STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245329	A. Building B. Wing	11/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Warroad Care Center	1401 Lake Street Northwest Warroad, MN 56763

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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 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** 40943 Based on interview and document review, the facility failed to provide toileting cares in a dignified manner for 1 of 1 resident (R12) reviewed for dignity. Findings include: R12's quarterly Minimum Data Set (MDS) dated [DATE], identified R19 was severely cognitively impaired and R12 was dependent (helper performed all the effort and resident does none of the effort to complete the activity) for toileting and bed to chair transfers. R12 required substantial/maximal assistance (helper does more than half the effort) for personal hygiene. R12's care plan dated 8/9/24, identified R12 was cognitively impaired and required assist of two staff for ceiling lift transfers. During an interview on 10/28/24 at 2:38 p.m., R12 stated, last week, a nursing assistant left R12 in the bathroom in the ceiling lift alone. R12 was unable to say a name or date but R12 was crying and stated R12 waited at least 20 minutes. R12 was in the bathroom already in the lift, up in the air, and R12's feet were dangling and going numb. Staff usually left R12 in the ceiling lift, hanging over the toilet, but usually not for that long. R12 stated she urinated almost immediately when she got to the toilet and could have gone back to bed. R12 did report the incident to facility staff and stated she was told by facility staff it always felt longer when you're in the lift, but it wasn't that long. R12 was crying and stated she felt neglected. I don't like to complain and get people in trouble, but I can't put up with this either. I just can't. R12 was grasping her bed linens in her hands and stated she was told there were many other people to help take care of. During an interview on 10/30/24 at 9:20 a.m., licensed practical nurse (LPN)-A stated she was very concerned regarding resident and staff safety. The facility did not have enough staff to provide assist of two with ceiling lift transfers. Residents were being left alone in the lifts in the bathrooms and not answering call lights timely. LPN-A stated she knew of an incident on 10/25/24 between R12 and NA-D, where R12 was left alone in the bathroom hanging from the ceiling lift. LPN-A did not report this to anyone but stated R12 was not safe to be left unattended in the ceiling lift in the bathroom nor was it dignified.R12 had a history of depression as well. (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 10/30/24 at 9:44 a.m., NA-C stated the facility was always short staffed. NA-C stated she had heard about an incident where R12 was left alone in the bathroom because staff were answering call lights because there wasn't enough staff. During an interview on 10/30/24 at 1:25 p.m., NA-B stated R12 reported the bathroom incident to her, and NA-B reported it to the nurse. After that, NA-B didn't know what happened. During an interview on 10/30/24 at 2:39 p.m., the social worker designee (SWD)-A stated she was informed of R12's bathroom incident and staff were expected to not leave residents unattended in the bathroom to ensure resident's safety and to provide comfort to the resident. However, there was no documented grievance for R12's concerns or follow up. During an interview on 10/30/24 at 6:21 p.m., the administrator stated staff were expected to provide cares in a dignified manner to maintain the resident's individuality and to provide comfort. A facility policy regarding dignity was requested but not received.

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42075 Based on interview and document review, the facility failed ensure a voiced grievance was acted upon; and provide a written policy for how the facility would handle grievances for 1 of 1 resident (R20) reviewed for missing property Findings include: R20's quarterly Minimum Data Set (MDS) dated [DATE], identified R20 was cognitively intact and demonstrated no delusional behavior and/or thinking. The facility 8/7/24, resident council minutes identified R20 was missing a long white, [NAME] nightgown that had been gone for an undetermined length of time. On 10/30/24 at 9:58 a.m., during a resident council discussion R20 stated she reported a missing night gown a few months ago at a resident council meeting. R20 stated she asked staff about the gown a couple weeks ago but had not received any follow up. An interview was completed on 10/30/24 at 2:45 PM, with environmental services manager (EVS) and laundry aide (LA)-A. LA-A stated in August 2024, the facility changed the laundry process, and all personal and facility laundry was done in the large laundry room and not on the units as previously done. Staff and/or family were instructed to label all the residents clothing and any unlabeled and/or unclaimed items were folded/hung on the cart and brought to the units for the nurses, residents, and family to look through and identify. EVS stated residents/families/staff notified the laundry staff of missing items. Residents also voiced concerns of missing items during resident council and laundry staff were notified to watch for the item/s. After an undetermined amount of time, the concern would be discussed with administration to make a decision regarding compensation. During interview on 11/4/24 2:32 p.m., nursing assistant (NA)-E stated staff would search for any missing items and notify the nurse and laundry staff. NA-E was unaware that R20 was missing a night gown and was uncertain if there was a form to fill out for missing items. During interview on 11/4/24 at 1:52 P.M., the activities director (AD) stated when missing items were brought to resident council meetings she would make a note in the minutes, highlights the concern, and placed a copy of the minutes in the appropriate manager's mailbox as well as the director of nursing (DON)'s for follow up. If the concern came up again at future resident council meeting would make another note in the minutes and place a highlighted copy in the administrator's mailbox. The AD stated once the copies were placed in the appropriate mailbox, the AD would not follow up any further. Missing items were discussed at the interdisciplinary meeting but did not recall that R20's missing night gown had been discussed. On 11/4/24 at 2:16 p.m., EVS stated she was unaware of R20 having any missing clothing items and if it had been prior to 8/24, the nursing staff would have tracked and followed through with the item. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A facility grievance policy was requested but not received.

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41575 Based on observation, interview and document review, the facility failed to ensure 1 of 1 resident (R39) with a known history of sexual behaviors towards others was comprehensively assessed and interventions implemented to mitigate risk to prevent ongoing sexual abuse for 2 of 2 residents (R31, R6) who were cognitively impaired, dependent on staff for their care, and were sexually abused by R39. The immediate jeopardy (IJ) began on 9/6/24, when R39 came up behind R31 and fondled her breasts. The facility failed to comprehensively assess and develop interventions to help manage and reduce the risk of injury or assault to others. This contributed to R39 continued episodes of sexual abuse toward R31 on 9/25/24, and again on 10/14/25, and toward R6 on 10/15/24. The administrator and director of nursing (DON) were notified of the IJ on 10/30/24, at 11:43 p.m. The IJ was removed on 11/5/20, at 9:09 p.m. when the facility successfully implemented a removal plan; but noncompliance remained at the lower scope and severity level 2, D-isolated, which indicated no actual harm with potential for more than minimal harm that is not immediate jeopardy. Findings include: R31: R31's quarterly Minimum Data Set (MDS) dated [DATE], identified R31 had severe cognitive impairment and exhibited physical behaviors of grabbing, hitting, scratching, or abusing others sexually one to three days per week, and verbal behaviors toward others one to three days per week. R31 required substantial assistance to dress and was independent with transfer and ambulation. Diagnoses included Alzheimer's disease, anxiety, mood disorder, dementia, restlessness, and agitation. R31's care plan dated 10/29/24, identified R31 was vulnerable due to disorientation, functional limitations, confusion, and repetitive verbalizations. R31 could be easily exploited or had a history of giving away money or belongings. R31 exhibited behaviors of pacing, rummaging, wandering, yelling, resistive to care, physically abusive toward staff, false beliefs, anger with self and others and easily annoyed. Staff were to use dementia approach, introduce self, uses short sentences, avoid questions, avoid saying no to resident, 1:1 visit, redirection, offer reassurances, determine, and meet basic needs, allow space when resistive. R31 had impaired cognitive function or thought processes related to dementia. Staff were directed to face resident when speaking, reduce distractions. R31 understood consistent, simple, directive sentences. Provide support when needed. R31 needed support and assistance with safe decision making. The care plan did not identify any interventions to protect R31 from resident-to-resident sexual abuse. R31's medical record lacked any assessment on capacity to consent to sexual activity. R6: (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	R6's quarterly MDS dated [DATE], identified R6 had moderate cognitive impairment and exhibited delusions, physical behaviors of grabbing, hitting, scratching, or abusing others sexually one to three days per week, verbal behaviors toward others four to six days per week and other behaviors not directed toward others four to six days per week. R6 required substantial assistance to dress and partial assistance with transfers. R6 was independent with ambulation once standing. Diagnoses included depression, anxiety, dementia, and sever mood disturbance. R6's care plan dated 8/1/24, identified R6 had a history of trauma related to experienced physical and verbal abuse from a care giver. Staff were directed to: express patience and not to rush resident with care, reassure R6 she was safe and cared for by staff and her family. The care plan identified R6 was vulnerable due to disorientation, history of delusions, functional limitations, confusion, and repetitive behavior. R6 could be easily exploited or had a history of giving away money or belongings. R6 exhibited behaviors of paranoia, false beliefs, pacing, disrobing in public areas, delusions, negative, anxious, or depressed statements, exit seeking, and crying. Interventions included: R6 preferred female caregivers and to avoid male caregivers, introduce self, explain each step of care, speak in short sentences, anticipate, and meet basic needs, offer reassurances, redirect, listen when resident has concerns and diversional activity. The care plan did not identify any interventions to protect R31 from resident-to-resident sexual abuse. R6's medical record lacked any assessment on capacity to consent to sexual activity. R39: R39's quarterly MDS dated [DATE], identified R39 had severe cognitive impairment with physical behaviors of grabbing, hitting, scratching, or abusing others sexually one to three days per week. R39 was able to transfer and ambulate independently. R39 diagnoses included dementia, psychotic disturbance, mood disturbance and anxiety. R39's care plan dated 9/24/24, identified R39 had targeted behaviors of wandering and touching female staff inappropriately. Interventions directed staff to provide verbal and tactile cues if he exhibited inappropriate touching and remind him to keep his hands to himself. Staff were directed to avoid having their back to R39, engage R39 in household activities, and to be out with other residents and staff. The care plan failed to identify R39's sexually inappropriate behaviors toward other residents and lacked interventions to ensure other residents' safety. R39's progress notes identified the following: - 8/23/24, R39 was observed to take R31 by her hands and lead R31 to his room and close the door. When staff entered the room, R39 was lying on his side in bed and R31 was just seated on R39's bed. Staff directed R31 out of room and reminded R39 they were not allowed alone in room with door shut. - 9/6/24, licensed practical nurse (LPN)-A documented R39 had approached a female resident [identified as R31 from interview] from behind and gave the resident what appeared to be a bear hug [identified in interview to be reaching from behind and grabbing breast] which staff observed from behind. The social service designee (SWD) was notified. - 9/18/24, R39 made attempts to enter an unidentified female resident's room when she was sleeping in bed with lights off. Staff redirected R39 out of the room several times. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	- 9/25/24, R39 was observed fondling R31's breast. Staff intervened and separated the two residents. - 10/11/24, R39 was walking back to his room when R39 approached a female resident [identified as R31 through interview] to grab her breast area. R39 was redirected away and reminded it was inappropriate to touch anyone without permission. The DON was notified. - 10/15/24, R6 was found in R39's room with the door closed. R6 was seated in her wheelchair beside R39's bed and R39 was fondling R6's breast. R6 was removed from area and R39 was reminded the behavior was not appropriate. R6 stated the incident made her uncomfortable and R39 had been squeezing her breast pretty hard. The DON and SWD were notified. R39's medical record lacked evidence R39's inappropriate sexual behaviors toward other residents had been comprehensively assessed and interventions implemented to mitigate potential abuse toward other residents, despite R39 being independently mobile and displaying ongoing inappropriate sexual behaviors. R31's medical record lacked any assessment to ensure her psychosocial needs were met and interventions implemented. R6's medical record lacked any assessment to ensure her psychosocial needs were met and interventions implemented. On 10/31/24 at 9:40 a.m., R39 was observed in the television area seated between two female residents, one on either side. SWD approached R39 to speak with him. R39 reached his hand underneath SWD's sweater and attempted to grab her breast. SWD pushed R39's hand down and left the area, leaving R39 to remain seated between the two female residents. Nursing assistant (NA)-A, who was present, stated R39 was 1:1 supervision now due to his behaviors. On 10/29/24 at 11:00 a.m., NA-A stated R39 could get grabby and try to grab staff breasts, you just needed to watch for it and remind him the behavior was not appropriate. NA-A was not aware R39 had inappropriate sexual behaviors toward other residents. The facility usually staffed the locked unit with one nursing assistant and a nurse would come on the unit on and off to pass medications. Once in a while they would have a float nursing assistant that would come on the unit occasionally to see if help was needed, but that did not happen very often. On 10/29/24 at 12:30 p.m., NA-B stated R39 liked to touch women's breasts. NA-B knew of R39 touching R31. NA-B and R31 were standing in the hall visiting when R39 came up behind R31 with a sort of bear hug and R39 clasped both his hands over R31's breasts in a kind of thrusting up motion. R39 let go and giggled. NA-B remembered R31's hard a startled look on R31's face. NA-B reported the incident to the charge nurse and the DON at the time. NA-B did not remember any changed interventions or approaches being implemented after that. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	When interviewed on 10/29/24, at 1:00 p.m. licensed practical nurse (LPN)-A stated R31 was observed walking back to R31's room and R39 was walking back to his. When R39 saw R31, R39 veered off toward R31 walking straight towards R31 and attempted to touch R31's breasts. LPN-A intervened and directed R39 to R39's room. LPN-A immediately reported the incident to SWD and the DON. LPN-A was told to make sure the incident was documented in R39's medical record and the DON and SWD would look into the incident. LPN-A asked SWD and the DON how much charting would need to occur before anything was done regarding R39's behaviors but was not given an answer. On on 9/6/24, LPN-A observed R39 approach R31 from behind, placing his arms on either side of R31 in a bear hug and grabbed R31's breasts. On 9/11/24, LPN-A stated housekeeper (HSK)-A watched R39 sit near R31 on the couch in the television room when R39 stood and took R31's hands and led her to his room and was just shutting the door. HSK-A went to the adjacent unit (unit A) to notify LPN-A. LPN-A entered the room and separated the two residents. Further, on 8/23/24, LPN-A stated R31 was in R39's room with R39 lying in bed. HSK-A observed the behavior and went to unit A to notify LPN-A. When LPN-A entered, R31 had just sat on R39's bed and LPN-A separated the two residents. LPN-A documented all the incidents into R39's medical record and reported each incident to either the DON or SWD after each occurrence. During interview on 10/29/24, at 2:00 p.m. RN-A stated she worked on the locked unit on 10/14/24, and observed R39 reach out to grab R31's breast in the common area. RN-A hollered to R39 No, don't do that and he immediately stopped. R31 stated, I told him that to. RN-A immediately reported the incident to SWD, however did not document the incident in R39's medical record. RN-A was not aware R39's inappropriate sexual behavior toward other residents was not addressed on R39's care plan, but RN-A was sure staff were aware of the behaviors. When interviewed on 10/29/24, at 1:30 p.m. SWD stated she was notified of some incidents with R39's behavior toward residents. SWD received calls regarding incidents of R39 inappropriately touching other residents on 10/14/24 and 10/15/24. SWD discussed the incidents regarding R31's behavior with the DON and it was determined there were no non-consensual type of feelings. The residents had not seemed upset, so SWD and the DON determined it would be ok to just document the incidents when they occurred. When the DON called SWD on 10/15/24, regarding R39 inappropriately fondling R6's breasts, SWD and the DON discussed the incident and determined there was no willful intent and the residents did not seem upset, so the behavior was fine. SWD stated she did not follow up on any of the reported incidents or change anything. Assessments were not completed with any of the residents involved. The reported incidents that occurred with R39 had not been investigated because it was determined both participants were willing and did not seem upset. R39's care plan did not get updated to reflect the inappropriate sexual resident to resident behavior because the facility had hired a new MDS coordinator. The MDS coordinator was going through all the resident care plans and trying to get them all updated and they were all just trying to catch up and survive. SWD did feel a reasonable person would be upset when approached from behind and breasts grabbed and SWD had just assumed someone else was looking into R39's behavior incidents. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	When interviewed on 10/29/24, at 2:00 p.m. the DON stated she was only aware of the two most recent incidents involving R39's inappropriate sexual behaviors toward other residents. DON discussed the incidents with SWD, and they determined because both residents had severe cognitive impairment and there did not seem to be any willful intent to be a sexual predator, the incidents would not need to be reported. The facility did not investigate any of the resident-to-resident incidents beyond reviewing the initial reports reported to them by staff. The DON had not been aware of all the incidents or near miss incidents of abuse. Had the staff notified the DON she would have realized there was a pattern and would have done things to prevent the incidents, such as placing an alarm on R39's room door as well as implementing care planned interventions and approaches to prevent resident to resident occurrences. R39's inappropriate sexual behaviors toward other residents should have been care planned with interventions for staff to follow. Assessment and care planned interventions had not been completed as the DON had not been aware there had been so many incidents. Even one incident would not be ok, but R39 was showing a pattern of behavior. If the DON had known a pattern had been identified, the facility could have done so much more to prevent reoccurrences. When interviewed on 10/29/24, at 5:30 p.m. family member (FM)-A stated he had not been notified of any resident-to-resident incidents regarding R31. FM-A felt it would have been very upsetting for R31 to be fondled in that manner. R31 would have never been ok with that type of attention. FM-A was surprised the facility had not notified him of the incidents as it was something R31's family would have wanted to have been made aware of. During interview on 10/29/24, at 5:30 p.m. the administrator stated he was not made aware of R39's inappropriate sexual behaviors toward other residents until the DON spoke with him around 3:00 p.m. or 4:00 p.m. on 10/29/24. Had the administrator been made aware of R39's behaviors he would have reported the incidents, notified the POA's of the residents, notified the physician and the ombudsman and investigated. During telephone interview on 10/30/24, at 10:00 a.m. R39's medical doctor (MD)-B stated he was not aware of any resident-to-resident inappropriate sexual incidents. MD-B would have certainly expected the facility to have mentioned R39's inappropriate resident to resident incidents when completing rounds at the facility on 9/20/24, as the incidents had been occurring even then. MD-B would have liked to have known. R39 was a challenge as R39 had no sense of boundaries. MD-B stated it was not known if R39 had a history of such behaviors prior to his placement in the nursing home. The sexual behaviors toward staff had started after his placement. MD-B would have liked to know when R39 started to direct the inappropriate behavior toward other residents. MD-B may have had the memory clinic get involved to address R39's behavior. Staff reported to MD-B in September R39's behavior had improved for staff related incidents, it could have been because R39 was directing sexual behaviors toward residents, targeting other residents instead of staff. The facility provided handwritten note undated, identified laundry aide (LA)-A entered R39's unit to pick up laundry and LA-A found R39 coming up behind R31 and her sides and R31 jumped and said you. LA-A called R39's name at the same time (LA-A was just seconds behind) and LA-A told R39 that was inappropriate, and we all needed to keep our hands to ourselves. R39 left R31 alone immediately. LA-A reported to the nursing assistant on the unit, and she reported to the nurse. At the time of the incident, the nursing assistant was getting someone food in the dining room. The note failed to identify when the incident occurred, how R39 touched R31, or staff involved. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The facility High Risk Monitoring Household: Pine dated 11/4/24, identified a grid of 30-minute time slots for five residents including R31 and R39. At 1:00 p.m., the form identified R39 grabbed R31 along with NA-B's initials. During an interview on 11/4/24 at 3:16 p.m. NA-G stated, before 11/4/24, staff were trying to keep R39, 6 feet away from female residents and were doing 15-minute checks. R39 was still on 15-minute checks but it was more that R39 needed to be an arm's reach away from female residents. R39 had been vacuuming all afternoon and staff were giving him fidgets to keep R39's hands busy. There was also a motion sensor on R39's door to alert staff of anyone going in or out of R39's room. NA-G provided the High-Risk Monitoring Household: Pine form and stated staff were to check on the residents every 30 minutes and mark the appropriate slot in the grid with a check mark. When asked what grabbed meant, NA-G stated she did not know because she wasn't working at that time but was told R39 gave a bear hug to R31. The nurse knows. During an interview on 11/4/24 at 3:40 p.m., the DON stated the 15-minute check were only for the first 36 hours because it wasn't feasible to do it with staffing. There was an incident on 11/4/24, and R39 gave a bear hug to R31. It was a good question how that happened because R39 was supposed to not have contact with female residents. The DON stated a call had been placed to find R39 placement at another facility because R39 was the only male resident on the unit. During an interview on 11/4/24 at 3:54 p.m., with the DON and administrator, the DON stated she was told by NA-B that LA-A just saw R39 come up behind R31. The DON did not assess R31 nor R39 and was told staff had taken R39 to his room. The DON was told R31 had said Oh and was surprised but not hurt. R39 went up behind R31 and (made gesture of grabbing breasts from behind). R39 grabbed R31's breasts. The DON stated she had spoken with the nurse on the unit regarding the 15-minute checks were not feasible and the 15-minute checks were removed after 48 hours on 11/2/24. After the 11/4/24, incident the DON directed staff to provide 1:1 observation and directed the SWD to call for placement in another facility, however, placement was not available. During an interview on 11/5/24 at 8:20 a.m., NA-B stated she was working on 11/4/24, when R39 grabbed R31. NA-B was in a resident room and when she came out of the room, LA-A told NA-B what happened. NA-B stated she did not know if R39 grabbed R31's breasts because she did not see it. When NA-B went into the resident room, R39 was in his room and R31 was really confused and wandering. NA-B immediately went to licensed practical nurse (LPN)-A and told her, but LPN-A was busy, and NA-B reported it to the DON. The DON told NA-B she would take care of it. Staff were doing 30-minute checks and watching the residents. NA-B stated she had to go into the resident room but the door between the dining rooms was open and LPN-A could see into the unit. Since the incident, staff were doing 1:1 observation of R39 and the High-Risk Monitoring form was changed. Staff were supposed to write down what the resident was doing like sleeping, wandering. Things like that. There was also a monitor in R39's room to tell staff when someone went in or out. R39 liked to play bingo and had a fishing game he would play with. R39 liked to vacuum and really enjoyed it. Staff were trying their best to prevent R39 from approaching R31, but R39 was just so fast. During an interview on 11/5/24 at 9:15 a.m., LPN-A stated, since midnight the night before, staff were doing 1:1 observation with R39. Before that, the DON was doing the 1:1 observation. Whoever was assigned to R39 had to always have eyes on R39. It was the only thing that would work. (continued on next page)

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	245329	A. Building B. Wing	11/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Warroad Care Center	1401 Lake Street Northwest Warroad, MN 56763

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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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 11/5/24 at 10:19 a.m., LA-A stated on 11/4/24, LA-A came onto the unit to get soiled laundry, had gone past R39's room and turned around because LA-A heard R39 moving. It was that quick. R39 went up to R31 from behind and grabbed R31 at the waist with both hands then said rawr like R39 was surprising R31. R31 was startled. LA-A told NA-B right away and then NA-B told LPN-A. LPN-A called and spoke with LA-A about it. The DON nor SWD-A spoke with LA-A about the incident. LA-A stated she did write down the description of the incident but never knew how much to put in those things. LA-A could not be sure if R39 touched R31's breast, it was more like he was trying to surprise R31. LA-A stated NA-B was in a room and R39 was unattended. The facilities Resident Abuse Prohibition Policy dated 6/7/23, identified sexual assault as sexual contact that resulted from threats, force, or the inability of the person to give consent. Sexual abuse was non-consensual sexual contact of any type with a resident, The facility's population may need to include monitoring of residents with needs and behaviors which might lead to conflict or neglect, such as a history of cognitive deficits, sensory deficits, aggressive behaviors, entering other residents rooms, wandering, self-injurious behaviors, verbal outbursts, communication disorders, nonverbal and those residents that required heavy care or totally dependent on staff. In event of suspected maltreatment, the needs of the resident would be immediately assessed and the safety of the resident would be ensured. Immediate steps would be taken to ensure that no resident remained in danger of maltreatment. The resident would be assessed for physical appearance, skin injuries, trauma, or changes in resident affect, mood and behavior, The residents responsible party and physician would be notified as soon as possible. All staff would monitor residents for possible signs of abuse and know how to identify signs and symptoms of abuse. When an incident or suspected incident of abuse was reported, the administrator or designee would investigate the incident which would consist of review of the report, an interview with the person reporting the incident and staff. A review of the resident's medical record and root cause analysis of all circumstances surrounding the incident. The resident or representative would be informed of the progress of the investigation. The investigation would be recorded and attached to the report. The resident and/or representative would be informed of the results of the investigation and corrective action taken. All residents would be protected from the alleged offender. The IJ that began on 9/25/24, was removed on 11/5/24, at 9:09 p.m. when the facility implemented the following immediate interventions; immediately seperated R6 and R31 from R39, referred R39 for psychological assessment, completed a comprehensive behavior assessment for R39, implemented increased supervision of R39, placed alarm outside R39's door, assessed R6 and R39 for psychological support, updated care plans to include safety measures, filed VA reports; and updated their abuse policy to include assessments and individualized interventions; educated staff on sexual abuse; and educated nurses on reporting, assessment and intervention. 40943

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41575 Based on interview and document review, the facility failed to ensure allegations of potential sexual abuse were reported or timely reported to the administrator and state agency (SA) for 1 of 1 resident (R39) reviewed for abuse involving 2 of 2 residents (R6, R31) with cognitive impairment, who was observed inappropriately touching other residents' multiple times, Findings include: R6's quarterly MDS dated [DATE], identified R6 had moderate cognitive impairment and exhibited delusions, physical behaviors of grabbing, hitting, scratching, or abusing others sexually one to three days per week, verbal behaviors toward others four to six days per week and other behaviors not directed toward others four to six days per week. R6 required substantial assistance to dress and partial assistance with transfers. R6 was independent with ambulation once standing. Diagnoses included depression, anxiety, dementia, and sever mood disturbance. R31's quarterly MDS dated [DATE], identified R31 had severe cognitive impairment and exhibited physical behaviors of grabbing, hitting, scratching, or abusing others sexually one to three days per week, and verbal behaviors toward others one to three days per week. R31 required substantial assistance to dress and was independent with transfer and ambulation. Diagnoses included Alzheimer's disease, anxiety, mood disorder, dementia, restlessness, and agitation. R39's quarterly Minimum Data Set (MDS) dated [DATE], identified R39 diagnoses included dementia, psychotic disturbance, mood disturbance and anxiety. R39 had severe cognitive impairment with physical behaviors of grabbing, hitting, scratching, or abusing others sexually one to three days per week. R39 was able to transfer and ambulate independently. R39's progress notes identified the following: - 9/6/24, licensed practical nurse (LPN)-A documented R39 had approached a female resident [identified as R31 from interview] from behind and gave the resident what appeared to be a bear hug [identified in interview to be reaching from behind and grabbing breast] which staff observed from behind. The social service designee (SWD) was notified. - 9/25/24, R39 was observed fondling R31's breast. Staff intervened and separated the two residents. - 10/15/24, R6 was found in R39's room with door closed. R6 was seated in her wheelchair beside R39's bed and R39 was fondling R6's breast. R6 was removed from area and R39 was reminded behavior was not appropriate. R6 stated the incident made her uncomfortable and R39 had been squeezing her breast pretty hard. The director of nursing (DON) and social services designee (SWD) were notified. (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 10/29/24, at 1:00 p.m. LPN-A stated on 9/6/23, she had observed R39 approach R31 from behind, placing his arms on either side of R31 in a bear hug and was just going to grab R31's breasts, when LPN-A intervened. LPN-A stated R39 had just come up behind R31 and she did not think R31 had even heard R39 coming. R31 had gotten scared and startled. During interview on 10/29/24, at 2:00 p.m. RN-A stated she had been working on 10/14/24 and witnessed R39 reaching out to grab R31's breast in the common area. RN-A hollered to R39 No, don't do that and he immediately stopped. R31 stated, I told him that to. RN-A immediately reported the incident to SWD, however did not document the incident in R39's medical record. When interviewed on 10/29/24, at 1:30 p.m. SWD stated she had been notified of some incidents with R39's behavior toward residents. SWD received a call from RN-A on 10/14/24, and on 10/15/24, from the DON regarding incidents of R39 inappropriate sexual touching of other residents. SWD discussed the incidents regarding R31's behavior with the DON and they determined there were no non-consensual type of feelings. The residents had not seemed upset, so it was felt to be ok to just document the incidents when they occurred. The DON notified SWD of the incident when R39 was fondling R6's breasts because staff had called the DON first. It was the facility's policy to file a vulnerable adult (VA) report when resident to resident incidents occurred, but assessments had not been completed for any of the residents involved. SWD did not think the facility had done any follow up after receiving reports on R39's behavior toward other residents. SWD did feel a reasonable person would be upset when approached from behind and breasts grabbed, and a VA report should have been filed. - The interdisciplinary team (IDT) and SWD was just trying to figure out the core regulations and what needed to be reported, as the previous DON would never let them report anything. The facility had so much going on with the covid outbreak and administrative changes, many days she came and just hit the floor to give care to residents due to staffing. Just trying to catch up and survive. SWD was notified of R39's behaviors but was not the first person notified and had already put in 70 hours, so SWD just assumed someone else would look into it. If SWD had been the first one notified of the behaviors, she would have handled it differently. When interviewed on 10/29/24, at 2:00 p.m. the DON stated she was only aware of the two most recent incidents involving R39's inappropriate sexual behaviors toward other residents. DON discussed the incidents with SWD, and they had determined because both residents had severe cognitive impairment and there did not seem to be any willful intent to be a sexual predator, the incidents did not need to be reported. Typically, when the DON received a report of resident-to-resident incidents, she entered it into risk management and then communications, depending on what the incident was. The DON would read through the report and made sure the facility staff were not culpable and then the report went to SWD. The DON reviewed the reports with SWD, and they had felt because the residents were vulnerable and did not know any better, and there was no malicious intent or culpability, that the incidents did not have to be reported. None of R39's allegations of sexual abuse toward other residents had been reported to the state agency as required. During interview on 10/29/24, at 5:30 p.m. the administrator stated he was not made aware of R39's inappropriate sexual behaviors toward other residents until the DON spoke with him on 10/29/24, around 3:00 p.m. or 4:00 p.m. If the administrator been made aware of the behaviors, he would have reported the incident and investigated. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility provided handwritten note undated, identified laundry aide (LA)-A entered R39's unit to pick up laundry and LA-A found R39 coming up behind R31 and her sides and R31 jumped and said you. LA-A called R39's name at the same time (LA-A was just seconds behind) and LA-A told R39 that was inappropriate, and we all needed to keep our hands to ourselves. R39 left R31 alone immediately. LA-A reported to the nursing assistant on the unit, and she reported to the nurse. At the time of the incident, the nursing assistant was getting someone food in the dining room. The note failed to identify when the incident occurred, how R39 touched R31, or staff involved. High Risk Monitoring Household: Pine dated 11/4/24, identified a grid of 30-minute time slots for 5 residents including R31 and R39. At 1:00 p.m., the form identified R39 grabbed R31 and NA-B initials. The facility reported event dated 11/4/24 at 11:32 p.m., identified at approximately 1:30 p.m. on 11/4/24, it was reported R39 grabbed R31 by her side. The witness redirected R39 right away. R31 was assessed and R31 was busy talking about going home to Ohio and did not mention the incident with R39. Upon inspection of R31's side, no injury and marks noted, and R31 told author, Don't do that even though author informed R31 about what was going to happen. Author spoke with the witness, witness stated she only saw R39 grabbing R31's side. Incident report to the SSD. R31's son notified of the incident. Plan of care on going. However, the report failed to identify previous incidents between R39 and R31, interventions implemented to prevent further incidents nor if the care plans were being followed. During an interview on 11/4/24 at 3:54 p.m., with the DON and administrator, the DON stated she was told by nursing assistant (NA)-B that LA-A just saw R39 come up behind R31. The DON was told R31 had said Oh and was surprised but not hurt. R39 went up behind R31 and (made gesture of grabbing breasts from behind). R39 grabbed R31's breasts. The DON stated she had spoken with the nurse on the unit regarding the 15-minute checks were not feasible and the 15-minute checks were removed after 48 hours on 11/2/24. After the 11/4/24, incident the DON directed staff to provide 1:1 observation and directed the SWD to call for placement in another facility, however, placement was not available. During an interview on 11/5/24 at 10:19 a.m., LA-A stated on 11/4/24, LA-A came onto the unit to get soiled laundry, had gone past R39's room and turned around because LA-A heard R39 moving. It was that quick. R39 went up to R31 from behind and grabbed R31 at the waist with both hands then said rawr like R39 was surprising R31. R31 was startled. LA-A told NA-B right away and then NA-B told LPN-A. LPN-A called and spoke with LA-A about it. The DON nor SWD-A spoke with LA-A about the incident. LA-A stated she did write down the description of the incident but never knew how much to put in those things. R39 did not touch R31's breasts, it was more like he was trying to surprise R31. LA-A stated NA-B was in a room and R39 was unattended. The facility's Resident Abuse Prohibition Policy with revision date 6/7/23, identified an employee must report abuse immediately to supervisor in house. The supervisor would then immediately notify the administrator. If an incident or allegation was considered reportable the administrator or designee would make a report to the Minnesota Department of Health (MDH) online reporting web site immediately, but no later than two hours after the allegation was made, if the allegation involved abuse or resulted in serious bodily injury. 40943

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41575 Based on interview and document review, the facility failed to provide immediate protection and investigate allegations of resident-to-resident sexual abuse for 2 of 2 residents (R31, R6) reviewed for abuse, who were abused by R39. Findings include: R6's quarterly MDS dated [DATE], identified R6 had moderate cognitive impairment and exhibited delusions, physical behaviors of grabbing, hitting, scratching, or abusing others sexually one to three days per week, verbal behaviors toward others four to six days per week and other behaviors not directed toward others four to six days per week. R6 required substantial assistance to dress and partial assistance with transfers. R6 was independent with ambulation once standing. Diagnoses included depression, anxiety, dementia, and sever mood disturbance. R31's quarterly MDS dated [DATE], identified R31 had severe cognitive impairment and exhibited physical behaviors of grabbing, hitting, scratching, or abusing others sexually one to three days per week, and verbal behaviors toward others one to three days per week. R31 required substantial assistance to dress and was independent with transfer and ambulation. Diagnoses included Alzheimer's disease, anxiety, mood disorder, dementia, restlessness, and agitation. R39's quarterly Minimum Data Set (MDS) dated [DATE], identified R39 diagnoses included dementia, psychotic disturbance, mood disturbance and anxiety. R39 had severe cognitive impairment with physical behaviors of grabbing, hitting, scratching or abusing others sexually one to three days per week. R39 was able to transfer and ambulate independently. R39's progress notes identified the following: R39's progress notes identified the following: - 9/6/24, licensed practical nurse (LPN)-A documented R39 had approached a female resident [identified as R31 from interview] from behind and gave the resident what appeared to be a bear hug [identified in interview to be reaching from behind and grabbing breast] which staff observed from behind. The social service designee (SWD) was notified. - 9/25/24, R39 was observed fondling R31's breast. Staff intervened and separated the two residents. - 10/15/24, R6 was found in R39's room with door closed. R6 was seated in her wheelchair beside R39's bed and R39 was fondling R6's breast. R6 was removed from area and R39 was reminded behavior was not appropriate. R6 stated the incident made her uncomfortable and R39 had been squeezing her breast pretty hard. The director of nursing (DON) and social services designee (SWD) were notified. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 10/29/24, at 1:00 p.m. LPN-A stated on 9/6/23, she had observed R39 approach R31 from behind, placing his arms on either side of R31 in a bear hug and was just going to grab R31's breasts, when LPN-A intervened. LPN-A stated R39 had just come up behind R31 and she did not think R31 had even heard R39 coming. R31 had gotten scared and startled. During interview on 10/29/24, at 2:00 p.m. RN-A stated she had been working on 10/14/24 and witnessed R39 reaching out to grab R31's breast in the common area. RN-A hollered to R39 No, don't do that and he immediately stopped. R31 stated, I told him that to. RN-A immediately reported the incident to SWD, however did not document the incident in R39's medical record. The facility was unable to produce any investigation file on the above incidents including, staff and resident interviews and observations and record review. When interviewed on 10/29/24, at 1:30 p.m. social worker designee (SWD) stated she had been notified of some incidents with R39's behavior toward residents. SWD was called on 10/14/24, by registered nurse (RN)-A and on 10/15/24, by the DON regarding incidents of inappropriate touching. The reported incidents that occurred with R39 had not been investigated because they had determined both participants were willing and did not seem upset. When interviewed on 10/29/24, at 2:00 p.m. the DON stated she was only aware of the two most recent incidents involving R39's inappropriate sexual behaviors toward other residents. The facility staff did not investigate any of the resident-to-resident incidents beyond reviewing the initial reports called to them by staff. DON had not been aware of all the incidents or near miss incidents and had not been aware there were so many. During interview on 10/29/24, at 5:30 p.m. the administrator stated he was not made aware of R39's inappropriate sexual behaviors toward other residents until the DON spoke with him on 10/29/24, around 3:00 p.m. or 4:00 p.m. Had he been made aware of the behaviors he would have reported the incidents, notified the POA's of the residents, notified the physician and the ombudsman and investigated. Administration should have been notified and the incidents investigated. The facility's Resident Abuse Prohibition Policy with revision date 6/7/23, identified a nurse would begin the investigation of reports of abuse immediately. A root cause investigation and analysis would be completed and given to the administration. The investigation would include who was involved, residents' statements, involved staff and witness statements of events, a description of the residents' behavior and environment at the time of the incident, injuries present, observation of resident and staff behaviors during the investigation, environmental considerations, and resident skin checks. Administration would investigate the incident to consist of a review of the completed complaint report, an interview with the person reporting, interviews with any witnesses, a review of the resident medical record, interviews with staff members having contact with the resident during relevant periods of the alleged incident, interviews with the resident's family and visitors if applicable, and a root cause analysis of all circumstances surrounding the incident.

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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** 40943 Based on interview and document review the facility failed to ensure accurate coding of the Minimum Data Set (MDS) for 1 of 3 residents (R7) reviewed for catheters. Findings include: R7's significant change Minimum Data Set (MDS) dated [DATE], identified R7 had severely impaired cognition and an indwelling urinary catheter. Diagnoses included multiple sclerosis (MS), type 2 diabetes, and history of urinary tract infection (UTI). The MDS failed to identify R7 had a multi-drug resistant organism (MDRO). R7's care plan revised 8/9/24, identified R7 needed total assistance with toileting needs and catheter management. The care plan failed to identify R7 had an MDRO. R7's Physical Therapy Skilled Nursing Facility Treatment Note dated 9/12/24, identified R7 had an open wound on her right ischial tuberosity and had an increased risk of infection. Precautions/Restrictions: methicillin-resistant staphylococcus aureus (MRSA). During an interview on 10/30/24 at 10:06 a.m., the director of nursing (DON) stated staff were expected the staff to document and submit the MDS timely and accurately to ensure resident care was provided accurately and safely. Additionally, the facility's reimbursement depended on an accurate MDS submission. During an interview on 10/31/24 at 1:10 p.m., registered nurse (RN)-D stated you wouldn't know a resident's history of having an MDRO unless you were digging in their charts. RN-D had just found out the other day R7 was colonized for MRSA. During an interview on 11/6/24 at 2:34 a.m., registered nurse (RN)-C stated she did conduct and submit R7's MDS assessment, however, did not review R7's MDRO status because the MDS was related to R7's COVID-19 diagnosis. RN-C stated she guessed she missed it. RN-C could not say why an accurate MDS could affect a resident's care nor why the accurate MDS was important. I don't understand what you mean. A facility policy regarding MDS assessments was requested but not received.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40943 Based on interview and document review, the facility failed to develop a comprehensive care plan for 1 of 2 residents (R7, R99); and failed to involve family during the care conference and document the care conference fully for 1 of 2 residents (R7) reviewed for catheters. Findings include: R7's significant change Minimum Data Set (MDS) dated [DATE], identified R7 had severely impaired cognition and an indwelling urinary catheter. Diagnoses included multiple sclerosis (MS), type 2 diabetes, and history of urinary tract infection (UTI). However, the MDS failed to identify R7 had a multi-drug resistant organism (MDRO). R7's care plan revised 8/9/24, identified R7 needed total assistance with toileting needs and catheter management. The care plan failed to identify R7's preferences for family involvement with her care nor to identify R7 had an MDRO. R7's Physical Therapy Skilled Nursing Facility Treatment Note dated 9/12/24, identified R7 had an open wound on her right ischial tuberosity and had an increased risk of infection. Precautions/Restrictions: methicillin-resistant staphylococcus aureus (MRSA). R7's Care Conference Summary New dated 6/26/24, identified a nursing, dietary and activities summary. T The note failed to identify when the care conference was held, who attended and/or who was invited to attend. R7's Care Conference Summary New dated 10/3/24, identified an activities summary. The note failed to identify when the care conference was held, who attended and/or who was invited to attend. R7's Care Conference Summary New dated 10/21/24, identified an activities summary. The note failed to identify when the care conference was held, who attended and/or who was invited to attend. During an interview on 10/28/24 at 3:54 p.m., family member (FM)-A stated the facility was supposed to notify R7's daughter by text with the date and time of R7's care conference so R7's daughter could participate. After all the changes in staff, that just did not happen anymore. FM-A stated he did get a letter but preferred R7's daughter be involved too. That's what the plan always was. Why can't they continue to do it that way? If R7's daughter received a text, R7's daughter could show her employer and the employer was good to give R7's daughter the time off to attend the care conference. During an interview on 10/31/24 at 1:10 p.m., registered nurse (RN)-D stated staff were expected to follow the facility's catheter care policy to prevent the spread of infection, however, RN-D did not update R7's care plan to direct staff regarding enhannced barrier precautions during catheter care. (continued on next page)

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Warroad Care Center	1401 Lake Street Northwest Warroad, MN 56763

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/4/24 at 2:27 p.m., the social worker designee (SWD) stated RN-C did all the MDS assessments, scheduled the care conference meetings, documented the care conference notes and the care coordinator updated the care plan. The care coordinator was out of the building and unavailable during survey. The SWD stated she could not find where R7's history of MRSA was care planned and/or R7's completed care conference notes were completed. During an interview on 11/4/24 at 2:34 p.m., RN-C stated she only scheduled the care conference meetings but did not attend them because she wasn't always onsite. Because of this, RN-C did not document the care conference note. RN-C updated the MDS calendar and sent that to the nurses, activities, and the SWD. Who updated the care plan and/or notified R7 or R7's family was between the care coordinator and SWD. During interview on 11/6/24 1:13 p.m. the director of nursing (DON) stated the previous care coordinator was really good about texting and communicating with residents' families regarding changes in condition and/or care conferences. The care coordinator had left the facility prior to the DON taking her role at the facility. That's just what I've been told. However, the DON stated she was aware that was no longer taking place and communication needed to improve. Resident care plans should be updated timely and accurately, and care conference documentation needed to be complete to ensure the staff knew what to provide to ensure the resident received resident-centered care. A policy regarding resident care conferences and/or care planning was requested but not received. 42075 R99's admission MDS dated [DATE], identified R99 had moderate cognition and diagnoses including neurogenic bladder, Alzheimer's disease, and dementia. R99 required intermittent catheterization and did not participate in a bladder program. R99's care plan dated 10/22/24, failed to identify a care plan goal and measurable objectives for straight catheterizing R99. R99's Bowel and Bladder Comprehensive assessment dated [DATE], identified R99 required intermittent catheterization performed by nursing staff every shift and as needed. On 10/30/24 at 1:55 p.m., stated R99 required staff to use a straight catheter to empty his bladder. Observed while licensed practical nurse (LPN)-A used a straight catheter to empty R99's bladder. LPN-A wore gloves and used sterile technique but failed to wear a gown. LPN-A stated she had failed to wear a gown during R99's catheter cares. LPN-A stated she should have worn a gown to protect herself, other residents and R99 from splashing of urine and the potential spread of bacteria causing an infection. During interview on 11/6/24 1:13 p.m. the DON resident care plans should be updated timely and accurately and to ensure the staff knew what to provide and to ensure the resident received resident-centered care. A facility policy regarding care planning was requested but not received.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 40943 Based on observation, interview and document review, the facility failed to provide range of motion (ROM) services for 4 of 4 residents (R7, R19, R22 ,R43) reviewed for range of motion. Findings include: R7's significant change Minimum Data Set (MDS) dated [DATE], identified R7 had severe cognitive impairment. Diagnoses included multiple sclerosis (MS) (a potentially disabling disease of the brain and spinal cord that affects nerve fibers and causes communication problems), type 2 diabetes and peripheral vascular disease (PVD) (reduced blood flow to the arms and legs). R7 had a restorative nursing program (RNP) but R7 did not participate during the look back period. R7's care plan revised 8/9/24, identified R7 had a RNP. Restorative Therapy nursing assistant would monitor R7's progress and tolerance daily and document. RT staff were to report concerns to nursing and/or physical therapy/occupational therapy for assessment and recommendations. Staff were directed to provide: RT-UBC x15 mins (tension 90). Pulleys at level 2 (reps of 5 as tolerated). Red squeeze ball (30 second reps). [NAME] level 3 Thera putty. 3# free weight bicep curls. AROM with green Thera Bands. Lower AROM (AAROM - marching, knee extensions, hip adductions and abductions, ankle pumps). 5 times a week or as tolerated. R7's Range of Motion task documentation dated 10/7/24 through 11/1/24, identified R7 received RNP services 3 times, was unavailable 2 times, R7 refused 2 times and was not applicable for 5 times. During the time-period, R7 should have been offered RNP services a total of 17 times. During an observation on 10/29/24 at 12:30 p.m., R7 did not have visible contractures and was able to lift/extend arms during a ceiling lift transfer. R19's quarterly Minimum Data Set (MDS) dated [DATE], identified R19 had moderately impaired cognition and diagnoses included Alzheimer's disease, anxiety and heart failure. R19 had a restorative nursing program (RNP) but R19 did not participate during the look back period. R19's care plan revised 8/1/24, directed staff to provide seated general lower and upper extremity exercises to be completed 3 times a week. R19's Range of Motion task documentation dated 10/7/24 through 11/1/24, identified R19 received RNP services 3 times, was unavailable 1 time and not applicable 7 times. During the time period, R19 should have been offered RNP services a total of 11 times. During an observation on 10/29/24 at 1:22 p.m., NA-C and licensed practical nurse (LPN)-A transferred R19 to the toilet using the ceiling lift. R19 had no visible contractures and was able to extend her upper and lower extremities. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R22's significant change MDS dated [DATE], identified severe cognitive impairment. R22 had no impairment in range of motion and required substantial to maximal (helper does more than half the effort) with bed mobility, transferring and toileting. R22's diagnoses included arthritis, Alzheimer's disease, and lumbago with sciatica (pain radiating from back to legs and feet which can be eased with range of motion/stretching). R22 did not have a restorative nursing program. R22's care plan dated 6/23/23, identified R22 had chronic pain related to arthritis and lumbago with sciatica. Staff were to monitor and report any decrease in range of motion (ROM). R22's provider's order dated 10/2/24, identified R22 was to receive functional maintenance program (FMP) by restorative therapy (RT). The order directed staff to complete active ROM (AROM) (resident helping with range of motion) to both arms and legs in all ranges and planes (normal range of motion) for all joints and to walk as tolerated with transfers five times a week. R22's restorative therapy documentation from 10/4/24 through 11/3/24, identified 21 opportunities for R22 to receive AROM. There was one documented occurrence of AROM being done, one documented resident not available, and 19 marked not applicable. During observation on 11/4/24 at 1:58 p.m., R22 was sitting in her wheelchair and there we no visible contractures. R22 was able to move hands and feet without restriction. R43's quarterly MDS dated [DATE], identified R43 had moderate cognitive impairment. R43 required supervision to touch assistance with transfers, toileting, and walking. R43 had a diagnosis of Parkinson's disease. R43 had one fall without injury since last assessment. R43 was not part of a restorative nursing program. R43's provider order dated 7/25/24, identified RT program-seated or standing general lower extremity exercises as tolerated. Nustep level 2-5 up to 15 minutes 3 times a week. R43's care plan dated 7/30/24, identified R43 was to receive RT seated or standing general lower extremity exercises as tolerated. Nustep (a low impact exercise machine) level 2-5 up to 15 minutes 3 times a week. R43's restorative therapy documentation from 10/4/24 through 11/3/24, identified 13 opportunities for R43 to receive RT. There were three documented occurrences of RT being done, one refusal, and 9 times were marked not applicable. During observation on 11/4/24 at 1:54 p.m., R43 was sitting in her recliner in her room scrolling through her phone. R43 had no visible contractures. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 11/4/24 at 11:51 a.m., restorative therapy (RT)-A stated not applicable in the Range of Motion task documentation meant a resident was not offered RNP services. RT-A stated when a resident was admitted to the facility, they're asked if they wanted to participate in exercise. If so, the physical therapist did an evaluation and entered the orders in the resident's chart. RT-A followed those orders during RNP services. RNP services were supposed to be offered Monday through Saturday every week and RT-A scheduled each resident according to their RNP on the calendar. RT-A stated the RT department had staffing problems and RT-A was the most consistent staff member. Currently, there was another staff member trained and passed competency, but that person had not been at the facility often. RT-A worked at the facility Mondays, Wednesdays, and Fridays. The other days were not consistently staffed and no RNP was offered on those days unless a resident was independent enough to do the exercises on their own without staff assistance. - The residents were welcome to come down to the RT department and get on the machines and do exercises. The door was always open, and the residents had access if they wanted. Because of limited time, RT-A started with residents who had contractures to prevent worsening and ambulatory residents. RT-A stated there were 37 residents who had an RNP program ordered, and RT-A was getting to 18-20 per day. I just can't complete it. RT-A stated she had not reported any refusals and/or inability to complete RNP services so the residents were re-evaluated and/or RNP orders changed. RT-A stated she did inform administration that she was not able to complete tasks but there were no other staff available. During an interview on 11/5/24 at 3:30 p.m., the director of nursing (DON) stated she was aware the facility's restorative aide was at the facility only three days a week even though there were residents requiring RNP 5 days a week. However, a plan to address the issue had not been implemented. Staff were expected to provide RNP to maintain a resident's abilities and/or to prevent contractures. A policy regarding restorative therapy was requested but not received. 40948

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	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** 40943 Based on observation, interview and document review, the facility failed to ensure staff were following care planned interventions of two staff assist when transferring residents with a ceiling lift; and failed to complete therapy/or nursing assessments to determine the appropriate sling sizes per manufacturers guidelines for 3 of 4 residents (R12, R7, R2) reviewed who were transferred via ceiling lifts. These deficient practices resulted in immediate jeopardy (IJ) for R12, R7 and R2 who were at risk of serious injury as a result of the deficient practice. The IJ began on 10/29/24, when R7 was observed to be transferred in the ceiling lift from her bed to the toilet by assist of one staff when R7 was care planned to be transferred with two staff. The administrator and director of nursing (DON) were notified of the IJ on 10/30/24 at 12:57p.m. The IJ was removed on 11/5/24, at 9:09 p.m.; but noncompliance remained at the lower scope and severity, level 2, (D) which indicated no actual harm with potential for more than minimal harm that is not immediate jeopardy. Findings include: The Maxi Sky 440 Instruction for Use revised 3/2020, identified the lift was designed to assist caregiver in hospitals, long-term care, nursing homes and home care environments, including private homes and patients with reduced mobility. Patient transfers must be done under the supervision of appropriately trained caregivers in accordance the instructions. Constant attention to the patient was required from caregiver during the whole transfer. In the unlikely event of a failure of the device, the caregiver must be ready to react. The Maxi Sky 440 Portable Lift and Charger Station Product Description undated, identified ceiling lifts enabled a single caregiver to transfer patients or residents smoothly without any manual lifting. All slings are color coded for size by having a different colored edge binding or attachment strap coloring: - Grey or Teal -Extra Extra Small -XXS [weight range 0-55 pounds (lbs)] - [NAME] or [NAME] -Extra Small -XS [weight range 55-77 pounds (lbs)] - Red -Small -S [weight range 77-132 pounds (lbs)] - Yellow -Medium -M [weight range 121-165 pounds (lbs)] - [NAME] -Large -L [weight range 154-264 pounds (lbs)] - Blue -Extra Large -XL [weight range 308-440pounds (lbs)] - Terracotta -Extra Extra Large -XXL [weight range 440-500 pounds (lbs)] (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The option of a headrest for many slings was available if it is considered necessary for a particular patient. A range of special purpose slings were available as accessories. R12: R12's quarterly Minimum Data Set (MDS) dated [DATE], identified R12 had severe cognitive impairment and R12 was dependent on staff (helper performed all the effort and resident does none of the effort to complete the activity) for toileting and bed to chair transfers. R12's care plan dated 8/9/24, identified R12 was cognitively impaired and required assist of two staff for ceiling lift transfers. R12's care plan did not identify the ceiling lift sling size to be used with the transfer. R12's Rehabilitation Services Physical Therapy Out-Patient Treatment Note dated 5/10/23, identified a mechanical lift was used with assistance x 2 to transfer. The note failed to identify what ceiling lift sling size staff should use for R12. R12's medical record identified R12 weighed 167.1 lb. During an interview on 10/28/24 at 2:38 p.m., R12 stated, last week a nursing assistant left R12 in the bathroom in the ceiling lift alone. R12 was unable to say a name or date but R12 was crying and stated R12 waited at least 20 minutes. R12 was in the bathroom already in the lift, up in the air, and R12's feet were dangling and going numb. R12 stated staff usually left R12 in the ceiling lift, hanging over the toilet, but usually not for that long. R12 stated she urinated almost immediately when she got to the toilet and could have gone back to bed. R12 did report the incident to facility staff and was told by facility staff it always felt longer when you're in the lift, but it wasn't that long. R12 was crying and stated she felt neglected. I don't like to complain and get people in trouble, but I can't put up with this either. I just can't. R12 was grasping her bed linens in her hands and stated she was told there were many other people to help take care of. During an observation on 10/29/24 at 5:50 p.m., NA-E and registered nurse (RN)-B transferred R12 with the ceiling lift into the bathroom using a green (large sling). R12 was holding the sling straps with her shoulders extended 90 degrees with the sling bunched up in her underarms. R12's fingers were grasping the straps tightly and her knees were pointed up towards the ceiling and her bottom hanging from the bottom of the sling. During an observation on 10/30/24 at 5:20 p.m., R12 had a green (large) sling laying in her bathroom. R7: R7's significant change MDS dated [DATE], identified R7 had severe cognitive impairment and was dependent for toileting, personal hygiene, and bed to chair transfers. R7's care plan dated 8/9/24, identified R7 was cognitively impaired and required assist of two for ceiling lift transfers and R7 used a size medium ceiling lift sling. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	R7's Kardex dated 10/29/24, directed staff to provide assist of one with transfers using the ceiling lift. However, the Kardex additionally directed staff to use ceiling lift with total assist of two with a medium Arjo sling. R7's medical record failed to identify a physical therapy or nursing evaluation was completed to determine safe transferring of R7 or what ceiling lift size should be used. R7's medical record identified R7 weighed 130.1 lb. During an observation on 10/29/24 at 12:23 p.m., nursing assistant (NA)-C assisted R7 to the bathroom using a ceiling lift, without another staff person present as care planned. R7 was in the ceiling lift and holding the sling straps with both hands. R7's shoulders were extended 90 degrees and R7's bottom was hanging from the bottom of the sling. R7 had facial grimacing and moaned ooohh. NA-C asked R7 if she was having pain and R7 stated yes, along her ribcage. NA-C stated this was residual pain due to R7 having just recovered from COVID-19. NA-C stated she would report R7's pain to the nurse. During an interview on 10/29/24 at 12:45 p.m., NA-C stated R7 had been an assist of one with the ceiling lift since NA-C started working at the facility two years ago. NA-C stated R7's care plan contradicted itself and NA-C wasn't even sure what R7's care planned need for transfer was. NA-C never asked anyone what R7 needed because she felt safe transferring R7 in the ceiling lift by herself. NA-C stated she used the sling in her room. Laundry replaced the sling if it was soiled, and NA-C didn't have to get a new one. NA-C stated she didn't even know how to tell what size the sling was. During an interview on 10/29/24 at 6:46 p.m., NA-E stated R12 was never to be left alone while in the ceiling lift. Staff routinely transferred R12 using the ceiling lift with assist of one, but NA-E wasn't comfortable with this because you saw. She [R12] has chicken wings sticking out. NA-E didn't trust R12 not to fall. R7 was the same way. NA-E wouldn't transfer R7 alone either. NA-E stated she always just asked the nurse to help her because if R7 or R12 raised their arms due to the pressure of the sling they would slip right out and fall. NA-E stated staff transferred residents with assist of one because they can't find anyone to help. During an interview on 10/29/24 at 6:55 p.m., RN-B stated R7 and R12 were care planned for assist of two with ceiling lift transfers but with the way staffing was going, staff usually transferred using assist of one. Nursing helped as much as they could but there just wasn't enough staff. If the nurse couldn't help with transfers, the nursing assistants had been doing assist of one. R12 had lost a lot of muscle tone and just kind of hung in the sling like that. Hanging in the sling like that could potentially lead to a shoulder dislocation or a rotator cuff injury. If that happened, R12 could slip out of the sling and fall, however, RN-B had never heard of that happening. RN-B never reported any safety concerns for R7 or R12 during ceiling lift transfers to the unit coordinator nor had requested a physical/occupational therapy evaluation to determine if they were safe to transfer. I'm just a floor nurse so I'm not the one to ask about that. R2: (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	R2's annual MDS dated [DATE], identified R2 had severe cognitive impairment and a diagnosis of dementia. R2 had functional limitation with range of motion in both lower extremities and was dependent on staff for bed mobility, toileting, and transfers. R2 had one fall with injury (including skin tears, abrasions, lacerations, superficial bruises, hematoma's, and sprains) during assessment dates. R2's care plan dated 6/28/22, identified R2 required assist of two staff to move between surfaces using the ceiling lift. The ceiling lift sling size was not identified on the plan. R2's therapy orders dated 8/1/24, recommended staff use the ceiling lift or total mechanical lift to transfer the resident. The orders failed to identify how many staff were required for transfers and what size sling to use. R2's medical record lacked any other assessment to identify how many staff were needed to transfer and what size lift sling to use. R2's medical record identified R2 weighed 166 lbs. On 10/30/24 at 8:22 a.m., nursing assistant (NA)-D was standing in R2's room. R2 was fully dressed in their wheelchair. The ceiling lift sheet, size unidentified, was underneath with the straps crossed between the resident's legs. NA-E proceeded to use the ceiling lift to transfer R2 from the bed to the toilet, without a second staff member present as care planned. NA-E stated when R2 was calm like today she would transfer the resident by herself using the ceiling lift. When R2 was resistive NA-D would ask for other staff assistance. The care plan provided direction that two staff were required for ceiling lift transfers. NA-E stated she did not have any problems and the transfer went as it usually did when R2 was calm. NA-E stated she had not looked at the care plan and was uncertain how many staff were required to safely transfer R2 with the ceiling lift. On 10/30/24 at 8:22 a.m., NA-D stated she had no time to check the care plan so was unaware what the care plan directed. On 10/30/24 at 9:17 a.m., the director of nursing (DON) stated all staff were aware all mechanical lifts, including the ceiling lifts, required two staff to safely transfer a resident. During an observation on 10/30/24 at 5:20 p.m. R7 had a yellow (medium) sling folded in a chair in her room. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 10/30/24 at 9:20 a.m., licensed practical nurse (LPN)-A stated she was very concerned regarding resident and staff safety. The facility did not have enough staff to provide assist of 2 with ceiling lift transfers. Residents were being left alone in the lifts in the bathrooms, staff were transferring resident by assist of 1 with the ceiling lifts, and not answering call lights timely. LPN-A stated she knew of an incident on 10/25/24, between R12 and NA-D where R12 was left alone in the bathroom hanging from the ceiling lift. LPN-A did not report this to anyone but stated R12 was not safe to be left unattended in the ceiling lift in the bathroom. R12 did not have the ability to sit up and could have fallen. LPN-A further stated there were five residents who required assist of two for ceiling lift transfers and staff routinely transferred using assist of one. Staff were supposed to ask for assistance, but who were they going to ask? By the time a staff person was found to help, the resident only waited even longer. Plus, with call lights, bed alarms and chair alarms going off, what were staff supposed to do? That's what happened when R12 was left in the bathroom, NA-D was answering call lights. During an interview on 10/30/24 at 9:44 a.m., NA-C stated the facility was always short staffed. The A-wing was just too heavy of care for one nursing assistant. There was supposed to be a float nursing assistant that would go between the different units but that rarely happened and especially when the nurse had to bounce between units as well. Again, NA-C stated she got confused by the rules for ceiling lift transfers. One day, staff are told it's ok to use assist of one then they're told only use assist of two. NA-C just did her thing and, besides, NA-C couldn't magically pick up a staff member to help. When directed to use assist of two for ceiling lift transfers, NA-C stated she told administration that the workload was too heavy to do that. NA-C stated she felt it was safe to transfer using assist of one and/or to leave a resident in the bathroom while in the ceiling lift. NA-C routinely transferred R12 and R7 in the ceiling lift by herself without assistance of another staff person. NA-C stated she had heard about an incident on 10/25/24, where R12 was left alone in the bathroom because staff were answering call lights because there wasn't enough staff. NA-C stated she felt R12 was safe to be in the bathroom alone and had left R12 alone as well to answer call lights. There were residents who were at risk for falling and staff had to check on them. Who else would do it? During an interview on 10/30/24 at 9:58 a.m., the DON stated staff were expected to follow care planned interventions for ceiling lift transfers for the resident and staff safety. That's so unsafe. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 10/30/24 at 10:34 a.m., NA-D stated she had worked at the facility a little over a month as an agency nursing assistant. NA-D was trained by another traveler and wasn't told where they could find care plans or cheat sheets. NA-D had to go to the interim DON and ask where to find it. NA-D was not going to transfer someone until NA-D knew how it was supposed to be done. NA-D stated she was told to look at the kardex, but with twelve residents to care for it was hard to be read through each one. NA-D stated she asked for a little sheet for like teeth, diet, transfers and was told there was a sheet but it was not up to date. There were residents that the sheet said were sit-to-stands but because things happened and they became weaker, they can't do it. The sheet needed to be updated. NA-D would have liked better training. Agency nursing assistants knew what their job consisted of but haven't cared for these residents before. NA-D told the interim DON that the facility needed staff who were employees of the facility to train agency nursing assistants. When NA-D asked the nurse or the float nursing assistant to help with assist of two transfers. NA-D was told the ceiling lifts required assist of two, then it changed to assist of one, and now it was assist of two again. NA-D needed a definite answer for this because NA-D didn't want to lose her certificate for something that was out of her control. Regarding the 10/25/24, incident with R12, NA-D wouldn't call it an incident. R12 wanted to sit on the toilet because she was smearing bowel movement (BM). NA-A transferred R12 to the toilet via the ceiling lift but had never worked with R12 before. NA-D didn't know R12 got anxiety in the bathroom if left alone. NA-D left R12 in the ceiling lift sling and left her in the bathroom alone and answered other call lights. NA-D went back into R12 and R12 was like what took you so long. NA-D stated she told R12 NA-D tried to get to R12 as fast as NA-D could. The float nursing assistant couldn't use the lift because she was [AGE] years old. It was probably 10 minutes. NA-D did someone's cares and went back and did my thing. The next day NA-D reported the bathroom thing.The staff were shorthanded. NA-D did the best she could. R12 should have been assist of two and staff should have stayed with R12 while she was in the bathroom. NA-D did not know why they didn't stay because it was dangerous to leave R12. R12's feet were literally up in the air, not resting on the floor, because R12 was unstable. R12 was unstable and flailing and moving all the time so R12 needed assist of two with ceiling lift transfers. Staff have said if R12 was calm he could be assist of one. On 10/30/24, R12 was calm so NA-D transferred him in the ceiling lift by herself. No, I shouldn't have. NA-D stated she had no idea where it said there were times R12 could be assist of one because NA-D had never been able to read all the care plans. During an interview on 10/30/24 at 1:25 p.m., NA-B stated R12 reported the 10/25/24, bathroom incident to her and NA-B reported it to the nurse. After that, NA-B didn't know what happened. During a telephone interview on 10/30/24 at 2:36 p.m., the medical director stated staff were expected to follow a resident's care plan to ensure safety. During an interview on 10/30/24 at 2:39 p.m., the social worker designee (SWD) stated she was informed of R12's bathroom incident and staff were expected to not leave residents unattended in the bathroom while in the ceiling lift and were expected to follow the resident's care plan during ceiling lift transfers to ensure safety. On 10/30/24 at 5:09 p.m., RN-A stated the nursing assistants were trained to size slings for residents. The slings were color coded for size. However, RN-A stated she did not know if the size was documented in the resident's care plan or not. She would have to ask. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 10/30/24 at 5:24 p.m., NA-E stated she just knew what size a resident needed. For example, a reddish pink color was an extra small, a yellow was a small and a green was a medium. For R12, she used a green and it was kind of big and NA-E had considered getting a different size for her to try. Staff just went in the cage and got one. NA-E stated she didn't know if there was a size listed for the residents anywhere, even the care plan or Kardex. NA-E stated that was a good question, but NA-E just went by her gut. For example, another resident in the facility had a pink sling in his room. NA-E knew that was way too small, so NA-E just grabbed a bigger sized sling to be safe. I go by my gut, During an interview on 10/30/24 at 5:26 p.m., NA-F stated staff were usually assigned to a certain wing all the time and staff just knew what sling a resident used. Like R12, used a green sling and, if it was dirty, staff just went to the cage and got a new one. If staff were floated to a different wing and they didn't know what sling to use, they would just ask the nurse or another aide which sling to use. NA-F didn't know if sling size was written down anywhere. NA-F knew the nurses did check the slings and would put different ones in the rooms sometimes, but NA-F stated she didn't know if they put that anywhere either. You just know. During an interview on 10/30/24 at 6:14 p.m., the DON stated R12 and R2 did not have a ceiling lift sling size care planned. R7's care plan directed staff to use a size medium sling, however, R7 had lost weight since admission and her size may be incorrect. It was important to have a resident's sling size care planned so all staff were able to easily determine the correct size to ensure safe transferring of the resident. Unsafe ceiling lift transfers could result in resident injury or a fall. Any nurse could request a physical therapy (PT) evaluation for sizing, and it was important for sling size to be care planned for safety for everyone to see. Further, no unlicensed staff member should attempt to size a ceiling lift sling for a resident. During an interview on 10/30/24 at 6:21 p.m., the administrator stated staff were expected to report concerns with sling size and to request a PT evaluation to ensure resident safety. The facilities Safe Resident Handling Program dated 5/14/24, identified it was the policy of the facility that when residents required assistance to move, the assistance would be provided in a manner that was safe for both the resident and employee. A facility policy regarding ceiling lift slings and transfers was requested but the facility did not have one to provide. The IJ was removed on 11/6/24 at 9:09 p.m., when it could be verified through observation, interview and document review the facility implemented the following immediate interventions of: assessing R12, R7 and R2 for correct amount of staff to ensure safe transfers, assessed for the appropriate sling size per manufacturers recommendation's, educated nursing staff and created a policy for ceiling lift assessments and ensured there were enough staff to transfer residents according to their care plans. 42075

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42075 Based on interview and document review the facility failed to follow provider's orders for intermittent catheterization for 1 of 1 resident (R99); and failed to ensure catheter care was provided in a manner to prevent potential urinary tract infection (UTI) for 1 of 3 residents (R7) reviewed for catheters. Findings include: R99's admission Minimum Data Set (MDS) dated [DATE], identified R99 had moderate cognition. R99 required intermittent catheterization and did not participate in a bladder program. Diagnoses included neurogenic bladder, Alzheimer's disease and dementia. R99's interagency transfer orders signed 10/24/24, identified orders for staff to perform scheduled straight catheterizations 4 times a day; If staff were consistently draining >500 mL per catheterization, then add a scheduled catheterization. R99's Bowel and Bladder Comprehensive assessment dated [DATE] identified R99 required intermittent catheterization every shift and as needed, requires extensive assist from staff with transfers on/off the toilet and peri cares. Intermittent catheterization performed by nursing every shift and as needed. R99's care plan 10/22/24, failed to identify R99's catheterization. R99's October electronic treatment administration record (TAR), directed staff to straight catheterize R99 every shift or as requested by resident, related to neuromuscular dysfunction of bladder, with a start date 10/24/24 at 3:00 p.m., signed by care coordinator (CC)-G. CC-G was out of the office and unable to be interviewed during the survey dates. On 10/29/24 at 10:17 a.m., R99 was seated in a wheelchair in his room. R99 stated he used a catheter to empty his bladder due to being unable to urinate on his own. There were individually wrapped sterile straight catheters and sterile glove kits on the bathroom counter. On 10/30/24 at 7:04 a.m., licensed practical nurse (LPN)-A stated staff assisted resident with straight catheterization every shift because R99 was not able to complete it himself. On 10/30/24 at 4:48 p.m., LPN-B stated R99 was unable to urinate on the toilet and staff were using a straight catheter to empty R99's bladder three times per day; although, the original orders dated 10/24/24, were as follows: straight catheterizations 4 times a day; If staff are consistently draining >500 mL per catheterization, then add a scheduled catheterization. LPN-B stated the orders entered into the computer system on 10/24/24, for intermittent catheterization every shift and as needed were incorrect and not as originally ordered. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/30/24 at 5:18 p.m., the director of nursing (DON) stated R99 had been using a straight catheter to empty his bladder since before admission. The DON reviewed the original order and the order that was entered by the nursing staff and stated the orders entered by the staff were incorrect and staff should have assisted R99 with catheterization 4 times per day and as ordered by the doctor on 10/24/24. The risk of incorrectly completing the orders as directed were a high risk for infection. On 10/30/24 at 6:03 p.m., the medical doctor stated he was not notified that staff were only assisting R99 with catheterization once per shift and not four times daily as originally ordered. R99's medical record did not identify any pain or hospitalization s related to not providing catheterization four times a day as ordered. 40943 R7's significant change MDS dated [DATE], identified R7 had severe cognitive impairment with diagnoses of multiple sclerosis (MS), type 2 diabetes, history of UTI, and peripheral vascular disease. R7 had two stage 3 pressure ulcers and had a suprapubic indwelling urinary catheter (a tube that drains from your bladder through a small incision in your abdomen). The MDS failed to identify R7 had an MDRO. R7's care plan revised 8/9/24, identified R7 had an activities of daily living self-care performance deficit due to weakness related to MS. The care plan directed staff to provide assist of 1-2 for repositioning, dressing, grooming, and toileting/catheter care. During an observation on 10/29/24 at 10:17 a.m., nursing assistant (NA)-B was providing morning cares for R7. R7's catheter bag was uncovered and lying on the floor. During an interview on 10/29/24 at 10:34 a.m., NA-B stated yea, the catheter bag was on the floor, but NA-B had just wiped it down with alcohol. NA-B stated she guessed there could be residual urine on the catheter bag that could soil the floor. NA-B also guessed there was dirt on the floor and there could be germs in the dirt that could potentially cause a UTI. It doesn't make sense but there's so many by-the-book rules in nursing homes. The bag touching the floor was overkill. To tell you the truth, in a nursing home, care was never going to be perfect and just too much was expected. During an interview on 10/29/24 at 10:39 a.m., LPN-A stated a catheter bag should never touch the floor due to infection control because it can lead to an infection. During an interview on 10/31/24 at 1:10 p.m., registered nurse (RN)-A stated staff were expected to follow the facility's catheter care policy. During an interview on 10/31/24 at 2:18 p.m., DON stated staff were expected to provide catheter care per facility policy and to demonstrate understanding of infection control to prevent the spread of microorganisms in the facility to prevent possible infections. The facility policy Suprapubic Catheter Placement dated 3/1/17, identified the purpose of this procedure was to relieve the retention of urine in the bladder in a resident who required a permanent or long-term catheter. However, the policy/procedure failed to address catheter care after placement.

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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** 40948 Based on observation, interview and document review, the facility failed to provide sufficient staff to transfer residents in lifts according to their care plan for 3 of 4 residents (R12, R7, R2); failed to provide appropriate supervision to mitigate resident-to-resident abuse for 2 of 2 (R31, R6) residents abused by 1 of 1 residents (R39) reviewed for abuse: failed to provide sufficient staff to complete range of motion for 4 of 4 residents (R7, R19, R22, R43) reviewed for restorative therapy. In addition, 4 of 46 residents (R7, R30, R25, R34,) 10 of 10 staff members (RN-A RN-B, NA-D, LPN-A, NA-C, NA-A, SWD, RT-A, NA-H, DON); 1 of 3 family members (FM-A) voiced concerns of lack of sufficient staffing in the facility. The lack of sufficient staffing had the potential to affect all 46 residents in the facility. Findings include: Transfer with Lifts: See also F689: Based on observation, interview and document review, the facility failed to ensure staff were following care planned interventions when transferring residents with a ceiling lift; and complete therapy/or nursing assessments to determine the appropriate sling sizes per manufacturers guidelines for 3 of 4 residents (R12, R7, R2) reviewed who were transferred via ceiling lifts. R12's quarterly Minimum Data Set (MDS) dated [DATE], identified R19 had severe cognitive impairment and R12 was dependent on staff (helper performed all the effort and resident does none of the effort to complete the activity) for toileting and bed to chair transfers. R12's care plan dated 8/9/24, identified R12 was cognitively impaired and required assist of two staff for ceiling lift transfers. R12's care plan did not identify the ceiling lift sling size to be used with the transfer. During an observation on 10/29/24 at 5:50 p.m., NA-E and registered nurse (RN)-B transferred R12 with the ceiling lift into the bathroom using a green (large sling). R12 was holding the sling straps with her shoulders extended 90 degrees with the sling bunched up in her underarms. R12's fingers were grasping the straps tightly and her knees were pointed up towards the ceiling and her bottom hanging from the bottom of the sling. R7's significant change MDS dated [DATE], identified R7 had severe cognitive impairment and was dependent for toileting, personal hygiene, and bed to chair transfers. R7's care plan dated 8/9/24, identified R7 was cognitively impaired and required assist of two for ceiling lift transfers and R7 used a size medium ceiling lift sling. R7's Kardex dated 10/29/24, directed staff to provide assist of one with transfers using the ceiling lift. However, the Kardex additionally directed staff to use ceiling lift with total assist of two with a medium Arjo sling. (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 observation on 10/29/24 at 12:23 p.m., nursing assistant (NA)-C assisted R7 to the bathroom using a ceiling lift, without another staff person present as care planned. R7 was in the ceiling lift and holding the sling straps with both hands. R7's shoulders were extended 90 degrees and R7's bottom was hanging from the bottom of the sling. R7 had facial grimacing and moaned ooohh. NA-C asked R7 if she was having pain and R7 stated yes, along her ribcage. NA-C stated this was residual pain due to R7 having just recovered from COVID-19. NA-C stated she would report R7's pain to the nurse. R2's annual MDS dated [DATE], identified R2 had severe cognitive impairment and a diagnosis of dementia. R2 had functional limitation with range of motion in both lower extremities and was dependent on staff for bed mobility, toileting, and transfers. R2 had one fall with injury (including skin tears, abrasions, lacerations, superficial bruises, hematomas, and sprains) during assessment dates. R2's care plan dated 6/28/22, identified R2 required assist of two staff to move between surfaces using the ceiling lift. The ceiling lift sling size was not identified on the plan. During an interview on 10/29/24 at 6:55 p.m., registered nurse (RN)-B stated R7 and R12 were care planned for assist of two with ceiling lift transfers but with the way staffing was going, staff usually transferred using assist of one. Nursing helped as much as they could but there just wasn't enough staff. On 10/30/24 at 8:22 a.m., nursing assistant (NA)-D was standing in R2's room. R2 was fully dressed in their wheelchair. The ceiling lift sheet, size unidentified, was underneath with the straps crossed between the resident's legs. NA-E proceeded to use the ceiling lift to transfer R2 from the bed to the toilet, without a second staff member present as care planned. NA-E stated when R2 was calm like today she would transfer the resident by herself using the ceiling lift. When R2 was resistive NA-D would ask for other staff assistance. The care plan provided direction that two staff were required for ceiling lift transfers. On 10/30/24 at 8:22 a.m., NA-D stated she had no time to check the care plan so was unaware what the care plan directed. During an interview on 10/30/24 at 9:20 a.m., licensed practical nurse (LPN)-A stated she was very concerned regarding resident and staff safety. The facility did not have enough staff to provide assist of 2 with ceiling lift transfers. Residents were being left alone in the lifts in the bathrooms, staff were transferring resident by assist of one with the ceiling lifts, and not answering call lights timely. During an interview on 10/30/24 at 9:44 a.m., NA-C stated the facility was always short staffed. The A-wing was just too heavy of care for one nursing assistant. There was supposed to be a float nursing assistant that would go between the different units but that rarely happened and especially when the nurse had to bounce between units as well. Abuse: (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	See also F600: Based on observation, interview and document review, the facility failed to ensure 1 of 1 resident (R39) with a known history of sexual behaviors towards others was comprehensively assessed and interventions implemented to mitigate risk to prevent ongoing sexual abuse for 2 of 2 residents (R31, R6) who were cognitively impaired, dependent on staff for their care, and were sexually abused by R39. R31's quarterly Minimum Data Set (MDS) dated [DATE], identified R31 had severe cognitive impairment and exhibited physical behaviors of grabbing, hitting, scratching, or abusing others sexually one to three days per week, and verbal behaviors toward others one to three days per week. R31 required substantial assistance to dress and was independent with transfer and ambulation. Diagnoses included Alzheimer's disease, anxiety, mood disorder, dementia, restlessness, and agitation. R6's quarterly MDS dated [DATE], identified R6 had moderate cognitive impairment and exhibited delusions, physical behaviors of grabbing, hitting, scratching, or abusing others sexually one to three days per week, verbal behaviors toward others four to six days per week and other behaviors not directed toward others four to six days per week. R6 required substantial assistance to dress and partial assistance with transfers. R6 was independent with ambulation once standing. Diagnoses included depression, anxiety, dementia, and sever mood disturbance. R39's quarterly MDS dated [DATE], identified R39 had severe cognitive impairment with physical behaviors of grabbing, hitting, scratching, or abusing others sexually one to three days per week. R39 was able to transfer and ambulate independently. R39 diagnoses included dementia, psychotic disturbance, mood disturbance and anxiety. R39's progress notes identified the following: - 8/23/24, R39 was observed to take R31 by her hands and lead R31 to his room and close the door. When staff entered the room, R39 was lying on his side in bed and R31 was just seated on R39's bed. Staff directed R31 out of room and reminded R39 they were not allowed alone in room with door shut. - 9/6/24, licensed practical nurse (LPN)-A documented R39 had approached a female resident [identified as R31 from interview] from behind and gave the resident what appeared to be a bear hug [identified in interview to be reaching from behind and grabbing breast] which staff observed from behind. The social service designee (SWD) was notified. - 9/18/24, R39 made attempts to enter an unidentified female resident's room when she was sleeping in bed with lights off. Staff redirected R39 out of the room several times. - 9/25/24, R39 was observed fondling R31's breast. Staff intervened and separated the two residents. - 10/11/24, R39 was walking back to his room when R39 approached a female resident [identified as R31 through interview] to grab her breast area. R39 was redirected away and reminded it was inappropriate to touch anyone without permission. The DON was notified. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	- 10/15/24, R6 was found in R39's room with the door closed. R6 was seated in her wheelchair beside R39's bed and R39 was fondling R6's breast. R6 was removed from area and R39 was reminded the behavior was not appropriate. R6 stated the incident made her uncomfortable and R39 had been squeezing her breast pretty hard. The DON and SWD were notified. R39's medical record lacked evidence R39's inappropriate sexual behaviors toward other residents had been comprehensively assessed and interventions implemented to mitigate potential abuse toward other residents, despite R39 being independently mobile and displaying ongoing inappropriate sexual behaviors. R31's medical record lacked any assessment to ensure her psychosocial needs were met and interventions implemented. R6's medical record lacked any assessment to ensure her psychosocial needs were met and interventions implemented. On 10/29/24 at 11:00 a.m., NA-A stated R39 could get grabby and try to grab staff breasts, you just needed to watch for it and remind him the behavior was not appropriate. NA-A was not aware R39 had inappropriate sexual behaviors toward other residents. The facility usually staffed the locked unit with one nursing assistant and a nurse would come on the unit on and off to pass medications. Once in a while they would have a float nursing assistant that would come on the unit occasionally to see if help was needed, but that did not happen very often. When interviewed on 10/29/24, at 1:30 p.m. SWD stated she was notified of some incidents with R39's behavior toward residents. SWD received calls regarding incidents of R39 inappropriately touching other residents on 10/14/24 and 10/15/24. SWD discussed the incidents regarding R31's behavior with the DON and it was determined there were no non-consensual type of feelings. The residents had not seemed upset, so SWD and the DON determined it would be ok to just document the incidents when they occurred. The MDS coordinator was going through all the resident care plans and trying to get them all updated and they were all just trying to catch up and survive. Range of Motion: See also F688: Based on observation, interview and document review, the facility failed to provide range of motion (ROM) services for 4 of 4 residents (R7, R19, R22 ,R43) reviewed for range of motion. R7's significant change Minimum Data Set (MDS) dated [DATE], identified R7 had severe cognitive impairment. Diagnoses included multiple sclerosis (MS) (a potentially disabling disease of the brain and spinal cord that affects nerve fibers and causes communication problems), type 2 diabetes and peripheral vascular disease (PVD) (reduced blood flow to the arms and legs). R7 had a restorative nursing program (RNP) but R7 did not participate during the look back period. R7's care plan revised 8/9/24, directed staff to provide: RT- UBC x15 mins (tension 90). Pulleys at level 2 (reps of 5 as tolerated). Red squeeze ball (30 second reps). [NAME] level 3 Thera putty. 3# free weight bicep curls. AROM with green Thera Bands. Lower AROM (AAROM - marching, knee extensions, hip adductions and abductions, ankle pumps). 5 times a week or as tolerated. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	R7's Range of Motion task documentation dated 10/7/24 through 11/1/24, identified R7 received RNP services 3 times, was unavailable 2 times, R7 refused 2 times and was not applicable for 5 times. During the time-period, R7 should have been offered RNP services a total of 17 times. R19's quarterly MDS dated [DATE], identified R19 had moderately impaired cognition and diagnoses included Alzheimer's disease, anxiety and heart failure. R19 had a restorative nursing program (RNP) but R19 did not participate during the look back period. R19's care plan revised 8/1/24, directed staff to provide seated general lower and upper extremity exercises to be completed 3 times a week. R19's Range of Motion task documentation dated 10/7/24 through 11/1/24, identified R19 received RNP services 3 times, was unavailable 1 time and not applicable 7 times. During the time period, R19 should have been offered RNP services a total of 11 times. R22's significant change MDS dated [DATE], identified severe cognitive impairment. R22 had no impairment in range of motion and required substantial to maximal (helper does more than half the effort) with bed mobility, transferring and toileting. R22's diagnoses included arthritis, Alzheimer's disease, and lumbago with sciatica (pain radiating from back to legs and feet which can be eased with range of motion/stretching). R22 did not have a restorative nursing program. R22's provider's order dated 10/2/24, identified R22 was to receive functional maintenance program (FMP) by restorative therapy (RT). The order directed staff to complete active ROM (AROM) (resident helping with range of motion) to both arms and legs in all ranges and planes (normal range of motion) for all joints and to walk as tolerated with transfers five times a week. R22's restorative therapy documentation from 10/4/24 through 11/3/24, identified 21 opportunities for R22 to receive AROM. There was one documented occurrence of AROM being done, one documented resident not available, and 19 marked not applicable. R43's quarterly MDS dated [DATE], identified R43 had moderate cognitive impairment. R43 required supervision to touch assistance with transfers, toileting, and walking. R43 had a diagnosis of Parkinson's disease. R43 had one fall without injury since last assessment. R43 was not part of a restorative nursing program. R43's provider order dated 7/25/24, identified RT program-seated or standing general lower extremity exercises as tolerated. Nustep level 2-5 up to 15 minutes 3 times a week. R43's care plan dated 7/30/24, identified R43 was to receive RT seated or standing general lower extremity exercises as tolerated. Nustep (a low impact exercise machine) level 2-5 up to 15 minutes 3 times a week. R43's restorative therapy documentation from 10/4/24 through 11/3/24, identified 13 opportunities for R43 to receive RT. There were three documented occurrences of RT being done, one refusal, and 9 times were marked not applicable. (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 11/4/24 at 11:51 a.m., restorative therapy (RT)-A stated RNP services were supposed to be offered Monday through Saturday every week and RT-A scheduled each resident according to their RNP on the calendar. RT-A stated the RT department had staffing problems and RT-A was the most consistent staff member. Currently, there was another staff member trained and passed competency, but that person had not been at the facility often. RT-A worked at the facility Mondays, Wednesdays, and Fridays. The other days were not consistently staffed and no RNP was offered on those days unless a resident was independent enough to do the exercises on their own without staff assistance. I just can't complete it. RT-A stated she did inform administration that she was not able to complete tasks but there were no other staff available. During an interview on 11/5/24 at 3:30 p.m., the director of nursing (DON) stated she was aware the facility's restorative aide was at the facility only three days a week even though there were residents requiring RNP 5 days a week. However, a plan to address the issue had not been implemented. Staff were expected to provide RNP to maintain a resident's abilities and/or to prevent contractures. General Resident/Staff and Family Staffing Concerns: During an interview on 10/28/24 at 12:43 p.m., R7 stated a lot of the time you wait at least a half hour for someone to come when you turn on your call light. R7 had times when she was incontinent of bowel because she didn't make it to the bathroom on time. That makes me [R7] feel embarrassed. Dumb. R7 was weepy and wiped away tears. During an observation on 10/30/24 at 7:27 a.m., R7 was lying in bed with her lights off. R7's door was partially open and R7 was screaming help over 10 times. - At 7:28 a.m., R7 screamed help 8 times. R7 can be clearly heard at each each of the unit. - At 7:29 a.m., R7 was again screaming help. R27 came out of her room and asked if R7 was alright. No staff were in the area. - At 7:31 a.m., R7 continued to scream help repeatedly, however, there were no staff to assist R7. - At 7:32 a.m., R27 came out of her room and stood in her doorway rubbing at her eyes and stated she was worried for R7. Is she ok? - At 7:33 a.m., R7 screamed help 5 times in a row. R27 walked to R7's doorway and peeked in stating What's going on? R27 was barefoot on the right foot and a gripper sock on the left. No staff were in the area and R27 turned back to her room. - At 7:39 a.m., R7 screamed help and nursing assistant (NA)-B entered R7's room and asked R7 if she had a bad dream. Provided a blanket for R7 and told R7 she could go back to sleep. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	- At 7:42 a.m., NA-B stated she was the float nursing aide that day. NA-C was the nursing aide assigned to R7's wing and had a phone that NA-C carried that alerted her to the call lights. The float nursing aide used to have a phone but didn't anymore. NA-B did not know why. NA-B stated when she's in a room she was able to hear the call light box that announced call lights at the nurses' station. That's how she knew she needed to check on R7 because R27's bed alarm went off, or that's how NA-B heard R7 screams for help. When in a room, staff could turn on the call light if they needed help. There was no walkie system or any other way to request help unless staff left the room. On 10/28/24 at 3:27 p.m., NA-H stated there was usually one staff on either side and a float that went back/forth between the two units. If there wasn't a float staff, then she would have to run over to the other side or find the medication nurse will help with two person transfers. STAFF INTERVIEWS: On 10/28/24 at 3:27 p.m., NA-H stated there was usually one staff on either side and a float that went back/forth between the two units. If there wasn't a float staff, then she would have to run over to the other side or find the medication nurse will help with two person transfers. During an interview on 10/28/24 at 4:07 p.m., family member (FM)-A stated R7 had wounds and a physical therapist changed the dressings at 1:00 p.m. Because of that, there was a lot of days R7 didn't get out of bed until after that because there wasn't enough staff. During interview on 10/30/24 at 8:22 a.m. NA-D stated she was uncertain if R2 needed assist of one or two for ceiling transfers. NA-D stated she had not reviewed the care plan prior to transferring R2 because she did not have time. On 10/30/24 at 9:58 a.m., a resident council meeting was held and R34, R25 and R20 expressed concerns regarding staffing. - R34 stated she had to wait a long time for her food at meals. R34 was unable or unwilling to share specific date/times of incidents, although stated it happened frequently. R34's significant change MDS dated [DATE], identified R34 had intact cognition and was dependent on staff for toileting; partial/moderate assistance with bathing; and substantial/maximal assistance for dressing. - R25 stated more times than not there were not enough staff. R25 was unable or unwilling to share specific date/times of incidents, although stated it happened frequently. R25's quarterly MDS dated [DATE], identified R25 had intact cognition and needed substantial/ maximal assistance with for toileting, bathing, and dressing. - R20 stated the wait time of call lights at times was too long. R20 was unable or unwilling to share specific date/times of incidents, although stated it happened frequently. R20's annual MDS dated [DATE], identified R20 had intact cognition and was dependent on staff for toileting, bathing; and substantial to dependent on staff for dressing. During interview on 10/31/24 at 10:14 a.m. RN-A stated she was trying to do the DON position and work the floor. Staffing took up so much time and there was only so much a person could do and they were trying to get done what they could. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The Payroll Based Journal (PBJ) Staffing Data Report for the third quarter of 2024, identified excessively low weekend staffing. The daily staffing/working schedules from 8/1/24 thru 10/28/24 were reviewed. The facility was unable to provide a working schedule for 8/3/24, 8/4/24, 8/10/24, and 8/11/24. The Facility assessment dated 2023, identified a need for a ratio of nurse (RN/LPN) to resident was 1:16 to 1:24 for day shift and evening shift and 1:24-1:48 for overnight shift. The assessment also identified a ratio of NA's to residents including: 1:12 -1:13 during each shift (day, evening, overnight) and each shift would consist of a minimum of 4 NA's. The facility daily staffing/working schedules dated 8/17/24 and 8/25/24 identified only 2 NA's were scheduled for the overnight shift; and the nurse staff posting observed on 10/29/24 at 4:53 p.m. identified there was one nurse for A-wing (Pine Island, and The Angle), one for B-wing (Birch-Lake of the Woods) during day and evening. B-wing also had a TMA for day. Each wing had three nursing assistants a.m. and two nursing assistants for B-wing and 2.5 nursing assistants for A-Wing in evening. There was 1 nurse and three nursing assistants combined for the A and B wings. During an interview on 10/30/24 at 9:58 a.m., the DON stated when the DON first started at the facility, she approached the former administrator because they were using 70% agency staff and had lost many experienced staff. To determine resident to staff ratios, they looked at resident acuity and the number of residents requiring lifts. The previous administrator insisted all lifts required assist of 2 staff to complete. However, it took one aide away from a wing entirely to help the other side if the nurse was busy. It's a mess. The DON stated she went to the administrator and requested to add two nursing assistants to A-wing as That's what I needed. The DON needed two staff on another unit as well. That was the goal. I'll be honest with you, it's difficult. Sometimes, there was a float, but it hadn't come to fruition yet and hasn't been consistent. The DON also went to the board and explained staff couldn't be retained and/or incentivized, especially when the facility was losing agency staff as well, when the facility's wages were $5 lower than all the other facilities around. The facility finally approved a pay increase, but it was on pause due to the start of survey. The DON stated she was excited because the former administrator just would not let that happen. The DON stated she also needed a care coordinator for a unit. Ultimately, the DON's plan was to incentivize to get staff to come and get agency staff out of the facility. Some agency staff were great and most worked evenings. A policy on staffing was requested but none were received. 40943 42075

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations and emergencies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40943 Based on interview and document review, the facility failed to update the facility assessment when changes occured to ensure an effective plan was in place to maintain the highest practicable care for residents. This had the potential to affect all 46 residents residing at the facility. Findings include: During the course of the survey conducted on 10/28/24 through 11/6/24, an immediate jeopardy level deficiency was identified related to a resident (R39) who had known inappropriate sexual behaviors and the facility's failure to conduct comprehensive assessments and implement interventions to mitigate risk to others and to prevent ongoing sexual abuse for 2 of 2 residents (R31 and R6) who were cognitively impaired and dependent on staff for their care and were sexually abused by R39 (See F600). During the course of the survey conducted on 10/28/24 through 11/6/24, an immediate jeopardy level deficiency was identified related to the facility failed to ensure staff were following care planned interventions when transferring residents with a ceiling lift; and complete therapy/or nursing assessments to determine the appropriate sling sizes per manufacturers guidelines for 3 of 4 residents (R12, R7, R2) to ensure resident and staff safety. These deficient practices resulted in immediate jeopardy for R12, R7 and R2. The Facility Assessment 2023 dated 12/18/23, included the facility identified the need to develop and implement policies and procedures for the provision of care and the following areas of concern were identified: - Staff turnover rate: YTD as of December 11, 2023 was 22.95%. Turnover had declined from one year ago when it was 24.44%. Staff will continue to work on creating a great culture and sufficient staffing levels in all areas to be able to hire and keep good people on our team. We are impacted by the current labor shortages as well as students both leaving for and returning to school. Our goal was to reduce our number to approach 20%. However, the assessment failed to identify interventions to improve the staff turnover rate nor how to ensure safe resident care was provided. - An Infection Prevention Risk Assessmenl was completed annually, which guides infection prevention improvements. APIC's Infection Preventionists Guide to Long [NAME] Care and the Centers for Disease Control are the primary resources that guide our Infection Prevention Program. The facility was registered with NHSN. Covid-19 reporting was being done. However, the facility assessment failed to identify changes in guidance related to Enhanced Barrier Precautions (EBP) and/or staff education needs related to infection prevention. - Additionally, the facility assessment failed to identify the changes in leadership and/or how to mitigate the risks in resident care due to lack of leadership. (continued on next page)

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 11/6/24 at 2:18 p.m., the administrator stated he was a contracted interim administrator and began his role at the facility on 10/9/24. The facility had undergone several administration changes since the previous survey. The administrator reviewed the facility assessment and stated he expected the assessment to be reviewed at the end of every Quality and Performance Improvement (QAPI) meeting and revised at that time to reflect identified needs. However, the administrator could not find any revised facility assessment documents since 12/1/23, and did not have an answer as to why. A policy related to the facility assessment review and revision was requested and none was provided.

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F 0840 Level of Harm - Potential for minimal harm Residents Affected - Many	Employ or obtain outside professional resources to provide services in the nursing home when the facility does not employ a qualified professional to furnish a required service. 40943 Based on interview and document review, the facility failed to provide the facility agreements for contracted services which had the potential to affect all 46 residents residing in the facility reviewed during the extended survey. Findings include: A copy of any agreement the facility had such as dental, hospital transfer, and/or psychiatric services was requested. The only agreement received was a Nursing Facility Services Agreement dated 8/26/13, identified the facility had an agreement with LifeCare Medical Center for hospice services. During document review on 11/6/24, at 12:47 p.m. the administrator confirmed he had been unable to locate any current agreements other than the one hospice agreement. No further information was provided.

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F 0841 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Designate a physician to serve as medical director responsible for implementation of resident care policies and coordination of medical care in the facility. 40943 Based on interview and document review, the facility failed to develop a policy and procedure defining the responsibilities of the medical director and ensure the medical director assisted in the implementation and guidance of resident care policies, and coordination of resident medical care in the facility. This had the potential to impact all 46 residents who resided in the nursing home at the time of the survey. Findings Include: During an extended survey, on 11/6/24, a medical director (MD) policy and the MD's job description and/or contract was requested; however, these items were not provided. During a telephone interview on 10/30/24 at 2:36 p.m., MD stated he was at the facility twice per month. Once to do residents rounds and the other was for paperwork; signing orders etc. The MD attended quality meetings as well. The MD was informed of staffing concerns; however, he was not in control of staff. The MD provided medical care to the residents, and he did review resident incident reports such as falls as well. During an interview on 11/6/24 at 2:18 p.m., the administrator stated he was a contracted interim administrator and began his role at the facility on 10/9/24. The facility had undergone several administration changes since the previous survey, and he was unable to find the MD job description and/or policy related to the MD's responsibilities at the facility. The administrator stated he expected the facility to have all the required policies and/or job descriptions. No further information was provided.

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F 0843 Level of Harm - Potential for minimal harm Residents Affected - Many	Have an agreement with at least one or more hospitals certified by Medicare or Medicaid to make sure residents can be moved quickly to the hospital when they need medical care. 40943 Based on interview and document review, the facility failed to develop and/or have evidence of an in-effect transfer agreement with a local Medicare participating hospital entity. This had potential to affect all 46 residents in the facility who could require hospitalization on an emergent basis. Findings include: During the extended survey from 10/30/24 through 11/6/24, evidence was requested to demonstrate the facility had a transfer agreement in place with a local Medicare participating hospital entity. However, no information or evidence was provided. During an interview on 11/6/24 at 2:18 p.m., the administrator stated he was a contracted interim administrator and began his role at the facility on 10/9/24. The facility had undergone several administration changes since the previous survey, and he was unable to find a transfer agreement in place with a local Medicare participating hospital entity. The administrator stated he expected the facility to have all the required policies and/or procedures to provide care the residents. No further information was provided.

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a plan that describes the process for conducting QAPI and QAA activities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40943 Based on interview, and document review, the facility failed to develop and implement appropriate plans of action to correct quality deficiencies identified during the survey that the facility was aware of or should have been aware. This had the potential to adversely affect all 46 residents residing in the facility. Findings include: See also F600: The facility failed to ensure 1 of 1 resident (R39) with known sexual behaviors towards others was comprehensively assessed and interventions implemented to mitigate risk to others and prevent ongoing sexual abuse for 2 of 2 residents (R31, R6) who were cognitively impaired and dependent on staff for their care and were sexually abused by R39. See also F689: The facility failed to ensure staff were following care planned interventions when transferring residents with a ceiling lift; and complete therapy/or nursing assessments to determine the appropriate sling sizes per manufacturers guidelines for 3 of 4 residents (R12, R7, R2) to ensure resident and staff safety. These deficient practices resulted in immediate jeopardy for R12, R7 and R2 but had the potential to affect all 12 residents who used ceiling lifts. See also F880: The facility failed to develop and implement an infection control surveillance plan for identifying, tracking, monitoring and/or reporting infections and communicable disease along with a monthly analysis; failed to conduct COVID-19 testing of staff and residents per Centers for Disease Control (CDC) guideline; failed to implement contact precautions and/or enhanced barrier precautions (EBP) for 2 of 2 residents (R7, R30) reviewed with a multi drug resistant organism (MDRO) and chronic wounds; and failed to implement standard precautions while catheterizing 1 of 1 resident (R99) observed to be catheterized. In addition, the facility failed to review and update their infection control policies on an annual bases. These deificient practices had the potential to affect all 46 residents residing in the facility. See also F725: The facility failed to provide sufficient staff to transfer residents in lifts according to their care plan for 3 of 4 residents (R12, R7, R2); failed to provide appropriate supervision to mitigate resident-to-resident abuse for 2 of 2 (R31, R6) residents abused by 1 of 1 residents (R39) reviewed for abuse: failed to provide sufficient staff to complete range of motion for 4 of 4 residents (R7, R19, R22, R43) reviewed for restorative therapy. In addition, 4 of 46 residents (R7, R30, R25, R34,) 10 of 10 staff members (RN-A RN-B, NA-D, LPN-A, NA-C, NA-A, SWD, RT-A, NA-H, DON); 1 of 3 family members (FM-A) voiced concerns of lack of sufficient staffing in the facility. The lack of sufficient staffing had the potential to affect all 46 residents in the facility. The Facility Assessment 2023 dated 12/18/23, identified the facility had identified the need to develop and implement policies and procedures for the provision of care and the following areas of concern were identified: (continued on next page)

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	- Staff turnover rate: YTD as of December 11, 2023 was 22.95%. Turnover had declined from one year ago when it was 24.44%. Staff will continue to work on creating a great culture and sufficient staffing levels in all areas to be able to hire and keep good people on our team. We are impacted by the current labor shortages as well as students both leaving for and returning to school. Our goal was to reduce our number to approach 20%. However, the assessment failed to identify interventions to improve the staff turnover rate nor how to ensure safe resident care was provided. - An Infection Prevention Risk Asscssmenl is completed annually, which guides infection prevention improvements. APIC's Infection Preventionists Guide to Long [NAME] Care and the Centers for Disease Control are the primary resources that guide our Infection Prevention Program. The facility was registered with NHSN. Covid-19 reporting was being done. However, the facility assessment failed to identify changes in guidance related to Enhanced Barrier Precautions (EBP) and/or staff education needs related to infection prevention. The February QAPI Education Report dated 3/8/24, identified staff education compliance was at 72.8%, however, the facility could not provide evidence actions were taken to increase compliance. The Quality and Safety Meeting (Quarter 1 Data) dated 4/15/24, identified a table of QAPI team reviewed topics: emerging infectious disease, staff influenza vaccination program, emergency preparedness, environmental services, Minnesota Pollution Control Agency (MPCA), skilled nursing safety report (Casper, MDS, QIIP), safe resident handling, consultant pharmacist report, and performance improvment project (PIP) discussion. The data failed to identify goals and measurable actions taken regarding abuse, staffing concerns, accidents and/or infection prevention. The Quality and Safety Meeting (April Data) dated 5/20/24, identified a table of QAPI team reviewed topics: emerging infectious disease, staff influenza vaccination program, emergency preparedness, environmental services, Minnesota Pollution Control Agency (MPCA), skilled nursing safety report (Casper, MDS, QIIP), safe resident handling, consultant pharmacist report, and performance improvment project (PIP) discussion. The data failed to identify goals and measurable actions taken regarding abuse, staffing concerns, accidents and/or infection prevention. The Quality and Safety Meeting (May Data) dated 4/15/24, identified a table of QAPI team reviewed topics: emerging infectious disease, staff influenza vaccination program, emergency preparedness, environmental services, Minnesota Pollution Control Agency (MPCA), skilled nursing safety report (Casper, MDS, QIIP), safe resident handling, consultant pharmacist report, and performance improvment project (PIP) discussion. The data failed to identify goals and measurable actions taken regarding abuse, staffing concerns, accidents and/or infection prevention. The Annual Safe Resident Handling Assessment completed on 5/15/24, idendentified poor attendance. NAR meetings would start being held on the 2nd Wed of each month at 1:30 p.m. and 3:00 p.m. and the following Thurs at 7:00 a.m. to accommodate night shift. The meetings were part of the Safe Resident Handling policy. Follow-up from previous meeting: lock-out-tag-out policy was going to be reviewed (r/t [NAME] Steady lift had loose hardware). Update: Lock-out/Tag-out policy is primary designed for electrical equipment. Will be reviewing policies including equipment maintenance policies to ensure that protocols were in place for equipment such as the [NAME]-Steady lifts. The data failed to identify goals and measurable actions taken for staffing concerns, accidents and/or infection prevention and no further data was provided regarding the NAR meeting attendance. (continued on next page)

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	245329	A. Building B. Wing	11/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Warroad Care Center	1401 Lake Street Northwest Warroad, MN 56763

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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 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The QAPI Meeting Minutes dated 8/12/24, identified the following: - Falls- 26 falls documented in the month of July. PIP written and reviewed on 4/15/24 for fall reduction. PIP was ongoing and continued to be implemented. The fall committee initiated weekly meetings along with the introduction of the Falling star program and policy the week of 8/1/24. 13 less falls identified than the previous 60 days. - Resident Council- held 7/3/24 - All concerns have been communicated and completed. - Grievances - No formal family or resident in the month of July - Resident Quality of Life/Nursing Home report card-addressed with team and will continue in the month of August. The data failed to identify goals and measurable actions taken regarding abuse, staffing concerns, accidents and/or infection prevention. During an interview on 11/06/24 at 1:53 p.m., the administrator stated he was a contracted interim administrator and began his role at the facility on 10/9/24. The facility had undergone several administration changes since the previous survey and the administrator had been told the facility held a QAPI meeting in July or August but he could not find any data that reflected that. The administrator did find an agenda but nothing substantial that reflected how the facility was working towards improvement. The administrator stated he was unsure what happened to the facility files because even common items were missing. The QAPI plan should be reviewed at the end of every QAPI meeting and PIP discussed as well. Does it need to be changed? Is there improvement and, if not, why? The administrator expected staff to report concerns to discuss during QAPI, the minutes to reflect work done and to work towards improvement. The facility Quality Assurance Performance Improvement Plan dated 2/24/17, identified the written QAPI plan provided guidance for the overall quality improvement program. Quality assurance and performance improvement principles w drive the decision making within our organization. Decisions will be made to promote excellence in quality of care, quality of life, resident choice, person directed care, and resident transitions. Focus areas will include all systems that affect resident and family satisfaction, quality of care and service provided, and all areas that affect the quality of life for persons living and working in our organization. The executive director will assure that the QAPI plan is reviewed minimally on an annual basis by the QAA committee. Revisions will be made to the plan ongoing, as the need arises, to reflect current practices within our organization. These revisions will be made by the QAA committee. Revisions to the QAPI plan will be communicated as they occur to board members, residents, families, and staff through meetings and newsletters as deemed appropriate by the QAA committee. A project charter will be developed for each PIP at the beginning of the project that clearly establishes the goals, scope, timing, milestones, team roles, and responsibilities. The PIP charter will be developed by the QAA committee and then will be given to the team that will carry out the PIP. (continued on next page)

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	For ongoing monitoring of the PIP, we will use the CMS PIP Inventory to include milestones, PDSAs, outcomes, and other lessons learned from the PIP. Information about PIPs will be shared via our quality improvement dashboard, quarterly newsletter provided to all residents, families, and staff, and discussed during the QAPI agenda items on all staff, resident, and family monthly meetings.

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40943 Based on interview, and document review, the facility failed to develop, monitor, and evaluate their identified performance measures. This had the potential to affect all 46 residents residing in the facility. Findings include: The February QAPI Education Report dated 3/8/24, identified staff education compliance was at 72.8%, however, the report failed to identify actions taken to increase compliance. The Quality and Safety Meeting (Quarter 1 Data) dated 4/15/24, identified the QAPI team reviewed the following topics: - Emerging infectious disease - Staff influenza vaccination program - Emergency preparedness - Environmental services - Minnesota Pollution Control Agency (MPCA) - Skilled nursing safety report (Casper, MDS, QIIP) - Safe resident handling - Consultant pharmacist report - PIP discussion. The data failed to identify the facility developed and implemented action plans with measurable goals and/or identify actions taken. The Quality and Safety Meeting (April Data) dated 5/20/24, identified the QAPI team reviewed the following topics: - Emerging infectious disease - Staff influenza vaccination program - Emergency preparedness - Environmental services (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 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	- Housing Report - Social Services Report - Employee incidents The data failed to identify the facility developed and implemented action plans with measurable goals and/or identify actions taken. The Quality and Safety Meeting (May Data) dated 6/17/24, identified the QAPI team reviewed the following topics: - Emerging infectious disease - Staff influenza vaccination program - Emergency preparedness - Environmental services - Housing Report - Social Services Report - Skilled Nursing Safety Report - Safe resident handling: Annual Safe Resident Handling Assessment completed on 5/15/24, poor attendance. NAR meetings will start being held on the 2nd Wed of each month at 1:30 p.m. and 3:00 p.m. and the following Thurs at 7:00 a.m. to accommodate night shift. These meetings are part of the Safe Resident Handling policy. Follow-up from previous meeting: lock-out-tag-out policy was going to be reviewed (r/t [NAME] Steady lift had loose hardware). Update: Lock-out/Tag-out policy is primary designed for electrical equipment. Will be reviewing policies including equipment maintenance policies to ensure that protocols were in place for equipment such as the [NAME]-Steady lifts. - Consultant pharmacy resport - PIP discussion The data failed to identify the facility developed and implemented action plans with measurable goals and/or identify actions taken. The QAPI Meeting Minutes dated 8/12/24, identified the following: - Falls- 26 falls documented in the month of July. PIP written and reviewed on 4/15/24 for fall reduction. PIP was ongoing and continued to be implemented. The fall committee initiated weekly meetings along with the introduction of the Falling star program and policy the week of 8/1/24. 13 less falls identified than the previous 60 days. (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	- Resident Council- held 7/3/24 - All concerns have been communicated and completed. - Grievances - No formal family or resident in the month of July - Resident Quality of Life/Nursing Home report card-addressed with team and will continue in the month of August The data failed to identify the facility developed and implemented action plans with measurable goals and/or identify actions taken. The Facility Assessment 2023 dated 12/18/23, revealed the facility had identified the need to develop and implement policies and procedures for the provision of care and the following areas of concern were identified: - Staff turnover rate: YTD as of December 11, 2023 was 22.95%. Turnover had declined from one year ago when it was 24.44%. Staff will continue to work on creating a great culture and sufficient staffing levels in all areas to be able to hire and keep good people on our team. We are impacted by the current labor shortages as well as students both leaving for and returning to school. Our goal was to reduce our number to approach 20%. However, the assessment failed to identify interventions to improve the staff turnover rate nor how to ensure safe resident care was provided. - An Infection Prevention Risk Asscssmenl is completed annually, which guides infection prevention improvements. APIC's Infection Preventionists Guide to Long [NAME] Care and the Centers for Disease Control are the primary resources that guide our Infection Prevention Program. The facility was registered with NHSN. Covid-19 reporting was being done. However, the facility assessment failed to identify changes in guidance related to Enhanced Barrier Precautions (EBP) and/or staff education needs related to infection prevention. During an interview on 11/06/24 at 1:53 p.m., the administrator stated he was a contracted interim administrator and began his role at the facility on 10/9/24. The facility had undergone several administration changes since the previous survey and the administrator had been told the facility held a QAPI meeting in July or August but he could not find any data that reflected that. The administrator did find an agenda but nothing substantial that reflected how the facility was working towards improvement. The administrator stated he was unsure what happened to the facility files because even common items were missing. The QAPI plan should be reviewed at the end of every QAPI meeting and PIP discussed as well. Does it need to be changed? Is there improvement and, if not, why? The administrator expected staff to report concerns to discuss during QAPI, the minutes to reflect work done and to work towards improvement. The facility Quality Assurance Performance Improvement Plan dated 2/24/17, identified the written QAPI plan provided guidance for the overall quality improvement program. Quality assurance and performance improvement principles w drive the decision making within our organization. Decisions will be made to promote excellence in quality of care, quality of life, resident choice, person directed care, and resident transitions. Focus areas will include all systems that affect resident and family satisfaction, quality of care and service provided, and all areas that affect the quality of life for persons living and working in our organization. (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The executive director will assure that the QAPI plan is reviewed minimally on an annual basis by the QAA committee. Revisions will be made to the plan ongoing, as the need arises, to reflect current practices within our organization. These revisions will be made by the QAA committee. Revisions to the QAPI plan will be communicated as they occur to board members, residents, families, and staff through meetings and newsletters as deemed appropriate by the QAA committee. A project charter will be developed for each PIP at the beginning of the project that clearly establishes the goals, scope, timing, milestones, team roles, and responsibilities. The PIP charter will be developed by the QAA committee and then will be given to the team that will carry out the PIP. For ongoing monitoring of the PIP, we will use the CMS PIP Inventory to include milestones, PDSAs, outcomes, and other lessons learned from the PIP. Information about PIPs will be shared via our quality improvement dashboard, quarterly newsletter provided to all residents, families, and staff, and discussed during the QAPI agenda items on all staff, resident, and family monthly meetings.

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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** 41575 Based on observation, interview and document review, the facility failed to develop and implement an infection control surveillance plan for identifying, tracking, monitoring and/or reporting infections and communicable disease along with a monthly analysis; failed to conduct COVID-19 testing of staff and residents per Centers for Disease Control (CDC) guideline; failed to implement contact precautions and/or enhanced barrier precautions (EBP) for 2 of 2 residents (R7, R30) reviewed with a multi drug resistant organism (MDRO) and chronic wounds; and failed to implement standard precautions while catheterizing 1 of 1 resident (R99) observed to be catheterized. In addition, the facility failed to review and update their infection control policies on an annual bases. These deificient practices had the potential to affect all 46 residents residing in the facility. Findings include: Surveillance: The Monthly Infection Control Log (Line List) September 2024, for Unit A, identified resident name, date of onset, body site, and type of infection, antibiotic start date and type, date resolved and type of isolation. The log identified one resident (R7) with skin infection which was treated with antibiotic. The isolation type initiated and date the infection was resolved was not documented. The log further identified two residents (R7, R5) both who had tested postive for COVID-19 and placed on contact precautions. There were no listed infections or resident infection symptoms which were not treated with antibiotics (i.e. common cold symptoms, viral infections). The facility did not provide an analysis of the infections to include patterns or what interventions were implemented to reduce incidences of further infection. The Monthly Infection Control Log (Line List) September 2024, for Unit B, identified resident name, date of onset, body site, and type of infection, antibiotic start date and type, date resolved and type of isolation. The log failed to identify any resident not treated with an antimicrobial. The log identified three residents (R30, R32, R40,) with skin infections requiring antibiotics, Organisms or culture results were not identified for the wounds. The residents were placed on barrier precautions and date resolved was listed as ongoing. The log further identified one resident (R10) with respiratory infection requiring antibiotic treatment. The resident was placed on precautions and resolved date was recorded. There were no listed infections or resident infection symptoms which were not treated with antibiotics (i.e. common cold symptoms, viral infections). The facility did not provide an analysis of the infections to include patterns or what interventions were implemented to reduce incidences of further infection. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The Monthly Infection Control Log (Line List) October 2024, for Unit A, identified resident name, date of onset, body site, and type of infection, antibiotic start date and type, date resolved and type of isolation. The log failed to identify any resident not treated with an antimicrobial. The log identified three residents (R19, R7, R99) with urinary tract infections, one with colonized Methicillin-resistant Staphylococcus Aureus (MRSA), all three requiring antibiotics. Barrier isolation was identified and the infections were listed as ongoing. There were no listed infections or resident infection symptoms which were not treated with antibiotics (i.e. common cold symptoms, viral infections). The facility did not provide an analysis of the infections to include patterns or what interventions were implemented to reduce incidences of further infection. The log failed to identify R7 and R19 signs and symptoms of potential infection (identified below). The Monthly Infection Control Log (Line List) October 2024, for Unit B, identified resident name, date of onset, body site, and type of infection, antibiotic start date and type, date resolved and type of isolation. The log failed to identify any resident not treated with an antimicrobial. The log identified two residents (R32, R43,) with urinary tract infections, with the same organism, requiring antibiotics. Isolation and date resolved was not docuemented. The log further identified one resident (R30) with a wound infection and organism identified as MRSA requiring antibiotic treatment. The log identified a date of resolved infection and that isolation was required, however, did not list type of isolation implemented. There were no listed infections or resident infection symptoms which were not treated with antibiotics (i.e. common cold symptoms, viral infections). The facility did not provide an analysis of the infections to include patterns or what interventions were implemented to reduce incidences of further infection. R7's significant change Minimum Data Set (MDS) dated [DATE], identified R7 was [AGE] years of age. Diagnoses included multiple sclerosis, peripheral vascular disease, pulmonary edema and diabetes. R7's nursing progress note dated 10/27/24, identified R7 had nausea and vomiting after supper. R7's medical record failed to identify if any further follow up was completed or if R7 had been placed in isolation. R19's quarterly MDS dated [DATE], identified R19 was [AGE] years of age. Diagnoses included diabetes, hypertension, atrial fibrillation and dementia. R19's nursing progress note dated 10/21/24, identified R19 complianed of not feeling good. R19 was flushed and having difficulty staying awake. Afebrile and tested negative for COVID antigen test. R19's medical record failed to identify in any further follow up was completed or if R19 had a confirmatory COVID-19 test or if R19 had been placed in isolation. There was no documented, provided evidence which demonstrated the facility had a system for tracking non-antibiotic treated infections (i.e. viral infections); nor any evidence demonstrating a comprehensive analysis of the identified infections was completed despite have two UTI with the same causative organism. Further, there was no provided evidence the facility had reviewed or investigated the developed infections for potential causes and addressed any subsequent action needed to reduce the risk of recurrence to the same and/or other resident(s). (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	When interviewed on 10/31/24, at 3:00 p.m. registered nurse (RN)-A stated she had not been tracking or trending resident or staff illness/symptoms. The nurse responsible for infection control quit in September and RN-A had not taken the program over until about two weeks ago. RN-A was trying to get resident antibiotic use logged and tracked and had not started on tracking resident or employee symptoms of illness or infection. RN-A told the director of nursing (DON) the facility should be tracking when a resident had diarrhea or a fever, but RN-A had not been able to get tracking of infections implemented. The facility was using an infection control program called Peerlytics, but RN-A was unable to access that program. The facility was working on getting RN-A access to the computerized infection control program. - RN-A was not tracking employee illness and only recorded when staff called in with positive COVID-19. The facility did not require confirmation of test results when employees reported symptom of illness. RN-A stated it would be important to track other illness in both staff and residents to determine the source of illness and track if it could spread. RN-A just did not have the time and had only recently taken the infection preventionist role. The facility did not isolate residents for symptoms of illness. Residents were only isolated if they tested positive for COVID-19. RN-A felt the residents all had a private room and so were kind of isolated anyway. If a resident exhibited symptoms such as a cough, fever, or diarrhea the facility did not isolate them and did not require staff to wear personal protective equipment (PPE) when providing care to symptomatic residents. RN-A supposed some of the symptom's residents exhibited should require some PPE, but the facility did not direct staff to wear PPE when residents exhibited symptoms of illness. Staff should wear PPE when caring for residents with potentially contagious symptoms. Staffing took up so much of RN-A's time, there was only so much a person could do. RN-A was just trying to get what she could done. At this time, the surveillance and analysis of the facility's infection prevention and control program was requested. During interview on 10/31/24, at 2:40 p.m. the DON stated tracking and trending of resident and employee illness should be done and it was not currently being completed. The tracking and trending of illness was important so the facility could quickly recognize when they had a problem. The facility should be isolating and implementing PPE with any resident that was noted with infectious type of symptoms such as cough, fever, or diarrhea. The facility's policy Infection Control Surveillance with revision date 4/4/24, identified infection prevention began with ongoing surveillance to identify infections that were causing or have the potential to cause an outbreak. The facility would establish routine, ongoing and systematic collection, analysis, interpretation, and dissemination of surveillance data to identify infections, infection risks, communicable disease outbreaks, and to maintain or improve resident health status. The facility nurses would identify residents with symptoms or identified infections and complete a wait and watch in Peerlytics and in the residents' medical record, documenting the signs and symptoms the resident was exhibiting. The infection preventionist would be alerted to identify any necessary interventions and add to Peerlytics for follow up and data collection. The infection preventionist would utilize the information to monitor infection sit, type, pathogen if known, signs and symptoms and resident location to identify trends or clusters for action. COVID-19 Testing: (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Centers for Disease Control (CDC) website Infection Control Guidance: SARS-CoV-2 (COVID-19) dated 6/24/24, identified a single new case of COVID-19 infection in any health care provider (HCP) or resident should be evaluated to determine if others in the facility could have been exposed. Perform testing for all residents and HCP identified as close contacts or on the affected unit. Testing was recommended at day 1, day 3 and day 5, where day of exposure is day 0. If additional cases were identified, testing should continue on affected units or facility-wide every 3 to 7 days until there were no new cases for 14 days. A facility Employee COVID Line List Spread Sheet for months of September and October 2024 identified employee name, age, sex, onset date, positive testing collection date, day one isolation, day 7 test result, day 10 test result and date return to work. The spread sheet identified eight employees with onset positive dates which included: maintenance (maint)-A on 9/22/24, housekeeper (HSK)-A on 9/25/24, cook (CK)-A on 9/26/24, the director of nursing (DON) on 9/26/24, nursing assistant (NA)-F on 9/26/24, registered nurse (RN)-D on 9/27/24, NA-B 10/14/24 and care coordinator (CC)-G on 10/27/24. A facility Resident COVID Line List Spread Sheet for the month of September 2024 identified resident name, age, sex, onset date, positive testing collection date, day one isolation, day 7 test result, day 10 test result and date out of isolation. The spread sheet identified two resident names with positive test results; R5 on 9/24/24 and R7 on 9/25/24. A facility October calendar listed resident testing dates for all units on 10/2/24, 10/4/24, 10/7/24, 10/9/24, 10/11/24. Residents who resided on unit A were tested on [DATE] due to an exposure with NA-B on 10/14/24, however, the facility failed to continue COVID-19 testing day 3 and day 5 to determine if there were any additional positive cases as required. Unit A residents were tested again on 10/28/24 due to an exposure with CC-G on 10/27/24, however, the facility failed to continue COVID-19 testing day 3 and day 5 to determine if there were any additional positive cases as required. On the bottom of the calendar it was indicated any other resident testing would be done randomly with any resident that exhibited symptoms and not every three to seven days until no further new cases were identified as required. The facility documented when testing occured on resident units, the facility failed to track which residents were tested and results of individual tests. The facility documented positive employees COVID-19 test results when the tests results were reported by the employee. The facility failed to produce evidence of any employee testing. The facility failed to track and document which employees tested , when and how the employees tested as well as employee COVID-19 test results. Furthermore, the facility failed to track and document if employees tested and/or results of COVID-19 testing prior to working their scheduled shifts . The testing of residents was not completed on day 1, day 3 and day 5, after a known exposure from a positive staff members 10/14/24 and 10/28/24, as required. Nor did testing occur every three to seven days until no further additional staff or residents tested positive for COVID-19. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During interview on 10/29/24, at 9:30 a.m. RN-A stated she did not have documentation of residents testing or testing results other than individual entries in each resident's chart that were tested . RN-A was unable to identify exactly which residents had tested without going into each individual resident medical record and was unable to identify if any residents had refused or were absent when COVID-19 testing was conducted. RN-A stated she thought the facility was in outbreak when three employees all tested positive on 9/26/24, despite having been notified an employee (maintenace (maint)-A) had tested positive on 9/22/24, after working the day prior. RN-A instructed all employees to test when the facility was in outbreak, however did not track or record which employees tested or their results. The facility continued testing all residents and employees were reminded to test for COVID-19 until 10/12/24. RN-A felt, because the facility had not had any further positive COVID-19 test results since 9/27/24, the facility completed outbreak testing and were out of outbreak status on 10/12/24. On 10/14/24, NA-B reported fatigue, sore throat and a positive COVID-19 test. NA-B had worked the weekend (10/12/24 & 10/13/24) prior to positive test result on 10/14/24. RN-A did not conduct or record any formal contact tracing, other than review of where NA-B had been scheduled. RN-A felt only residents on unit A had been exposed to NA-B, because that was the unit NA-B was scheduled, so RN-A tested all residents on unit A on 10/15/24. RN-A had instructed staff to test if they knew they had exposure to NA-B, however, did not track or document which staff had contact with NA-B and/or tested . RN-A felt staff would know if they had an exposure and test accordingly. RN-A did not do formal contact tracing of who NA-B had contact with when she worked on 10/13/24 and 10/14/24, prior to having symptoms of fatigue and sore throat on 10/14/24, and positive test result. All residents on unit A tested negative for COVID-19 on 10/15/24, and no further testing was conducted. RN-A did not know why testing exposed residents was not completed on day 3 and day 5 of exposure as required. RN-A did not conduct contact tracing on employees who may have been exposed to NA-B and did not know which employees had tested when NA-B had reported positive on 10/14/24. RN-A stated CC-G reported nausea, vomiting, headache and positive COVID-19 test result on 10/27/24. RN-A did not conduct or record any formal contact tracing, other than review of where CC-G had been scheduled. RN-A felt only residents on unit A had been exposed to CC-G, so RN-A tested all residents on that unit on 10/28/24. All residents on unit A tested negative for COVID-19 on 10/28/24, and no further testing was conducted. RN-A did not know why testing exposed residents was not completed on day 3 and day 5 of exposure as required. RN-A did not conduct contact tracing on employees who may have been exposed to CC-G and did not know which employees had tested when CC-G had reported positive on 10/28/24. RN-A felt staff would know if they had an exposure and test accordingly. RN-A could not say if all staff were tested prior to starting their shift, even during the outbreak. RN-A had given all staff instructions via communication email, to test prior to their shift and so all staff were aware they needed to test. Tracking or documentation of staff testing had not been completed to ensure testing had been completed, other than documentation of the positive tests that were reported to RN-A. Employees were not required to provide proof of testing When interviewed on 10/31/24, at 2:30 p.m. the DON stated staff testing should have been tracked to keep the transmission of COVID-19 to a minimum and to keep residents safe. All testing for COVID-19 should have been documented. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The facility's Long Term Care and Assisted Living Response Plan for COVID-19 Testing, approved 9/1/20, identified an outbreak and testing trigger as one or more residents confirmed to have COVID-19, a direct care staff member who tested positive for COVID-19 and worked in the facility while ill or 48 hours prior to development of symptoms or a symptomatic resident who has tested negative. MDH and CDC would be consulted for current recommendations for the particular disease epistemology at the time that testing was considered. The infection preventionist would ensure that records were maintained regarding the testing process, resident and staff consent for testing and test results. 40943 Contact/Enhanced Barrier Precautions: R7's significant change MDS dated [DATE], identified R7 had severe cognitive imairment R7 had two stage 3 pressure ulcers and had a suprapubic indwelling urinary catheter (a tube that drains from your bladder through a small incision in your abdomen). The MDS failed to identify R7 had an MDRO. Diagnoses included multiple sclerosis (MS), type 2 diabetes, history of UTI, and peripheral vascular disease. R7's care plan revised 8/9/24, identified R7 had an activities of daily living self-care performance deficit due to weakness related to MS. The care plan directed staff to provide assist of 1-2 for repositioning, dressing, grooming, and toileting/catheter care. However, the care plan failed to address R7's need for contact precautions or enhanced barrier precautions (EBP). R7's Physical Therapy Skilled Nursing Facility Treatment Note dated 9/12/24, identified R7 had an open wound on her right ischial tuberosity and had an increased risk of infection. Precautions/Restrictions: methicillin-resistant staphylococcus aureus (MRSA). During an observation on 10/29/24 at 10:17 a.m., nursing assistant (NA)-B was providing morning cares for R7. There was a 3-drawer plastic bin outside of R7's door containing gowns, gloves, facemasks and face shields. No signage was on R7's door directing staff what personal protective equipment (PPE) was required or when it was required. R7's catheter bag was uncovered and lying on the floor. NA-B did not apply a gown or gloves and stated the only time she needed to do so was if she was emptying R7's urinary catheter bag because pee could get on me. Wearing gowns and gloves for catheters was something new, but NA-B could not remember what it was called. No one had ever explained why sometimes staff needed to wear personal protective equipment (PPE) and it was something staff never did before. It's just something to be 'extra'. It doesn't make sense but there's so many by-the-book rules in nursing homes. The bag touching the floor was overkill. To tell you the truth, in a nursing home, care was never going to be perfect and just too much was expected. NA-B could not explain what an MDRO was and/or if R7 was known to have a history of MRSA. During an observation on 10/29/24 at 12:23 p.m., NA-C assisted R7 to the toilet using the ceiling lift. NA-C did not don a gown and gloves. - At 12:28 p.m., NA-C put on gloves and pulled down R7's pants, then lowered R7 onto the toilet. NA-C then hung R7's catheter bag from the toilet handrail. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	- At 12:29 p.m., R7's catheter bag fell on to the floor. NA-C picked up the bag and again hung it from the toilet handrail. I don't know if it will hang there or not. NA-C did not clean R7's catheter bag. NA-C did not remove her soiled gloves and was touching scrubs and high touch areas in the bathroom. - At 12:33 p.m., NA-C straightened R7's pillows and bed linens. NA-C continued to wear the same soiled gloves. - At 12:35 p.m., NA-C raised R7 off the toilet and pulled up R7's pants. NA-C stated R7 didn't have a bowel movement so did not need wiping. NA-C continued to wear the same gloves. NA-C transferred R7 to bed using the ceiling lift and continued touching high touch areas with the same soiled gloves. During an interview on 10/29/24 at 12:23 p.m., NA-C stated you only need to wear a gown when you empty R7's catheter. That's it. NA-C stated she wore gloves, but the 3-drawer bin outside R7's room was left over from when R7 had COVID-19 in previous weeks. Someone just forgot to take it away. NA-C stated she was unaware if R7 had a history of a MRSA or any type of infection. NA-C stated she had never been told why sometimes staff wore PPE and other times they didn't need to. During an interview on 10/29/24 at 10:39 a.m., licensed practical nurse (LPN)-A could not recall what EBP was called or when it was required but only staff needed to wear a gown when doing anything with the catheter. I don't know why but that's what we were told. It started about a year ago, when staff needed to wear a gown when doing anything with a wound and/or a catheter. Staff were given a bunch of papers to review. LPN-A stated she asked for a simple explanation and not a stack of papers because it was just too much to understand, but LPN-A was told it's just the rules. That was just it. Staff should be wearing a gown and gloves every time they're in R7's room because we're supposed to. That's just what staff were told. During an observation on 10/30/24 at 7:42 a.m., NA-B did not gown or glove and entered R7's room to answer R7's yell for help. NA-B stated she did not gown or glove because she was told she only needed to do that if she was doing catheter care, but now that's changed. I don't know what I'm supposed to do now. NA-B pointed to R7's 3 drawer plastic bin that contained PPE and stated, I really don't know what that's about. NA-B stated she had not received any education regarding infection prevention precautions. You're my education. During an interview on 10/30/24 at 9:14 a.m., LPN-A stated anytime staff go into R7's room and provide care, staff were supposed to wear a gown. We need to work on that. LPN-A stated R7 had MRSA in her (R7) wounds. LPN-A could not explain the different types of precautions: standard, contact, droplet, and/or EBP. LPN-A became tearful and stated staff did not receive education. It started at the top and never trickled down to staff on the floor. We're not safe. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 10/31/24 at 1:10 p.m., registered nurse (RN)-A stated she took over the role of facility infection preventionist two weeks prior for the duration of her contract. I inherited this. Staff needed education regarding precautions. Any resident with a catheter or a wound (because there could also be an unknown organism) needed Enhanced Barrier Precautions (EBP). However, RN-A did not have a listing of residents with a known MDRO, a wound or a catheter. RN-A went room to room to look for a catheter. I just know. For MDRO, staff wouldn't know that unless they went digging in the charts. RN-A had just found out the other day R7 was colonized with MRSA and should be on Contact Precautions. Well, I guess staff did need to dig in charts. You know you are asking me for information. I find it hard to I know I'm accountable for speaking for the previous IP nurse. Staff were expected to follow Centers for Disease Control and Prevention (CDC) guidance to prevent the spread of infection. During an interview on 10/31/24 at 2:18 p.m., the director of nursing (DON) stated staff were expected to follow CDC precautions guidance for donning/doffing PPE per facility policy and to demonstrate understanding of infection control to prevent the spread of microorganisms in the facility to prevent possible infections. 40948 R30's admission MDS dated [DATE], identified R30 was cognitively intact and had a stage 3 pressure ulcer with a multi-drug resistant organism (MDRO). R30's care plan dated 10/1/24, identified Methicillin-resistant Staphylococcus aureus (MRSA) (an infection which is caused by a type of staph bacteria that's become resistant to many of the antibiotics used to treat ordinary staph infections. A type of MDRO) Intervention included contact isolation(precautions): wear gown, gloves and mask when providing any cares. Mask or face shield to be worn during procedures. The care plan did not address EBP for having a chronic wound. R30's provider's order dated 9/26/24, identified dressing change to right residual limb (the limb with stage 3 pressure ulcer and MRSA): cleanse with wound cleaner, Aquacel ribbon (a wound dressing that absorbs wound fluid and creates a moist environment to help wounds heal) lightly packed into wound bed and cover with a large Tegaderm foam (a highly absorbent, breathable wound dressing). During observation on 10/29/24 at 10:19 a.m., there was a sign on R30's door identifying resident was on contact precautions. An isolation cart was located outside her door and held gowns, gloves, face masks, and eye protection. During an interview on 10/29/24 at 12:40 p.m., nursing assistant (NA)-A stated R30 was on contact precautions and whenever NA-A would go into the room to assist the resident with cares, bed mobility, transfers, toileting or changing linens NA-A would wear a gown and gloves to help. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During observations on 10/30/24 at 8:43 a.m., physical therapy assistant (PTA)-A approached R30's room and took gloves from the isolation cart outside of the door. PTA-A then entered the room without putting on gloves. PTA-A gathered the supplied for the dressing change and prepared them for the dressing change. With the ungloved hands, PTA-A removed the ace bandage, lymph wrap (a wrap for legs to offer management of swelling and surgical areas) and stump sock (a compression stocking placed on a recently amputated limb). PTA-A then sanitized her hands and put gloves on and removed the final dressing over the wound. The bandage had some red drainage on it and the surgical site wound had a pencil eraser size hole with a small amount of purulent (pus) drainage. Wearing the same gloves, she cleaned the wound with saline spray and a 4 x 4 gauze dressing. PTA-A then removed the gloves and sanitized her hands. PTA-A took a cell phone from her pocket and took a picture of the wound for R30's chart and then placed the cell phone directly on R30's bed. PTA-A then sanitized her hand and placed clean gloves on. PTA-A then placed iodoform gauze (an antiseptic), then covered with an Aquacel dressing (a dressing to help contain drainage) and then placed foam dressing over the wound. PTA-A then removed the dirty gloves and sanitized her hands and gathered the remaining supplies and put them away in R30's room and placed the cell phone in her bag and then sanitized her hands. - At 9:00 a.m., PTA-A was finished with the dressing change and proceeded to work on exercises with R30 without wearing gloves. Exercises included marching in place while sitting on the edge of the bed by lifting her knees. Then asked resident to kick out with amputated limb and was placing ungloved hand on the dressing she just changed. PTA-A then rubbed her hands together and placed them on the outside of each knee and had R30 push against her hands. PTA-A then moved to the inside of the knees and did the same. A gait belt was then placed on R30 and with a walker PTA-A assisted R30 to stand while she held the gait belt and walker with her ungloved hands. R30 then proceeded to exercise her amputated limb. PTA-A was standing by R30 with on ungloved hand on the gait belt and one on the walker and did that exercise twice. R30 was then seated on the edge of her bed and repeated the initial exercises done with ungloved hands, which included placing the ungloved hands on the dressing which was just changed. When finished with the exercises PTA-A with her ungloved hands rolled up the Ace bandage which was originally wrapped around the amputated limb at the beginning of the observation. PTA-A then sanitized her hands and left the room. PTA-A did not wear a gown at any time during the encounter. During an interview on 10/30/24 at 7:56 a.m., PTA-A stated she seen the sign on door indicating contact precautions and knew it was for an infection in the wound. Since it had been mostly contained, she had been only wearing gloves during the dressing changes and was unsure of why a gown would be needed. PTA-A stated nobody reviewed contact precautions, and the only times a gown was worn is if wounds were worse than R30's, if the resident had a catheter or covid. R30 was on contact precautions, and she should probably have been wearing a gown and gloves. During and interview on 10/31/24 at 12:50 a.m., RN-A stated residents who were colonized with MDRO in urine and had a catheter or had an MDRO in a wound would be expected to be on contact precautions. Meaning any staff doing close contact cares, bed mobility, or dressing changes with a resident on contact precautions would be wearing a gown and gloves. The importance of contact precautions is to protect the resident on any infections that staff my unknowing bring into the room, and to protect the staff and other resident after contact with infected resident. R30 was on contact precautions for a MDRO in a wound on her leg and would expect all staff to follow contact precautions. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 10/31 24 at 1:07 p.m., the DON stated it was the expectation that all staff would follow infection control policies, and this included contact precautions. This was to protect the resident on contact precautions and all the other residents in the building. The facility's Transmission Based Precautions policy dated 4/4/24 identified contact precautions were intended to prevent transmission of infections and require the use of gown and gloves upon entering the room. The facility's Multidrug Resistant Organisms (MDROs) policy dated copyright 2009 identified contact precautions shall be considered for residents infected or colonized with a MDRO. 42075 Standard Precautions: R99's admission MDS dated [DATE], identified R99 had moderate cognition and required intermittent catheterization. Diagnoses included neurogenic bladder, Alzheimer's disease, and dementia. R99's physician notes dated 10/17/24, identified R99 performed catheterization by himself as needed to empty his bladder. R99's care plan dated 10/22/24, failed to identify R99's catheterization plan and goals including what personal protective equipment was needed. R99's medication administration report (MAR) dated 10/1/24 through 10/31/24, identified staff were required to perform catheterization for R99 every shift or as requested by the resident due to the resident's neuromuscular dysfunction of the bladder. On 10/29/24 at 10:17 a.m., R99 was seated in a wheelchair in his room. R99 stated he used a catheter to empty his bladder due to being unable to urinate on his own. Staff used gloves but did not wear gowns when catheterizing him. On 10/30/24 at 1:30 p.m., registered nurse (RN)-A stated when providing direct cares for R99, including being straight cathed, staff were required to wear a gown and gloves. On 10/30/24 at 1:55 p.m., licensed practical nurse (LPN)-A stated R99 required staff to use a straight catheter to empty

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F 0940 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Develop, implement, and/or maintain an effective training program for all new and existing staff members. 40943 Based on interview and document review, the facility failed to assure employee infection control training and education was completed for 4 of 10 (LPN-A, LPN-B, RN-A, DON) staff reviewed for training and education. This had the potential to affect all 46 residents residing in the facility. Findings include: Review of personnel records identified the following: - Director of nursing (DON) completed no assigned staff education including: dementia care, abuse, resident rights, quality assurance, infection prevention, compliance and ethics, behavior health, and activities of daily living (ADLs). - Registered nurse (RN)-E completed education for resident rights 9/20/23, behavior health 8/3/23, and abuse 6/27/23, but had no further completed education. - Nursing assistant (NA)-I did not complete education regarding effective communication - NA-B completed no education in 2024. During an interview on 11/6/24 at 12:42 p.m., human resources (HR)-A stated she used to assign the annual staff education but registered nurse (RN)-C now assigned assigned the annual training for staff and presented some of the general orientation education. The annual training was according to staff hire date: - RN-E: HR-A stated RN-E hire date was 8/29/13 and was past due for annual training. RN-C assigned annual trainings at the beginning of the staff's anniversary month and a reminder sheet with their log in was put in their box. However, HR-A stated it did not appear that RN-E had annual trainings assigned to RN-E. - DON: HR-A stated the DON did not complete any of the new hire trainings. - NA-I: HR-A stated NA-I's hire dated was 6/27/23. NA-I had no specific dementia training at the time she transferred position from dietary to nursing. NA-I's last dementia training was in 2022. NA-I would have needed extra courses assigned to her that dietary were not assigned. However, HR-A could not determine if any education was assigned to NA-I. - NA-B: HR-A stated NA-B's hire date was 6/28/16 and annual training was assigned to NA-B on 11/9/23. However, NA-B had not completed any training since that time. (continued on next page)

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F 0940 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 11/6/24 at 1:09 p.m., RN-C stated she did the general orientation and assigned staff education; which they were behind on. RN-C had missed assigning education for RN-E. RN-C stated she (RN-C) was responsible to follow-up and ensure the education had been done. RN-C had begun her role July 2024 and had not figured out a process to ensure staff had completed education. RN-C the person formerly responsible for it had a spreadsheet but RN-C had not figured out a process yet. It was important for staff to complete education as expected so staff knew how to take care of our vulnerable residents. During an interview on 11/06/24 at 2:17 p.m., the DON stated she was just informed of the need for staff education. The DON believed she only needed to provide her continuing education transcripts when she started her role and did not have log in information until now to complete the assigned education. The DON stated she was informed of the lack of education/training and staff were expected to complete as directed in the facility policy. During an interview on 11/6/24 at 2:18 p.m., the administrator stated staff were expected to complete education as directed by the facility policy. The Facility Assessment 2023 dated 12/18/23, identified staff attend General Orientation upon hire and annually. General Orientation included: - Emergency Preparedness - Abuse Prevention - Vulnerable Adult Reporting - Resident Rights - AWAIR&OSHA - Infection Control, TB, Blood borne pathogens, Emerging Infectious Diseases - Medicare Fraud, Waste & Abuse - Safety Program & Plan - Elder Justice Act - Safe Resident Handling - HIPAA - Trauma Informed Care - QAPI, Survey Preparedness - Compliance & Ethics (continued on next page)

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F 0940 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	- Communication - Staff Burnout - Assisted Living [NAME] of Rights - Mechanical Lift Training/Competencies Direct caregivers were provided 8 hours of dementia education upon hire. Non-direct caregivers were provided 4 hours of dementia education upon hire. All staff are provided at least 2 hours of dementia education annually. However, the assessment failed to identify nursing assistants required 12 hours of continuing education annually. A facility policy related to staff training/education was requested but not provided

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F 0941 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Develop, implement, and/or maintain an effective training program that includes effective communications for direct care staff members. 40943 Based on interview and document review, the facility failed to ensure staff completed mandatory communication training for 4 of 10 staff (DON, RN-E, NA-B, NA-I) reviewed for training requirements. This had the potential to affect all 46 residents residing in the facility. Findings include: Review of personnel records identified the following: - Director of nursing (DON) had not completed staff education including effective communication. - Registered nurse (RN)-E had not completed staff education including effective communication. - Nursing assistant (NA)-B had not completed staff education including effective communication. - NA-I had not completed staff education including effective communication. During an interview on 11/6/24 at 1:09 p.m., RN-C stated she was responsible for staffing training and was aware staff were not compliant with staff education requirements including effective communication training. During an interview on 11/06/24 at 2:17 p.m., the DON stated she was just informed of the need for staff education. The DON believed she only needed to provide her continuing education transcripts when she started her role and did not have log in information until now to complete the assigned education. The DON stated she was informed of the lack of education/training and staff were expected to complete as directed in the facility policy. During an interview on 11/6/24 at 2:18 p.m., the administrator stated staff were expected to complete education as directed by the facility policy. The Facility Assessment 2023 dated 12/18/23, identified the community surrounding the facility was home to a Laotian community and the facility had served Laotian residents in the past five to ten years. During admission, residents were given the opportunity to make special requests in terms of food, spiritual needs, and cultural considerations. Cultural considerations were included on our care conference agenda and addressed upon admission and quarterly. However, the assessment failed to identify how staff would effectively communicate with a resident that was a non-English native speaker.

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F 0942 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure that staff members are educated on resident rights and facility responsibilities to properly care for its residents. 40943 Based on interview and document review, the facility failed to ensure staff completed mandatory training for resident rights for 3 of 10 staff (DON, RN-E, NA-A) reviewed for training requirements. This had the potential to affect all 46 residents residing in the facility. Findings include: Review of personnel records identified the following: - Director of nursing (DON) had not completed staff education including resident rights. - Registered nurse (RN)-E had not completed staff education including resident rights since 9/20/23. - Nursing assistant (NA)-I had not completed staff education including resident rights. During an interview on 11/6/24 at 1:09 p.m., RN-C stated she was responsible for staffing training and was aware staff were not compliant with staff education requirements including resident rights training. During an interview on 11/06/24 at 2:17 p.m., the DON stated she was just informed of the need for staff education. The DON believed she only needed to provide her continuing education transcripts when she started her role and did not have log in information until now to complete the assigned education. The DON stated she was informed of the lack of education/training and staff were expected to complete as directed in the facility policy. During an interview on 11/6/24 at 2:18 p.m., the administrator stated staff were expected to complete education as directed by the facility policy. Facility Assessment 2023 dated 12/18/23, identified staff attend General Orientation upon hire and annually. General Orientation included Resident Rights. A facility policy related to resident rights was requested but not provided.

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	245329	A. Building B. Wing	11/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Warroad Care Center	1401 Lake Street Northwest Warroad, MN 56763

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F 0943 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Give their staff education on dementia care, and what abuse, neglect, and exploitation are; and how to report abuse, neglect, and exploitation. 40943 Based on interview and document review, the facility failed to provide facility specific abuse prevention training to 5 of 10 employees (DON, RN-E, LPN-C, NA-I, NA-B) reviewed for training. This had the potential to affect all 46 residents residing in the facility. Findings include: Review of personnel records identified the following: - Director of nursing (DON) completed no assigned staff education including abuse. - Registered nurse (RN)-E last complete abuse training 6/27/23. - Licensed practical nurse (LPN)-C last completed abuse training 4/20/23. - Nursing assistant (NA)-I last completed abuse training 2/21/22. - NA-B completed no education in 2024. During an interview on 11/6/24 at 1:09 p.m., RN-C stated she was responsible for staffing training and was aware staff were not compliant with staff education requirements including abuse, neglect, and exploitation training. During an interview on 11/06/24 at 2:17 p.m., the DON stated she was just informed of the need for staff education. The DON believed she only needed to provide her continuing education transcripts when she started her role and did not have log in information until now to complete the assigned education. The DON stated she was informed of the lack of education/training and staff were expected to complete as directed in the facility policy. During an interview on 11/6/24 at 2:18 p.m., the administrator stated staff were expected to complete education as directed by the facility policy. The Facility Assessment 2023 dated 12/18/23, identified staff attend General Orientation upon hire and annually. General Orientation included abuse prevention. A facility policy related to staff training/education was requested but not provided.

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F 0944 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Conduct mandatory training, for all staff, on the facility's Quality Assurance and Performance Improvement Program. 40943 Based on interview and document review, the facility failed to provide mandatory training on the facility specific Quality Assurance and Performance Improvement (QAPI) program to include goals and various elements of the program, how the facility intends to implement the program, staff's role in the facility's QAPI program, or how to communicate concerns, problems, or opportunities for improvement to the facility's QAPI program for 5 of 10 employees (DON, RN-E, LPN-C, NA-B, NA-I) reviewed for training requirements. Findings include: Review of personnel records identified the following: - Director of nursing (DON) completed no assigned staff education including quality assurance. - Registered nurse (RN)-E did not complete staff education including quality assurance. - Licensed practical nurse (LPN)-C last completed quality assurance training 4/20/23. - Nursing assistant (NA)-B did not complete staff education including quality assurance - NA-I did not complete staff education including quality assurance During an interview on 11/6/24 at 1:09 p.m., RN-C stated she was responsible for staffing training and was aware staff were not compliant with staff education requirements including effective QAPI training. During an interview on 11/06/24 at 2:17 p.m., the DON stated she was just informed of the need for staff education. The DON believed she only needed to provide her continuing education transcripts when she started her role and did not have log in information until now to complete the assigned education. The DON stated she was informed of the lack of education/training and staff were expected to complete as directed in the facility policy. During an interview on 11/6/24 at 2:18 p.m., the administrator stated staff were expected to complete education as directed by the facility policy. Facility Assessment 2023 dated 12/18/23, identified staff attend General Orientation upon hire and annually. General Orientation included QAPI, Survey Preparedness A facility policy related to staff training/education was requested but not provided.

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F 0945 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Include as part of its infection prevention and control program, mandatory training that includes written standards, policies, and procedures for the program. 40943 Based on interview and record review the facility failed to ensure staff were educated on infection control policies and procedures for 4 of 10 staff (DON, RN-E, LPN-C,NA-B) who's training records were reviewed and 3 of 3 staff (NA-B, NA-C, LPN-A) who identified they were not educated in procedures for standard, transmission-based and enhanced barrier precautions (EBP). This had the potential to impact all 46 residents who reside in the facility. Findings include: Review of personnel records identified the following: - Director of nursing (DON) completed no assigned staff education including infection prevention. - Registered nurse (RN)-E did not complete infection prevention training. - Licensed practical nurse (LPN)-C last completed infection prevention education 4/20/23. - Nursing assistant (NA)-B completed no assigned staff education including infection prevention in 2024. During an interview on 10/29/24 at 10:17 a.m., NA-B was unable describe to differentiate between the different types of precautions and/or when to use them. During an interview on 10/29/24 at 12:23 p.m., NA-C stated she had never been provided education regarding enhanced barrier precautions nor been told why sometimes staff wore personal protective equipment and other times they didn't need to. During an interview on 10/29/24 at 10:39 a.m., licensed practical nurse (LPN)-A could not recall what EBP was called or when it was required but only staff needed to wear a gown when doing anything with the catheter. I don't know why but that's what we were told. It started about a year ago, when staff needed to wear a gown when doing anything with a wound and/or a catheter. Staff were given a bunch of papers to review. LPN-A stated she asked for a simple explanation and not a stack of papers because it was just too much to understand, but LPN-A was told it's just the rules. That was just it. Staff should be wearing a gown and gloves every time they're in R7's room because we're supposed to. That's just what staff were told. During an observation on 10/30/24 at 7:42 a.m., NA-B stated she had not received any education regarding infection prevention precautions. You're my education. During an interview on 10/30/24 at 9:14 a.m., LPN-A could not explain the different types of precautions: standard, contact, droplet, and/or EBP. LPN-A became tearful and stated staff did not receive education. It started at the top and never trickled down to staff on the floor. We're not safe. (continued on next page)

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F 0945 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 10/31/24 at 1:10 p.m., registered nurse (RN)-A stated she took over the role of facility infection preventionist two weeks prior for the duration of her contract. I inherited this. Staff were expected to follow Centers for Disease Control and Prevention (CDC) guidance to prevent the spread of infection. However, staff needed education regarding precautions. RN-A could not verbalize what education, if any, had been provided to staff prior to the start of survey. During an interview on 10/31/24 at 2:18 p.m., the director of nursing (DON) stated staff were expected to follow CDC precautions guidance for donning/doffing PPE per facility policy and to demonstrate understanding of infection control to prevent the spread of microorganisms in the facility to prevent possible infections. The DON could not verbalize what education, if any, had been provided to staff prior to the start of survey. The Facility Assessment 2023 dated 12/18/23, identified staff training/education and competencies that were necessary to provide the level and types of support and care needed for the residents. General orientation was provided upon hire and annually. General orientation included education/training related infection control, blood borne pathogens and emerging infectious disease. However, the assessment failed to identify staff education requirements related to transmission-based precautions. Infection Prevention Plan Policy revised 4/4/24, identified would designate one individual as the infection preventionist (IP) who is responsible for the facility's IPCP. The infection preventionist would complete specialized training in infection prevention and control. However, the plan failed to identify the staff eduation/training required for infection prevention and/or regarding transmission-based precautions.

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F 0946 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide training in compliance and ethics. 40943 Based on interview and document review, the facility failed to ensure 4 of 10 staff (DON, RN-E, LPN-C, NA-B) received annual training on behaviors in Alzheimer's disease or related disorders, problem solving with challenging behaviors, and communication skills. This had the potential to affect all 46 residents residing in the facility. Findings include: Review of personnel records identified the following: - Director of nursing (DON) completed no assigned staff education including compliance and ethics. - Registered nurse (RN)-E did not complete compliance and ethics training. - Licensed practical nurse (LPN)-C last completed compliance and ethics traninig 4/20/23. - Nursing assistant (NA)-B completed no assigned staff education including compliance and ethics in 2024. During an interview on 11/6/24 at 1:09 p.m., RN-C stated she was responsible for staffing training and was aware staff were not compliant with staff education requirements including compliance and ethics training. During an interview on 11/06/24 at 2:17 p.m., the DON stated she was just informed of the need for staff education. The DON believed she only needed to provide her continuing education transcripts when she started her role and did not have log in information until now to complete the assigned education. The DON stated she was informed of the lack of education/training and staff were expected to complete as directed in the facility policy. During an interview on 11/6/24 at 2:18 p.m., the administrator stated staff were expected to complete education as directed by the facility policy. The Facility Assessment 2023 dated 12/18/23, identified staff attend General Orientation upon hire and annually. However, the facility assessment failed to identify the need for staff education/training related to behavioral health. A facility policy related to staff training/education was requested but not provided.

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. 40943 Based on interview and document review, the facility failed to ensure 12 hours of annual in-service training was completed for 2 of 5 nursing assistants (NA-A, NA-B) reviewed for in service requirements. This had the potential to affect all 46 residents residing in the facility. Findings include: Review of personnel records identified the following: - Nursing assistant (NA)-I did not complete 12 hours of continuing education. - NA-B did not complete 12 hours of continuing education. During an interview on 11/6/24 at 12:42 p.m., human resources (HR)-A stated she used to assign the annual staff education, but registered nurse (RN)-C assigned staff education now. RN-C assigned the annual training for staff and presented some of the general orientation education. The annual training was according to staff hire date: - NA-I: HR-A stated NA-I's hire dated was 6/27/23. NA-I had no specific dementia training at the time she transferred position from dietary to nursing. NA-I's last dementia training was in 2022. NA-I would have needed extra courses assigned to her that dietary was not assigned. However, HR-A could not determine if any education was assigned to NA-I. - NA-B: HR-A stated NA-B's hire date was 6/28/16 and annual training was assigned to NA-B on 11/9/23. However, NA-B had not completed any training since that time. During an interview on 11/6/24 at 1:09 p.m., RN-C stated she was responsible for staffing training and was aware staff were not compliant with staff education requirements including compliance and ethics training. During an interview on 11/06/24 at 2:17 p.m., the DON stated she was just informed of the need for staff education. The DON stated she was informed of the lack of education/training and staff were expected to complete as directed in the facility policy. During an interview on 11/6/24 at 2:18 p.m., the administrator stated staff were expected to complete education as directed by the facility policy. Facility Assessment 2023 dated 12/18/23, identified staff attend General Orientation upon hire and annually. Direct caregivers were provided 8 hours of dementia education upon hire. Non-direct caregivers were provided 4 hours of dementia education upon hire. All staff are provided at least 2 hours of dementia education annually. However, the assessment failed to identify nursing assistants required 12 hours of continuing education annually. A facility policy related to staff training/education was requested but not provided.

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F 0949 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide behavior health training consistent with the requirements and as determined by a facility assessment. 40943 Based on interview and document review, the facility failed to ensure 3 of 10 staff (DON, RN-E, NA-B) received annual training on behaviors in Alzheimer's disease or related disorders, problem solving with challenging behaviors, and communication skills. Findings include: Review of personnel records identified the following: - Director of nursing (DON) completed no assigned staff education including behavioral health. - Registered nurse (RN)-E last completed behavioral health training 8/3/23. - Nursing assistant (NA)-B completed no assigned staff education including behavioral health in 2024. During an interview on 11/6/24 at 12:42 p.m., human resources (HR)-A stated she used to assigned the annual staff education but registered nurse (RN)-C assigned staff education now. RN-C assigned the annual training for staff and presented some of the general orientation education. The annual training was according to staff hire date: - DON: HR-A stated the DON did not complete any of the new hire trainings. - RN-E: HR-A stated RN-E hire date was 8/29/13 and was past due for annual training. RN-C assigned annual trainings at the beginning of the staff's anniversary month and a reminder sheet with their log in was put in their box. However, HR-A stated it did not appear that RN-E had annual trainings assigned to RN-E. - NA-B: HR-A stated NA-B's hire date was 6/28/16 and annual training was assigned to NA-B on 11/9/23. However, NA-B had not completed any training since that time. During an interview on 11/6/24 at 1:09 p.m., RN-C stated she was responsible for staffing training and was aware staff were not compliant with staff education requirements including behavioral health training. During an interview on 11/06/24 at 2:17 p.m., the DON stated she was just informed of the need for staff education. The DON believed she only needed to provide her continuing education transcripts when she started her role and did not have log in information until now to complete the assigned education. The DON stated she was informed of the lack of education/training and staff were expected to complete as directed in the facility policy. During an interview on 11/6/24 at 2:18 p.m., the administrator stated staff were expected to complete education as directed by the facility policy. (continued on next page)

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F 0949 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The Facility Assessment 2023 dated 12/18/23, identified staff attend General Orientation upon hire and annually. However, the facility assessment failed to identify the need for staff education/training related to behavioral health. A facility policy related to staff training/education was requested but not provided.