shirt on in bed, or to be up and dressed to have breakfast in the dining room, they would expect those preferences be met.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48109 Based on observation, interview, and document review the facility failed to to ensure timely repositioning and coordination of care for a hospice patient with a change in condition for 1 of 5 (R8) residents; to ensure provider orders for weight monitoring were followed for 1 of 5 (R26) residents; to ensure dressing changes were completed as ordered for 1 of 5 (R40) residents; to ensure placement of ankle-foot orthosis (AFO) for 1 of 5 (R32) residents; and to ensure timely delivery of medications for 1 of 5 (R1) residents reviewed for quality of care. Findings include: R8: R8's significant change in condition Minimum Data Set (MDS) dated [DATE], identified moderately intact cognition and diagnoses of dementia and congestive heart failure. R8 was dependent on staff for eating, bed mobility and toileting. R8's provider orders dated [DATE], identified hospice care through Essentia East Range Hospice with orders to call hospice first for changes in condition, need for additional services, medications, supplies, questions, concerns, and notification of death. R8's care plan dated [DATE], identified risk for skin breakdown related to impaired mobility, decrease in range of motion to both upper and lower extremities, and need for mechanical lift. Interventions included repositioning every three hours during the day and on rounds at night as needed. R8's care plan also identified hospice care related to end-stage disease process with interventions to maintain communication with hospice and keep them informed of resident's condition, or changes in condition, as needed. Review of R8's progress notes didn't contain a progress note regarding her change in condition or notification of hospice. During an interview and observation on [DATE] at 4:24 p.m., family member (FM)-A stated she had been there for about an hour and a half, and FM-B had been there prior to that. FM-A and B explained they and their siblings spent most of every day at the facility to make sure R8 was taken care of. They stated the last time R8 had been repositioned was about 1:30 p.m. FM-A explained R8 had not been responsive today and hadn't taken in food or fluids. R8 was positioned in the bed on her left side with her left arm tucked under her body. During an observation on [DATE] at 4:59 p.m., nursing assistant (NA)-D went into R8's room, looked at her and then went to her neighbor and asked if she was ready to go to dinner. NA-D then left the room with R8's neighbor. At 5:08 p.m., NA-D walked past R8's room and to elsewhere in the building. There were no other staff present in the hall. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation and interview on [DATE] at 05:10 p.m., registered nurse (RN)-B entered R8's room with three whole pills in a cup and a glass of water. RN-B stated she was not sure the last time R8 was repositioned because her shift started at 2 p.m. today. RN-B donned gloves and approached R8's bedside with the medication. FM-A became upset and asked why RN-B would be giving R8 whole pills when she was supposed to have crushed meds in applesauce. RN-B was not able to explain adequately to calm FM-A regarding the medications and what her plan was. RN-B left the unit at 5:19 p.m. to find someone to help. At 5:20 p.m., NA-D returned to the hall and answered another resident's call light. During an interview on [DATE] at 5:25 p.m., NA-B stated they reposition residents every two hours. NA-B didn't recall when it was last done for R8 because he had been busy getting residents to dinner. NA-B explained he just takes care of the people on his sheet and R8 was not on his sheet, and right now there were call lights on for people who needed help going to the bathroom. NA-B stated he went around helping where he saw help was needed and didn't get report on when R8 was last repositioned because she wasn't on his list, adding there were only two people working on this hall and it was dinner time. During an interview on [DATE] at 5:29 p.m., RN-B stated they were short on the floor, so she was going to go join them in the dining room to feed the residents and then left the area. During an observation on [DATE] at 5:33 p.m., RN-B and NA-B came back to R8's room and proceeded to reposition her. R8 had two red areas on her right buttock, RN-B looked at the areas and applied barrier cream. During an interview on [DATE] at 3:20 p.m., hospice nurse (HN)-A stated they got a call from the facility regarding R8 at 6:45 p.m. on [DATE], and then made a visit to the facility to see R8 at 7:15 p.m. HN-A stated they assessed R8, showed RN-B how to crush the pain medication in a very small amount of water to be given buccally (into the inside of the cheek), and instructed on pain management. The facility notified hospice at 0345 that R8 had died . HN-A stated they wished they had known R8 was making changes that day so that hospice could have provided support to the family and the facility. During an interview on [DATE] at 9:10 a.m., the director of nursing (DON) stated R8 had varying abilities to swallow but would agree R8 had a change in condition on [DATE] and hospice should have been updated. The DON also stated it didn't meet her expectations for a resident to go four hours without repositioning with risks including skin breakdown and pressure injuries. R26: R26's quarterly MDS dated [DATE], identified moderately impaired cognition and diagnoses of congestive heart failure (CHF) and chronic kidney disease. R26's provider orders dated [DATE], identified weekly weight monitoring, to notify cardiology of an increase of five pounds in one week, and furosemide (a medication used to treat excess fluid) daily. R26's care plan didn't address CHF or weight monitoring. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of R26's medical record revealed the following lapses in weekly weight monitoring: -,d+[DATE] to [DATE] -,d+[DATE] to [DATE] -,d+[DATE] to [DATE] -,d+[DATE] to [DATE] -,d+[DATE] to [DATE] During an interview on [DATE] at 12:44 p.m., the DON stated the lapses in weekly weights do not meet her expectations. The risks of not monitoring weights for R26 would be fluid overload. R40: R40's admission MDS dated [DATE], identified intact cognition and diagnosis of acquired absence of the left leg with an above-the-knee amputation (AKA). R40's MDS also identified the presence of surgical wounds. R40's provider orders dated [DATE], identified daily wound care to left AKA surgical wound including moistening gauze with betadine, wringing it out and leaving the gauze moist, fluffing it, and applying it over the suture line. Cover all with an abdominal pad and secure with tape. R40's care plan dated [DATE], identified daily wound care to surgical site, to observe for and report changes, and weekly skin inspections by a licensed nurse. R40's treatment administration record (TAR) for [DATE] did not have any initials on Sunday [DATE] dressing change. During an observation and interview on [DATE] at 6:06 p.m., R40 was observed to have an abdominal pad taped to the left AKA site. The dressing was soiled with yellowish drainage the length of the dressing and about five centimeters wide. R40 stated no one had changed her dressing today. During an interview on [DATE] at 1:08 p.m., licensed practical nurse (LPN)-B stated she worked day shift [DATE] and didn't have time to do the dressing change during her regular shift but had stayed late to get it done and must not have signed it off. LPN-B further stated the dressing change took some time because R40 needed to have pain medication prior to the dressing change, and the nurses had to remove every other staple with each dressing change. Facility records revealed LPN-B clocked out for the day at 3:01 p.m. During an interview on [DATE] at 12:38 p.m., the DON stated she would expect a dressing to be changed daily if that was what was ordered and confirmed the dressing change was not checked off for [DATE]. The DON stated R40 was often non-compliant with repositioning, stayed up in her wheelchair too long, and the wound had opened up at the suture line so R40 was scheduled for another procedure to revise the wound. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	47263 R32: R32's quarterly MDS dated [DATE], Section C - Cognitive Patterns did not include a completed Brief Interview for Mental status. R32's quarterly MDS dated [DATE], identified R32 had significant cognitive impairment. Diagnoses included neurological disorders, heart failure and non-Alzheimer's dementia with depression and anxiety. Section GG identified R32 required maximal assistance to total dependence for ADL's and was dependent for transfers. R32's careplan last reviewed [DATE], identified R32 was a hoyer transfer of two and included the following instruction: -AFO brace to the left foot/ankle - on in the a.m. and off in the p.m. -Resting splint on Left hand - on during the day and off at bedtime. During an interview on [DATE] at 2:01 p.m., R32 was shirtless in bed with a blanket covering the waist down. R32 did not have a splint or their left hand. During an observation on [DATE] at 12:50 p.m., R32 was seated in dining at a table with peers. R32's left arm was resting across their abdomen, R32 did not have a hand splint on. During an observation on [DATE] at 8:56 a.m., R32 was seated in dining room eating breakfast. R32's was not wearing a hand splint and their left arm/hand was resting in their lap. During an observation on [DATE] at 1:06 p.m., R32 did not have a hand splint on, R32's wheelchair did not have a side tray on it. R32's left arm was draped across R32's lap. During an interview on [DATE] at 12:43 p.m., RN-A reviewed R32's care plan and confirmed R32 was care planed for a left-hand splint however the hand splint was not ordered nor was it included in R32's tasks. There was however the use of a half arm tray included in R32's tasks. RN-A confirmed they could not find any documentation that R32 had been refusing to wear the hand splint or use the half arm tray. RN-A confirmed R32 should be wearing the hand splint and added it to R32's task list. During an interview on [DATE] at 2:42 p.m., the DON stated they had helped R32 get up in the morning and sometimes he refused the hand splint and other times he put it on. The DON confirmed the hand splint was in R32's care plan, but not the orders, and confirmed they were not able to find documentation of R32's refusal to wear the hand splint. The DON left the interview room and returned with R32's Kardex. The DON pointed out the section of the Kardex which listed the splint instructions for the NAs to follow. The DON stated normally staff would document when a splint was on or off and refusals to wear. If a resident continued to refuse, then follow-up would be done and then if a resident continued to refuse it would be evaluated for discontinuation. RN-A had added R32's hand splint to the tasks earlier that day so NA's now had a place to document the splint. R1: (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R1's annual MDS dated [DATE], identified R1 was cognitively intact with the diagnoses of cancer, hypertension, GERD, arthritis, anxiety, and depression. Section E- Behavior did not identify R1 as having any behavior symptoms that negatively impacted self or others. Section N - Medications indicated R1 received high risk medications in the classes of antidepressant, anticoagulant, diuretic, opioid, and hypoglycemic. Section V - Care Area Assessment Summary section V0200 did not identify pain as a care area triggered to be addressed in the care plan. R1's careplan last reviewed on [DATE], focus area Alteration in comfort denoted the goal for R1 to have adequate relief from pain and instructed pain medication as ordered. R1's Medication Administration recorded provided by the facility showed the following medications had been administered to R1 on [DATE] at 11:12 a.m.: -Gabapentin Oral Capsule 100 milligrams (mg) -Celexa 10 mg give 10 mg by mouth in the morning related to anxiety -furosemide Tablet give 20 mg by mouth in the morning - chronic atrial fibrillation, unspecified (I48.20); essential (primary) hypertension (I10) -digoxin Tablet give 62.5 mcg by mouth in the morning related to unspecified atrial fibrillation (I48.91) Hold if APICAL pulse is 60 bpm. -tramadol HCl Oral tablet 50 mg give 50 mg by mouth every morning and at bedtime for Pain -Potassium tablet give 20 mEq by mouth in the morning related to hypokalemia (E87.6) administer with or after meals with full glass ,d+[DATE]oz water or juice R1' [DATE] Treatment Administration record identified to monitor for pain every shift. R1's pain levels were documented as follows: -[DATE] night shift pain level: 4 -[DATE] days shift pain level: 5 -[DATE] day shift pain level: 4 -[DATE] day shift pain level: N/A -All other pain assessments on day/eve/night shifts between the dates of [DATE] and ,d+[DATE] had documented pain level: 0. Assessments were not time stamped to identify the time pain assessments were completed. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on [DATE] at 1:08 p.m., LPN-A stated they usually passed medications for about 30 residents and often they also did the dressing changes too. They had a cart nurse a couple times a week, but the facility was trying to eliminate that position. LPN-A stated today they didn't finish their morning medication pass until 11:15 a.m., and then they had to start the afternoon medication pass at 11:30 a.m. LPN-A stated they worked dressing changes in between pill passes and indicated they hardly ever got a lunch break, maybe 10 minutes. LPN-A also frequently had to stay after their shift was over to get their work done. LPN-A stated there was not enough staff and their two nursing aids were constantly running. How can you toilet twenty-two plus people every two hours and get lights and pass meals, and help in the dining too? Even the agency staff tell us we don't have enough staff. During an interview on [DATE] at 1:31 p.m., R1 stated they had to wait and wait for their medications on [DATE]. They had their call light on, and they didn't get their medications until after 11:00 a.m. Someone had died , and staff were trying to do something with that, but nobody came in to tell me that was why they were not answering my call light. During an interview on [DATE] at 1:10 p.m., RN-A explained the window of time for morning medications was 5:30 a.m. to 10:00 a.m. If something was scheduled at 5:30 a.m., they had until 10:00 a.m. to give it unless the medication was time specified or had special instructions. Morning medications should be given by 10:00 a.m. Administration after 10:00 would be considered outside of the acceptable time frame. Administering morning medications late after 11:00 a.m. was not acceptable. RN-A confirmed the facility did have a death the morning of [DATE] and went on to say a death at the facility should not impact the care of other residents or their ability to get their medications. Staff should be responding to resident call lights, if R1 waited two hours, that is not acceptable. Usually, the Meadows unit is staffed with two nursing aids on the weekend. During an interview on [DATE] at 9:30 a.m., R1 stated they usually got their morning medications between 9:00 - 9:30 a.m., however on [DATE], they didn't get their mediation until after 11 a.m. and nobody went into their room. R1 reported staff were having a problem with a resident that died . R1 reported that morning they had tried everything to get someone in their room, they banged on their bedside table, put their call light on, turned the TV up, and yelled. R1 reported they had been so worked up and anxious because their pain was so bad, they had called a family member because they didn't know what else to do. R1 reported their leg, neck and back pain had been a nine out of ten. R1 pointed to their left leg and explained they had broken that leg in two places and even though it was healed, they still needed to take a heavy pill [opioid: Tramadol HCL] to reduce the leg pain. R1 stated on weekends they had one nurse and usually just one nurse aide in the morning, so nobody was really around. R1 stated it was upsetting when their medications were late because they had heart medication and pain medications they needed in the morning. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on [DATE] at 3:06 p.m., the DON opened R1's EMR and explained when a medication is ordered every morning and bedtime it falls into the open med pass so it can be given in the facility window for med pass. Nurses should prioritize resident medication administration by who is getting up first, etcetera. The DON reviewed R1's mediation and confirmed R1 had received their morning medication after 11:00 a.m. on [DATE]. The DON stated pain was a priority, but since they were not present on [DATE] they could not speak to what had occurred. The DON stated absolutely if they had a fall or an emergent situation, they expected that event to take priority over medication administration. The DON stated the facility was staffed to care for their residents and to take care of emergencies. It was unfortunate that R1 was waiting and upset and in pain while staff addressed the death of a resident on [DATE], however the DON felt it was an isolated incident, as they were not aware of this being an ongoing issue. The DON stated it was okay for medications to be given outside of the designated administration window if something else was pressing.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42587 Based on observation, interview, and document review, the facility failed to educate and document the education and refusals for pressure ulcer relief for 1 of 3 (R35) residents. In addition, the facility failed to ensure weekly skin inspections were performed as ordered and timely notification of the registered dietician (RD) of a resident's new and worsening wounds for 1 of 3 (R39) residents reviewed for pressure ulcers. Finding include: R35's significant change Minimum Data Set (MDS) dated [DATE], identified R35 had diagnoses which included hemiplegia and hemiparesis (muscle weakness or partial paralysis on one side of the body) following cerebral infarction affecting left non-dominant side, dementia with behavioral disturbance, diabetes mellitus, depression, and morbid obesity due to excess calorie intake. R35's MDS identified he was severely cognitively impaired and required substantial/maximal assistance to dependent for activities of daily living. R35's care plan identified R35 had stage II pressure ulcer and vascular ulcer present on admission. Interventions included to off load heels on both feet at all times and to document any refusals initiated on 10/4/23. In addition, resident was to have blue boots on while up in wheel chair and staff were to document any refusals initiated on 3/28/24. A review of R35's November progress notes did not have any documented education on floating heels or refusals by R35 to float heels. On 11/17/24 at 5:50 p.m., R35's right heel was wrapped in a dressing and resting on the bed. On 11/18/24 at 3:57 p.m., R35 was seated in his wheelchair in his room both feet were resting on the wheelchair foot peddles. R35 was wearing non-skid slipper no heel boots on. On 11/18/24 at 4:57 p.m., R35 was seated in his wheelchair in his room both feet were resting on the wheelchair foot peddles. R35 was wearing non-skid slipper no heel boots on. On 11/18/24 at 6:48 p.m., R35 was seated in his wheelchair in his room both feet were resting on the wheelchair foot peddles. R35 was wearing non-skid slipper no heel boots on. On 11/19/24, during a continuous observation from 8:13 a.m. to 10:22 a.m., R35 was observed lying in bed, dressed, wearing non-skid slippers with both feet resting on the bed - heels were not floated. -at 8:49 a.m., staff entered to bring in breakfast tray no offer was made to float heels. -at 9:00 a.m., staff entered with medications no offer was made to float heels. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/19/24 at 10:44 a.m., nursing assistant (NA)-A stated each time she would go into R35's room she was supposed to try to get him to elevate his heels. NA-A stated she tried in the morning but wasn't able to get him to do it. NA-A stated they were supposed to tell the nurse about refusals. On 11/19/24 at 11:46 a.m., registered nurse (RN)-A stated she would expect staff to try every couple of hours to float R35's heels. RN-A reviewed R35's record and could not find any education given to R35 about the importance of floating/elevating his heels or any documention of R35 refusing to float his heels. RN-A stated floating/elevating his heels would be important to promote wound healing. On 11/20/24 at 11:00 a.m., the director of nursing (DON) stated she would expect staff to follow the care plan for R35, she would expect the NAs to inform the nurse about refusals, the nurse to document the refusals, and for staff to re-approach R35 to encourage him to elevate his heels. 48109 R39's quarterly MDS dated [DATE], identified intact cognition and diagnoses of diabetes mellitus, and chronic kidney disease. R39 was dependent on staff for assistance with bed mobility, transfers, hygiene, and dressing the lower body. Section M identified R39 had one or more pressure ulcers acquired at the facility. R39's care plan dated 6/20/24, identified altered skin integrity related to ulcers on bilateral heels, top of right foot, and right great toe. Interventions included weekly skin inspections by a licensed nurse. The care plan didn't address nutrition needs related to wounds. R39's provider orders identified an order dated 6/19/24, for weekly skin inspections by a licensed nurse to be documented in the electronic health record (EHR). R39's diet order, dated 7/30/24, was for a consistent carbohydrate diet with soft and bite-sized texture and thin liquids. On 11/4/24, R39 had an order for liquid protein supplement of four ounces two times a day for wounds. Review of R39's Weekly Skin Inspection forms revealed gaps in inspection for the time periods of 7/1 to 7/15/24, 7/22 to 8/5/24, 9/2 to 9/23/24, 9/30 to 10/21/24, 10/21 to 11/11/24. Review of R39's EHR identified the following: -7/3/24 progress note indicated a deep tissue injury (DTI) to the right heel with interventions to apply barrier swab daily, a heel cup, to offload pressure, and no shoes. -7/15/24 the RD notes indicated a consistent carbohydrate diet with a two-gram sodium restriction, with four ounces of a house supplement four times per day. The RD estimated the daily caloric and protein content and noted a greater than five percent weight loss in one month. The RD suggested to liberalize R39's diet to remove the sodium restriction because that diet was more restrictive and had less calories and protein. The RD noted no additional nutrition concerns at the time. -7/30/24 progress note indicated a visit from a nurse practioner with Integrated Wound Care who noted wounds to be stable and to continue current treatments. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-8/5/24 the RD reviewed diet type, caloric and protein content, R39's intake of meals at greater than 75 percent and recommended discontinuing the house supplement due to noted weight gain and no additional nutrition concerns at that time. -8/6/24 progress note indicated a visit from a physician's assistant with Essentia Elder Care with a referral for Essentia wound care to round on R39 for concerns related to wounds. -8/8/24 Essentia Health wound provider consulted for concerns of cellulitis in the right great toe and wound to the right heel. The provider's assessment included diagnoses of pressure injury of skin of right heel, unspecified injury stage, cellulitis of right great toe, and an area of dark red skin discoloration to the top of the right foot which appeared to be related to pressure from the bandage. -9/23/24 the RD reviewed diet type, caloric content, R39's intake of meals at greater than 75-percent, and R39's weight with insignificant fluctuations. The RD further noted identified wound notes of 9/12/24 indicated R39 had unstageable pressure wounds to the left and right heels, a suspected deep tissue injury to the top of the right foot. The RD suggested increased protein related to wound needs and an order for Prostat (protein supplement) one ounce every day. During an interview on 11/20/24 at 12:03 p.m., the DON stated she expects weekly skin inspections to be done weekly and this was important to look at the skin to make sure things were improving and not worsened. The DON further stated they typically had done a monthly meeting with the RD and would agree it was important to alert the RD to wound needs. Policies regarding RD involvement in wound care and weekly skin inspections were requested but not received.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42587 Based on observation, interview, and document review the facility failed to ensure a palm protector was used for 1 of 1 (R4) residents reviewed for range of motion. Findings include: R4's quarterly Minimum Data Set (MDS) dated [DATE], identified R4's diagnoses included traumatic brain dysfunction, hemiplegia/hemiparesis (a symptom that causes partial or total paralysis on one side of the body/muscle weakness or partial paralysis on one side of the body), and traumatic brain injury (TBI). R4's quarterly MDS identified R4 was severely cognitively impaired, sometimes understood and sometimes understands, had unclear speech, and was dependent on staff for activities of daily living (ADLs). R4's care plan dated 6/28/22, identified R4 had a self care deficit with dressing, grooming, and bathing related to weakness and TBI. Interventions included encouraging resident to wear foam built-up palm protector under left 4th and 5th digit to reduce contraction. Palm protector was to be on overnight and removed in the morning. On 11/17/24 at 6:45 p.m., R4's left hand was in a fist, he was unable to open his left hand. On 11/19/24 at 2:04 p.m., licensed practical nurse (LPN)-A checked R4's room for a palm protector and was unable to locate one. LPN-A gently opened R4's hand and noted an odor, the skin was pink with no redness or open areas. On 11/19/24 at 2:07 p.m., nursing assistant (NA)-A stated she did not remove a palm protector from R4's hand when she completed his morning cares. NA-A stated she had not seen a palm protector for R4 for a long time but couldn't say how long. On 11/19/24 at 3:12 p.m. occupational therapist (OT)-E measured R4's extension for both hands. OT-E washed R4's left hand with a warm wash cloth, the white wash cloth had yellow and brown debris on it after washing, OT-E stated it looked like food. OT-E was unable to locate a palm protector in R4's room. On 11/20/24 at 9:09 a.m., OT-E stated when she compared the measurements from yesterday's measurements and the previous measurements, they were very similar. OT-E provided a new palm protector and obtained orders for use. On 11/20/24 at 11:06 a.m., the director of nursing stated R4 should have been wearing the palm protector as outlined in the care plan and staff should have been following the care plan. This would prevent further contractures. A policy on range of motion was requested but not provided.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42587 Based on observation, interview, and document review, the facility failed to ensure residents were supervised by nursing staff or trained feeding staff during dining for 1 of 1 (R20) resident reviewed for dining. Findings include: R20's annual Minimum Data Set (MDS) dated [DATE], identified R20's diagnoses included, dementia, multiple sclerosis (a disease in which the immune system eats away the protective covering of nerves), depression, and dysphagia (difficulty swallowing). R20's MDS identified R20 was severely cognitively impaired and required partial to moderate assistance with eating. On 11/18/24 at 6:24 p.m., one resident (R20) remained in the dining room with one dietary staff clearing tables. R20 remained at her table eating and drinking. -at 6:35 p.m., R20 remained alone in the dining room drinking beverages. -at 6:40 p.m., the dietary manager asked R20 if she wanted a ride to her room, shortly after that a nursing assistant entered the dining room and said she would take R20 to her room. On 11/19/24 at 11:49 a.m., registered nurse (RN)-A verified nursing staff should be in the dining room at all times when residents were eating for safety. On 11/20/24 at 10:51 a.m., the director of nursing (DON) verified nursing staff should be in the dining room during meals in the event someone choked. Dining Room Supervision dated 8/26/20, identified the following A nursing assistant or other designated, trained personnel will be assigned to the dining room at all meals. They will assist the residents in food preparation such as cutting, arranging food, andopening condiments and with feeding.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48109 Based on observation, interview and document review, the facility failed to ensure there was a sufficient number of staff to ensure all resident cares were completed timely for 9 of 9 anonymous reporters (AR-8, AR-1, AR-2, AR-3, AR-3, AR-4, AR-5, AR-6, and AR-7) interviewed. Also for family members, (FM)-L with concerns of resident (R32) being left soiled for extended periods of time, and nail care not being provided and environment being left soiled with stool, FM-K for long call light times, and FM-C for having to provide care themselves to ensure bedtime cares would be completed. In addition, residents R29 and R7 for long call light wait times, resulting in urinary incontinence for R7, R32 who was not assisted with morning cares until 2:30 in the afternoon, R4 for lack of nail care, R8 who was receiving end of life cares, but not repositioned and provided comfort cares timely, and R1 who did not receive pain medications timely due to inadequate staffing. In addition six residents (R1, R5, R21, R22, R31, and R37) who expressed ongoing concerns with not enough staff and significant wait times for cares. This had the potential to affect all 53 residents who resided in the facility. Findings include: Staff and Family Interviews: During an interview on [DATE] at 1:42 p.m., an anonymous reporter (AR)-8 stated they had concerns about the agency staff working at the facility without enough training, citing examples of residents being triple-briefed (layering incontinence products) and not actually being changed like they should be. Mainly the agency staff work afternoons and overnights. The reporter stated they had talked with the director of nursing (DON) and scheduler about their concerns and were told just to be nice. The reporter also stated they were short for this afternoon on the Meadows unit, so they would have to mandate someone after 8:30 p.m., someone would have to float between the two units, and tomorrow's schedule was the same. During an interview on [DATE] at 5:08 p.m., R29 stated they thought the facility was short staffed on weekends and reported they had witnessed very long call light times. R29 stated they had never been at risk; staff just took longer to answer lights and spent less time with them especially on nights and weekends. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on [DATE] at 5:42 p.m., family member (FM)-L stated they had recently filed a grievance, and they had never done that before because they knew the staff really tried hard. On [DATE], FM-L stated they had found R32 half out of bed with a diaper full, and a scratch along their diaper line which was raw and bleeding. At that time FM-L felt the facility didn't have enough staff working. FM-L stated they filed a second grievance last week because R32's bedrails had BM on them when they arrived for a visit. Staff explained R32 had messed themselves but was now in the dining room. FM-L found R32 seated in the dining room with a staff member ready to eat. When FM-L approached R32, they smelled BM and noted there was BM under R32's fingernails. At FM-L's request staff took R32 to the shower room. When staff removed R32's diaper, R32 was still dirty, it took staff a half hour to clean R32 up. FM-L stated they did not have enough staff to take care of the residents. They stated they were at the facility daily, and R32 did get good care, but when R32 was yelling for help, there was not enough staff to hear and help R32. Maybe they need to have a staff that rounds and answers call lights. FM-L also stated they help other residents when they visit when they can. During an interview on [DATE] at 5:59 p.m., FM-K stated the staff here are overworked. They work so hard, it makes you want to help them. They are good about getting to you when you ask, but it can be a long wait. They just really need more staff here. During an interview on [DATE] at 06:02 p.m., nursing aide (NA)-C stated the agency staff were not getting the training and education that core staff did. NA-C explained when they worked with agency staff it was harder to get their tasks done because a lot of their time was spent providing direction and explanation to the agency staff. During an interview on [DATE] at 6:17 p.m., FM-C stated they came to the facility two to three times per day, one of those times was at bedtime, because the facility didn't have enough staff and they wanted to make sure their resident was comfortable and tucked-in for the night. FM-C stated they were hopeful things would improve once the regular staff got back from vacation. During an interview on [DATE] at 7:07 p.m., AR-1 stated they had 32 residents to care for that evening with only two NAs, but a third NA was called in to work from 6 p.m. to 9 p.m. because state survey was in the building and it was presumed would leave by 9 p.m. The reporter stated they tried to get their work done, but it was killing them, and management wanted the showers, activities of daily living (ADLs), feeding at meals, turning, and repositioning all done but it was too much. The reporter stated they had many conversations with management about the workload and the agency staff who came in. The reporter also stated the agency staff didn't know anything and were not being trained. They were brought in at the start of the shift and put on the floor. The reporter and the other regular NAs would have to try and help the agency staff and still do their own work. Some of the things the reporter stated they couldn't get done were showers and sometimes call lights. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on [DATE] at 12:25 p.m., AR-2 stated sometimes there is only one NA scheduled on Meadows in the morning until 9:00 a.m. NAs must get all the residents up and ready for breakfast and lunch. Between meals some residents transferred back to bed and all residents needed toileting and repositioning between meals and throughout the day. They also usually had three showers to work into the day shift. The reporter stated it was especially difficult to get residents that required two staff for transfers and cares up because each NA had their own resident load they were responsible for. Staff don't get breaks, they have to eat while they are working. Staff usually worked through breaks so call lights got answered, but if they did, they might get in trouble for extra time. When they took their break, they would also get in trouble when call lights weren't answered while they were on break. For the most part they were able to get check and changes done but it was quick. We have to be task oriented and there was not time to support the social parts for residents. During an interview on [DATE] at 12:27 p.m., AR-3 stated they didn't feel they could get their work done during a shift. They used to have four aids on this hall and now they had two or three. Gardens used to have three aids and now cut down to two. AR-3 added they only had two aids again today so they would stay until 7 p.m. They tried their best not to skip showers but if there were more than two to be done in a shift, they may not get them done. Weekends were the worst. She had talked with management, and they said, what can they do. The reporter added agency staff were not helpful. During an interview on [DATE] at 12:32 p.m., AR-4 stated some days they could get their work done during their shift but that meant they didn't take any breaks. The reporter stated they busted their butt to make sure things got done because they don't want to leave work feeling like they couldn't get their work done. The reporter stated they had talked with management about how busy their shift was and had been clocking in early to try and get a jump-start on the day but they were told not to do that anymore. During an interview on [DATE] at 3:45 p.m., R7 stated they experienced some very long call light waits. R7 stated about two weeks ago they had put their call light on to go to the bathroom, and they waited so long they ended up having an accident in their pants because they couldn't hold it any longer. When staff did respond they felt so guilty and apologized, said they couldn't get to my room faster. The staff felt so guilty that it happened, they said they couldn't get in faster. R7 stated they had waited a really long time and it had been very embarrassing for them not being able to go to the bathroom on their own and having to go in their pants. During an interview on [DATE] at 10:23 a.m., AR-5 stated they could get their work done depending on who they were working with and whether they were short-staffed. The reporter also stated they tried to reposition residents every two to three hours, but it depended on when they could get to them. The reporter shared they worried about coming to work and being the only NA there because it had happened to other people and they didn't know what they would do in that scenario. AR-5 adds there used to be more aids on both the halls, four on one and three on the other, but now they regularly only had two aides and sometimes even one. During an interview on [DATE] at 10:35 a.m., AR-6 reporter stated they felt they could get their work done, but some days when they were short-staffed, they did the best they could. The reporter wasn't comfortable saying there were things they couldn't get done. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on [DATE] at 12:27 p.m., AR-7 stated they wished they had more staffing. They were usually responsible for 10 to 11 residents. NA-A stated there were things they wished they could get done like fingernails and shaving, but staff had to cut corners on one day and hope that they could do those things the next. Self-Determination and Activities of Daily Living: See also F561 and F677 R32: R32's careplan last reviewed [DATE], identified R32 preferred to dine in the main dining room and instructed staff to encourage resident to attend meals in the dining room where he could visit with others. Further, R32's care plan identified R32 required assistance with ADLS and preferred to get ready by 8:00 a.m. During an interview on [DATE] at 2:01 p.m., R32 was shirtless in bed with a blanket covering the waist down. R32 stated, they tell me every day they don't have enough people so here I am with just a blanket on. R32 indicated they needed help to get dressed and get out of bed so they were not able go to the dining room on their own. R32 preferred to be dressed for breakfast, but instead stated they felt like a fool in bed with just their pajama pants and blanket on. On [DATE] at 2:20 p.m., NA-E knocked on the door, entered R32's room and told R32 they would be back shortly with another NA to get them (R32) up for the day. After NA-E exited the room, R32 stated they would like to be dressed and out and about so they could visit with people, but instead they were stuck in bed. During an interview on [DATE] at 2:30 p.m., NA-E confirmed they were just now getting to R32 to get them up for the first time that day. NA-E explained when they didn't have the staff, they could only do what they could do. R32 was also a two-person transfer, so they had to find another staff who was also getting their residents up to assist them with R32's transfer. At times we are staffed so low we can't get our residents taken care of as they should be. During an interview on [DATE] at 4:42 p.m., R32 stated, they didn't get me up until noon today. During an interview on [DATE] at 10:30 a.m., R32 stated, here I am sitting in bed again still. During an interview at [DATE] at 12:25 p.m., NA-E stated R32 liked to go to the dining room for breakfast and they would like to get R32 up for breakfast, but because R32 was a two person transfer, it was not always possible to do on days when only one NA was scheduled until 9:30 a.m. on the Meadows unit. During an interview on [DATE] at 12:43 p.m., registered nurse RN-A stated if a resident wants to be up and dressed in the morning for breakfast then that preference should be honored. If a resident wanted to be up and dressed and instead was left in bed with just a shirt on, that would be a dignity issue. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on [DATE] at 2:42 p.m., the DON stated if it was a resident's preference to have a shirt on in bed, or to be up and dressed to have breakfast in the dining room, they would expect those preferences were met. The DON stated they knew R32 preferred to be up and out in the main area tooling around with his wife. The facility policy Activities of Daily Living (ADLs)/Maintain Abilities Policy dated [DATE], read Intent: it is the policy of the facility to specify the responsibility to create and sustain an environment that humanizes and individualizes each resident's quality of life by ensuring all staff, across all shifts and departments understand the principles of quality of life and honor and support these principles for each resident; and that care and services provided are person-centered, and honor and support each resident's preferences, choices, values and beliefs. R4: R4's quarterly Minimum Data Set (MDS) dated [DATE], identified R4's diagnoses included traumatic brain dysfunction, diabetes mellitus, hemiplegia/hemiparesis (a symptom that causes partial or total paralysis on one side of the body/muscle weakness or partial paralysis on one side of the body), and traumatic brain injury (TBI). R4's quarterly MDS identified R4 was severely cognitively impaired, sometimes understood and sometimes understands, had unclear speech, and was dependent on staff for ADLs. R4's care plan dated [DATE], identified R4 had a self care deficit with dressing, grooming, and bathing related to weakness and TBI. Interventions included nursing assistant to perform nail care for hands and feet on bath day. Weekly skin care assessments dated [DATE], [DATE], and [DATE], documented fingernails and toenails not addressed. Weekly skin care assessment dated [DATE], documented fingernails and toenails not necessary. On [DATE], R4 was lying in bed his left hand was in a fist and the fingernails on both hands were approximately ,d+[DATE] inch in length. On [DATE] at 2:04 p.m., licensed practical nurse (LPN)-A looked at R4's hand and stated the nails needed to be cut, she also observed a brown substance under some of the fingernails, and stated the nails were about a ,d+[DATE] in length. On [DATE] at11:06 a.m., the DON stated nail care should be completed by the nursing assistants on their shower day, unless the resident is diabetic then the nail care should be completed by the licensed nurse. The DON stated this should be documented on the weekly skin assessment form. The weekly skin assessments were requested but not provided. Quality of Care: See also F684. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	R8: R8's provider orders dated [DATE], identified hospice care through Essentia East Range Hospice with orders to call hospice first for changes in condition, need for additional services, medications, supplies, questions, concerns, and notification of death. R8's care plan dated [DATE], identified risk for skin breakdown related to impaired mobility, decrease in range of motion to both upper and lower extremities, and need for mechanical lift. Interventions included repositioning every three hours during the day and on rounds at night as needed. R8's care plan also identified hospice care related to end-stage disease process with interventions to maintain communication with hospice and keep them informed of resident's condition, or changes in condition, as needed. Review of R8's progress notes didn't contain a progress note regarding her change in condition or notification of hospice. During an interview and observation on [DATE] at 4:24 p.m., FM-A stated she had been there for about an hour and a half, and FM-B had been there prior to that. FM-A and B explained they and their siblings spent most of every day at the facility to make sure R8 was taken care of. They stated the last time R8 had been repositioned was about 1:30 p.m. FM-A explained R8 had not been responsive today and hadn't taken in food or fluids. R8 was positioned in the bed on her left side with her left arm tucked under her body. During an observation on [DATE] at 4:59 p.m., NA-D went into R8's room, looked at her and then went to her neighbor and asked if she was ready to go to dinner. NA-D then left the room with R8's neighbor. At 5:08 p.m. , NA-D walked past R8's room and to elsewhere in the building. There were no other staff present in the hall. During an interview on [DATE] at 5:25 p.m., NA-B stated they reposition residents every two hours. NA-B didn't recall when it was last done for R8 because he had been busy getting residents to dinner. NA-B explained he just takes care of the people on his sheet and R8 was not on his sheet, and right now there were call lights on for people who needed help going to the bathroom. NA-B stated he went around helping where he saw help was needed and didn't get report on when R8 was last repositioned because she wasn't on his list, adding there were only two people working on this hall and it was dinner time. During an interview on [DATE] at 5:29 p.m., RN-B stated they were short on the floor, so she was going to go join them in the dining room to feed the residents and then left the area. During an observation on [DATE] at 5:33 p.m., RN-B and NA-B came back to R8's room and proceeded to reposition her. R8 had two red areas on her right buttock, RN-B looked at the areas and applied barrier cream. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on [DATE] at 3:20 p.m., hospice nurse (HN)-A stated they got a call from the facility regarding R8 at 6:45 p.m. on [DATE], and then made a visit to the facility to see R8 at 7:15 p.m. HN-A stated they assessed R8, showed RN-B how to crush the pain medication in a very small amount of water to be given buccally (into the inside of the cheek), and instructed on pain management. The facility notified hospice at 0345 that R8 had died . HN-A stated they wished they had known R8 was making changes that day so that hospice could have provided support to the family and the facility. During an interview on [DATE] at 9:10 a.m., the DON stated R8 had varying abilities to swallow but would agree R8 had a change in condition on [DATE] and hospice should have been updated. The DON also stated it didn't meet her expectations for a resident to go four hours without repositioning with risks including skin breakdown and pressure injuries. R1: R1's annual MDS dated [DATE], identified R1 was cognitively intact with the diagnoses of cancer, hypertension, GERD, arthritis, anxiety, and depression. Section E- Behavior did not identify R1 as having any behavior symptoms that negatively impacted self or others. Section N - Medications indicated R1 received high risk medications in the classes of antidepressant, anticoagulant, diuretic, opioid, and hypoglycemic. Section V - Care Area Assessment Summary section V0200 did not identify pain as a care area triggered to be addressed in the care plan. R1's careplan last reviewed on [DATE], focus area Alteration in comfort denoted the goal for R1 to have adequate relief from pain and instructed pain medication as ordered. R1's Medication Administration recorded provided by the facility showed the following medications had been administered to R1 on [DATE] at 11:12 a.m.: -Gabapentin Oral Capsule 100 MG (Gabapentin). -Celexa 10 mg give 10 mg by mouth in the morning related to anxiety -furosemide Tablet give 20 mg by mouth in the morning - chronic atrial fibrillation, unspecified (I48.20); essential (primary) hypertension (I10) -digoxin Tablet give 62.5 mcg by mouth in the morning related to unspecified atrial fibrillation (I48.91) Hold if APICAL pulse is 60 bpm. -tramadol HCl Oral tablet 50 mg give 50 mg by mouth every morning and at bedtime for Pain -Potassium tablet give 20 mEq by mouth in the morning related to hypokalemia (E87.6) administer with or after meals with full glass ,d+[DATE] oz water or juice R1' [DATE] Treatment Administration record identified to monitor for pain every shift. R1's pain levels were documented as follows: -[DATE] night shift pain level: 4 (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on [DATE] at 3:06 p.m., the DON opened R1's EMR and explained when a medication is ordered every morning and bedtime it falls into the open med pass so it can be given in the facility window for med pass. Nurses should prioritize resident medication administration by who is getting up first, etcetera. The DON reviewed R1's mediation and confirmed R1 had received their morning medication after 11:00 a.m. on [DATE]. The DON stated pain was a priority, but since they were not present on [DATE] they could not speak to what had occurred. The DON stated absolutely if they had a fall or an emergent situation, they expected that event to take priority over medication administration. The DON stated the facility was staffed to care for their residents and to take care of emergencies. It was unfortunate that R1 was waiting and upset and in pain while staff addressed the death of a resident on [DATE], however the DON felt it was an isolated incident, as they were not aware of this being an ongoing issue. The DON stated it was okay for medications to be given outside of the designated administration window if something else was pressing. Facility Assessment: The Facility assessment dated [DATE], identified a need for nurse (RN/LPN) to resident ratio of 1:25 to 1:30 for day and evening shift and 1:59 for overnight shift. The assessment also identified a need for NA to resident ratio of 1:10 to 1:12 for day shift, 1:10 to 1:14 for evening shift, and 1:25 for overnight shift or 2.8 to 3.2 hours per resident days. Review of facility-submitted schedules, daily posted staffing, and payroll data for the time period of [DATE] to [DATE] revealed hours of care (calculated with the actual number of NA hours worked and the daily resident census) ranging from 1.6 to 2.2 hours per resident per day. On ,d+[DATE], ,d+[DATE], ,d+[DATE], ,d+[DATE], [DATE] the actual total NA hours worked was eight or more hours less than the total NA hours on the posted facility staffing. Of note, on Sunday [DATE] the actual NA hours worked was 20 hours more than the posted facility staffing, despite one NA working the Garden unit alone from a little before 7:30 a.m. until about 9 a.m. Surveyor: [NAME]-[NAME], Tr Resident Council: Six residents (R1, R5, R21, R22, R31, and R37) and the ombudsman attended a meeting with resident council members on [DATE] at 1:31 p.m. The residents agreed that staffing was an issue that came up at all their resident meetings. They stated call light response times was a big issue. Discussion included: -Multiple members expressed most staff worked really hard, and they just couldn't do it all. -One of the residents stated call lights were good now because the survey team was in the building. -Another resident shared sometimes when they put their call light on staff would turn it off and say they would be right back but then they never came back. Then staff got mad if you turned it back on again after waiting an hour for someone one to help. Other residents confirmed their call light had been turned off and forgot too. (continued on next page)

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	245283	A. Building B. Wing	11/20/2024

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-Others shared of call light waits as long as one to three hours and one resident shared they had had an accident in their pant because staff didn't answer their call light in time. -Members stated that administration had come to some of their meetings in the past and they had talked to them about concerns. One of the old administrators said the facility was monitoring call light logs, but residents stated they didn't really know what that meant. Members indicated when it came to staffing, the facility response had not really been much. They hadn't really had a good reply about staffing concerns. Members were not sure if administration was made aware of the concerns they discussed. The members indicated they knew how to file a grievance as an individual, but they were not sure about resident council filing a collective grievance. Administration Interviews: During an interview on [DATE] at 3:49 p.m., the administrator, the associate administrator, the DON, and the regional nurse consultant were all present. The administrator stated some of the things they took into consideration for staffing were metrics based on hours per patient day (PPD) and accounting for the level of care and the number of residents in house. The administrators, DON and nurse managers met every weekday morning to review the staffing plan and provide feedback based on what else was going on in the building. They also made rounds and checked in with the staff. The associate administrator stated they gave staff empathy when they were short-staffed and would look at the numbers on each of the wings and made sure they were within that. The administrator stated in addition to staffing ratios and calculations, they also looked at resident needs and what equipment was needed to support staffing levels. Unit meetings and Labor Management Committee were opportunities for staff input on staffing. The DON stated within the past month there were concerns with shifts in census within the building so they had changed work assignments around based on staff input to balance workload. When asked if the facility was adequately staffed to continue caring for residents in the event of a death or emergency, the administrator stated emergencies and events like deaths were planned for in their staffing ratios. Daily staffing plans factored in unexpected events and included an on-call staff that could come in to assist with an emergency or something the on-site staff could not handle. The administrator also indicated there may be some variances on other priority items during an unplanned event, but they believed the staffing ratios supported the care that was being provided. When asked how agency staff were trained and oriented, the administrator stated they had agency staff come in a half-hour prior to the start of their shift and complete the competencies and emergency preparedness information, to get acquainted to the units and introduce them to other staff. When they receive complaints regarding agency staff, they follow up with the staff to better understand what the issues were so they could help. 47263

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. 47263 Based on observation, document review, and interview the facility failed to ensure required nurse staffing information was posted daily over the weekend, this deficient practice had the potential to impact all 53 residents residing at the facility and visitors who may wish to review this information. Findings include: During an observation on Sunday, 11/17/24 at 6:32 p.m., the posted staffing sheet was dated Friday 11/15/24. For the remainder of the survey, Monday 11/18/24, to Wednesday 11/20/24, the daily staffing information sheets were updated and posted each day. During an interview on 11/20/24 at 3:49 p.m., the administrator stated the staffing hours should be updated and posted daily including weekend days. The charge nurse is given staffing sheets, and they are responsible to update and get the staffing hours posted on Saturdays and Sundays. The charge nurse should have posted a new staffing sheet each day this past weekend.

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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** 47263 Based on interview and document review the facility failed to ensure orders for the use of PRN (as needed) lorazepam, a psychotropic medication (mood altering medication) was time limited to 14 days of use with a documented associated diagnosis for 1 of 5 residents (R28) reviewed for PRN psychotropic medication use. Findings include: R28's significant change Minimum Data Set (MDS) dated [DATE], indicated R28 had severe cognitive impairment. MDS Section I - Active diagnoses listed dementia, hyperlipidemia, arthritis, low back pain, ataxia, and adult failure to thrive. There were no diagnoses selected in Section I, Psychiatric/Mood Disorder Diagnosis. R28's careplan last reviewed 10/30/24, included psychotropic drug ADR [adverse drug reaction] monitoring, identified target behaviors and provided interventions for alterations in cognition, communication, and mood. R28's Order Summary Report dated 11/5/24, signed by provider on 11/8/24, included the following orders: -Lorazepam oral tablet 0.5 mg, give 1 tablet every 4 hours as needed for anxiety for 6 months. Order Date: 10/1/24. End date: 4/1/25. -Olanzapine Oral Tablet 2.5 mg give 1 tablet by mouth in the evening related to unspecified dementia, unspecified severity, with other behavioral disturbance (F03.918) -Psychotropic Monitoring-Antianxiety Medication Order date: 7/18/24. -Psychotropic Monitoring-Antidepressant Medication Order date: 7/19/24. -Reminder to offer PRN when agitated et trying to get out of w/c. Document behaviors in progress note. Order date 7/11/24. -Target Behavior monitoring. Order date 10/1/24. The order summary lorazepam order lacked a medical diagnosis for the use of lorazepam. Consultant Pharmacy reviews were requested for the months of 5/2024, to 11/2024. The following reviews were received: -5/17/24: listed lorazepam, olanzapine, and trazadone with a notation after each medication: hospice covered. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-6/29/24: listed lorazepam, olanzapine, and trazadone with a notation after each medication: hospice covered. -7/21/24: pharmacist recommend adding behaviors for olanzapine and current dose need and or consider a dose reduction. Provider responded 7/29/24: agree please write order. The facility did not provide requested reviews for 8/2024, 9/2024, or 10/2024. Provider note dated 9/17/24, identified R28 was on hospice and was receiving Ativan [lorazepam] PRN for comfort and to manage symptoms such as distress and anxiety at end of life. The note recommended continuing the PRN Ativan for a duration of 6 months with an end date of 3/17/25. Provider note dated 10/2/24, identified R28 was being seen for equipment and medication refills which needed to be sent to Polaris [pharmacy] post discharge from hospice. The noted Assessment & Plan included: -Dementia with behavioral disturbance plan: olanzapine 2.5 mg tablet. Use broda chair when out of bed. -Primary osteoarthritis of knees plan: Cymbalta 60 mg delayed release capsule. The Assessment and Plan did not identify a diagnosis for lorazepam, nor did it include rationale for an extended order duration beyond 14 days for PRN lorazepam. The note's past medical history and current visit diagnosis lists did not include an anxiety disorder diagnosis. During an interview on 11/20/24 at 12:59 p.m., registered nurse RN-A stated R28 was discharged from hospice on 10/1/24. The hospice order should have been discontinued and a new order should have been entered with an indication for PRN lorazepam and a new rationale for PRN lorazepam use beyond 14 days should have been documented. The facility's policy Psychotropic Medication Use dated 7/2021, identified psychotropic medications would be prescribed at the lowest possible dosage for the shortest period of time and were subject to gradual dose reduction. Residents would not receive PRN doses of psychotropic medications unless the medication was necessary to treat a specific condition that was documented in the clinical record. The need to continue PRN orders for psychotropic medications beyond 14 days would require the practitioner to document the rationale for the extended order and the duration of the PRN order would be indicated in the order. PRN orders for psychotropic medications would not be renewed beyond 14 days unless the healthcare practitioner has evaluated the resident for the appropriateness of the medication.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 45842 Based on observation, interview and document review the facility failed to dispose of an expired bottle of half and half that was still available for residents to use. This had the ability to effect every resident who used half and half during meals. Findings included: On [DATE] at 1:24 p.m., an opened bottle of [NAME] half and half dairy product was noted in the refrigerator of the dinning hall dinette room. Hand written on the bottle was an open date of [DATE]. The manufacture's expiration date was [DATE]. During an interview on [DATE] at 1:30 p.m., culinary aide (CA)-A looked at the bottle and confirmed [DATE], was the dated the bottle was first opened. CA-A also acknowledged [DATE], was the manufacturer's expiration date on the bottle of half and half. CA-A stated dairy products like half and half are only good for 5 days after they are opened so this bottle of half and half should have been thrown away on [DATE], but for sure on [DATE], when the manufacturer says the dairy product is expired. she did not know why the dairy product was still accessible for residents to use. During an interview on [DATE] at 11:48 a.m.,the culinary director (CD) stated all dairy products are good for 5 days after being open. Dairy product should then be disposed of at that time, or the manufacturer's recommended expiration date. During an interview on [DATE] at 2:06 p.m., the infection preventionist (IP) stated the longer dairy products are used past the expiration date increased the risk of bacteria and food born illness occurring in residents. Facility policy Food Receiving and Storage , last revised 2017, lacked information related to monitoring of foods and liquids for expiration dates.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48109 Based on interview and record review, the facility failed to ensure the security of medical records for 1 of 1 (R8) resident reviewed for coordination of hospice care. Findings include: R8's significant change in condition Minimum Data Set (MDS) dated [DATE], identified moderately intact cognition and diagnoses of dementia and congestive heart failure. R8 was dependent on staff for eating, bed mobility and toileting. R8's provider orders dated 9/30/24, identified hospice care through Essentia East Range Hospice with orders to call hospice first for changes in condition, need for additional services, medications, supplies, questions, concerns, and notification of death. R8's care plan dated 3/14/23, identified hospice care related to end-stage disease process with interventions to maintain communication with hospice and keep them informed of resident's condition, or changes in condition, as needed. The Essentia Hospice care plan was not part of R8's electronic health record (EHR). On 11/19/24 at 2:48 p.m., corporate nurse consultant (CNC)-A provided an email indicating the facility could not locate R8's hospice chart but would keep looking. During an interview on 11/19/24 at 3:20 p.m., hospice nurse (HN)-A stated hospice staff wrote notes about their visits on paper in a binder. The binder was stored on a shelf at the nurse's station. HN-A confirmed the hospice staff didn't record progress notes in the EHR. On 11/19/24 at 3:24 p.m., the director of nursing (DON) provided an email indicating she had spoken with facility and hospice staff and was not able to locate the hospice chart. During an interview on 11/20/24 at 9:10 a.m., the DON confirmed the facility had not been able to locate R8's hospice papers which were in the hospice binder. A Monarch Healthcare Management (MHM) document, Retention of Medical Records dated December 2006, didn't address the security of medical records.

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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** 42587 Based on observation, interview and document review, the facility failed to ensure orders for respiratory care were implemented for 1 of 1 (R23) resident reviewed for respiratory care. Findings include: On 11/17/24 at 5:29 p.m., R23 was in her room lying in bed wearing oxygen per nasal cannula at 2 liters per minute. R23's oxygen was humidified and the bottle was dated 10/16/24. R23's quarterly Minimum Data Set (MDS) dated [DATE], identified R23 had diagnoses which included centrilobular emphysema (a form of chronic lung disease), chronic obstructive pulmonary disease (a group of lung diseases that block airflow and make it difficult to breathe), pulmonary fibrosis (a condition in which the lungs become scarred over time. Symptoms include shortness of breath, a dry cough), atherosclerosis of aorta (a condition where plaque builds up in the walls of the aorta), morbid obesity with alveolar hypoventilation (insufficient ventilation), and chronic respiratory failure with hypoxia (an absence of enough oxygen in the tissues to sustain bodily functions). R23's order summary dated 11/20/24, included orders to Fill concentrator bubbler every evening shift dated 10/24/22. The orders did not include changing the concentrator bubbler. R23's electronic medical record (EMR) did not include evidence of oxygen bubbler being changed on any schedule. On 11/19/24 at 11:34 a.m., regisetered nurse (RN)-A reviewed R23's EMR and verified there was not any documentation for changing the oxygen bubbler. RN-A stated she would expect the oxygen bubbler to be changed monthly per the policy and should be changed regularly for infection control purposes. RN-A verified the date on the oxygen bubbler as 10/16/24. On 11/20/24 at 10:53 a.m., the director of nursing (DON) stated she would expect oxygen bubblers to be changed per the policy for infection control purposes. Policies on respiratory care practices were requested but not provided.